

A Judicial Benchbook on Drugs and Families

KF
3829
N2
J8
1993

**Developed for
the State Justice Institute**



by

**The ABA Center on Children and
the Law**



Library
National Center for State Courts
300 Newport Ave.
Williamsburg, VA 23187-8798

HOW TO USE THIS BOOK

There are five ways to find information

1. Chapter Index
2. Subject Index
3. Main Idea Index
4. Colored Tabs
5. Sub-index Behind Each Tab

*Rec'd
6-27-95*

Preface

This bench book is prepared for the State Justice Institute by the American Bar Association Center on Children and the Law.

The need for the book became apparent during our development of judicial training on drug and alcohol issues in family law cases. A common fund of knowledge seemed required so that over time courts would begin to administer the drug and alcohol issues in their cases in a similar way. With that same attention to common knowledge, a book for social service agencies has been prepared to accompany this bench book. Judges may offer that book to their child protection agencies to guide social workers about the court's expectations.

The Board of Advisors, who were asked to serve based on their thorough knowledge of substance use or of the applicable law, offered a diversity of professions and points of view. They are::

Mignon Beranek, Deputy State Courts Administrator, State of Florida

Marilyn Benoit, M.D., Dept. of Psychiatry, Children's National Medical Center, Washington D.C.

Ira J. Chasnoff, M.D., President, National Association for Perinatal Addiction Research and Education, Chicago, Illinois

James A. Farrow, M.D., Director, Adolescent Clinic, University of Washington, Seattle, Washington

Janet Fink, J.D., Assembly Codes Commission, State of New York

The Hon. Ernestine Gray, Orleans Parish Juvenile Court, New Orleans, Louisiana

Ivory Johnson, Deputy Director, Children's Services Bureau, San Diego, California

The Hon. J. Dean Lewis, Juvenile and Domestic Relations Court, Fredericksburg, Virginia

The Hon. Truman A. Morrison III, D.C. Superior Court, Washington D.C.

The Hon. Mike McPhail, Forrest County Juvenile Court, Hattiesburg, Mississippi

Ms. **Janice Munsterman**, our State Justice Institute coordinator, reliably gave support and encouragement throughout the project. We thank her for that.

For special subject areas, we found ourselves repeatedly calling upon the advice of certain experts. On mental health issues, Board member **Dr. Marilyn Benoit** joined the following persons to explain preferred mental health assessment practices: **Robert O. Randle, Ph.D.**, Supervising Psychologist of the Youth Forensic Unit, D.C. Superior Court, and **Richard Lopez, Ph.D., J.D.**, Acting Director, Substance Abuse Unit, D.C. General Hospital. Dr. Lopez involved us in clinical observations, and Dr. Randle tested each of our theses against ac-

tual forensic practice. On infant assessment issues, **Katherine Frier, Ph.D.**, University of Miami School of Medicine, gave valuable analyses of Apgar scores, Brazelton Neonatal Behavioral Assessments, and the Bayley Scales of Child Development. On adolescent issues we found ourselves often turning to Board member **Dr. James Farrow**, Director of the Adolescent Clinic at the University of Washington School of Medicine. A close reading of our bibliographies at the end of each chapter will reveal the aid and advice of Board member **Dr. Ira J. Chasnoff**, and his capable support faculty at the National Association for Perinatal Addiction Research and Education. To understand judicial practice, we formed a close working relationship with Board member **Hon. J. Dean Lewis**, who guided us through several early versions of the bench book.

We deeply appreciate the efforts of three courts that sponsored pilot use of the bench book: D.C. Superior Court, **Hon. Geoffrey M. Alprin**, Presiding Judge of the Family Division; Circuit Court for Baltimore City, **Hon. David B. Mitchell** directing the project; and Juvenile and Domestic Relations Court, Fifteenth Judicial District, State of Virginia, **Hon. J. Dean Lewis**, presiding. With the encouragement of these judges we also trained attorneys and social service personnel who practice in their courts.

We feel grateful for the wholehearted efforts of the ABA Center's staff and consultants. Sally Inada, the marketing director, was tireless and clever. David Williams offered inventive graphics. Rita Lewis provided telephone, typing and mailing support, even when our needs were spur-of-the-moment. Howard Davidson, Director of the Center, maintained a fund of bright ideas for us to draw upon.

Author:

Judith Larsen
Special Consultant
ABA Center on Children and the Law

Project Director:

Robert Horowitz
Associate Director
ABA Center on Children and the Law

CHAPTER INDEX

Chapter Index

Preface preface

Chapter A: DRUG TESTS

Urine Drug Screens..... A-3

Other Tests (Blood, Meconium, Breath, Hair, Saliva) A-9

“Look Alike” Substances A-11

Passive Ingestion..... A-13

Fourth Amendment Issues A-15

Obtaining Drug Test Records A-21

When To Order Drug Tests..... A-25

Appendix

 Order For Drug Screen A-29

 Examination Of Laboratory Personnel A-31

 Examination Of Toxicologist Or Chemist A-34

 Chart of Drug and Drug Effects A-36

 End Notes A-37

Chapter B: MEDICAL ASSESSMENTS

Infant; Toddler

 Intoxication And Withdrawal B-5

 Drug Tests..... B-9

 Other Exposure Signs B-11

 Congenital Deformities..... B-13

 Cocaine Reactions..... B-17

 Alcohol Reactions..... B-19

 Neurobehavioral Tests B-27

 Role Of Father..... B-29

 Passive Ingestion..... B-31

Child; Teen

 Accidental Ingestion B-37

 Adult-Inflicted Abuse B-39

 Teen Health Issues B-41

Pregnant Woman - Fetus

 Health Issues B-45

 Court Use Of Medical Records..... B-47

Records

Interpreting Medical Records	B-51
Obtaining Medical Records	B-55

Appendix

Checklist: Medical, Newborn	B-59
Order For Neurobehavioral/ Developmental Assessment	B-63
Order For Child's Physical Exam	B-65
Examination Of Neonatologist Or Neonatal Nurse	B-66
End Notes	B-73

Chapter C: MENTAL HEALTH ASSESSMENT

Kind of Assessments

Court Identification Of Substance Use	C-5
When To Schedule Assessments	C-7
Mental Health Screening	C-9
Court Guidance To Mental Health Professionals	C-11
Full Mental Status Assessment (Psychiatric, Psychological)	C-13
Psychiatric Assessment	C-15
Psychological Tests	C-17
Infant-Child Mental Health Assessments	C-19
Adolescent Mental Health Issues	C-23

Interpretation Of Reports (DSM III-R)

Use, Abuse and Dependence	C-27
Organic Mental Syndromes	C-31

Records

Obtaining, With Consent or Court Order	C-35
Obtaining, Without Consent	C-37

Appendix

Checklist: Scheduling Family Assessments	C-41
Checklist: Child, Developmental	C-42
Examination Of Psychiatrist Or Psychologist	C-44
Order For Mental Health Screening	C-48
Order For Mental Health Assessment	C-49
List Of Commonly-Administered Psychological Tests	C-51
Annotations Of Specific Tests	C-53
End Notes	C-63

Chapter D: TREATMENT

Adults, Generally

Treatment, Defined	D-5
Overview Of Treatment Modalities	D-7
Treatment Needs Resulting From Use Of Particular Substances ..	D-9
Relapse	D-13
Aftercare	D-15

Women, Cultural Minorities

Separate Treatment from Men	D-19
Efficacy of Treatment for Pregnant Woman-Fetus	D-21
Detoxification Goals for Pregnant Woman-Fetus	D-23
Pregnant Women: Need for Multiple Services	D-25
Cultural Minorities	D-29

Children, Teens

Substance-Exposed Newborns	D-33
Substance-Exposed Toddlers	D-35
Child Victims of Drug/Alcohol Abusers	D-37
Adolescent Treatment Issues	D-39

Appendix

List of Local Treatment Facilities (to be filled in by local jurisdiction) .	D-43
Order for Drug/Alcohol Treatment	D-44
Order for Priority Treatment for Pregnant Woman	D-47
End Notes	D-49

Chapter E: SOCIAL SERVICES

Reasonable Efforts

Reasonable Efforts Law	E-5
Risk Assessment	E-7
Case Plan	E-9
In-Home Services	E-11
Kinship Placements	E-13
Visitation	E-15

Community Resources

Public Benefits And Other Community Resources	E-19
Drug And Alcohol Treatment	E-21
"Early Intervention": Infants And Children	E-23
Case Management	E-27

Appendix

Array Of Services (Federally Funded)	E-31
Protocol for Making Reasonable Efforts in Drug-Related Dependency Cases (Nat. Council on Juv. & Family Court Judges).....	E-37
Order For Multiple Services To A Family	E-40
Order For Visitation	E-42
Order For Drug/Alcohol Treatment	E-43
End Notes	E-44

Chapter F: ORDERS

Case Management	F-3
Drug Screen	F-5
Infant Neurobehavioral/ Developmental Assessment	F-7
Infant Needs Assessment	F-8
Child's Physical Examination	F-9
Mental Health Screening	F-10
Full Mental Health Assessment	F-11
Multiple Services To A Family	F-13
Visitation	F-16
Drug/Alcohol Treatment	F-17
Priority Drug Treatment, Pregnant Woman	F-18

BIBLIOGRAPHY.....	G-1
--------------------------	------------

SUBJECT INDEX

Subject Index

a

abruptio placenta (B-11)
accidental ingestion, child (B-37)
Addiction Severity Index (C-59)
Adolescent Assessment/ Referral System (C-60)
adolescent drug-alcohol use (B-41)
Adoption Assistance and Child Welfare Act of 1980 (E-5)
aftercare (D-15)
Alanon (D-15)
Alateen (D-15)
Alcoholics Anonymous (D-5)
Americans with Disabilities Act (E-25)
Apgar Score (C-19)
apnea monitor (B-18)
array of services (federally-funded) (E-31)

b

bibliography (G-1)
birth weight, low (B-11)
blood, drug-alcohol test (A-9)
Bayley Scale (B-28, C-20, C-62)
Bender-Gestalt test (C-53)
Brazelton Scale (B-27, C-19, C-62)
breast milk, drug transmission to infant (B-31)
breath, alcohol test (A-10)

c

C.A.S.T. (C-21, C-61)
case management (E-27)
case plan (E-9)
checklist, child developmental (C-42)

- newborn, medical (B-59)
- schedules, mental health (C-41)
- treatment (D-44)
- chemist, court examination of (A-34)
- Child of a Substance Abuser Screen (C-61)
- child victims of adult drug users (B-39, C-21)
- cocaine reactions, infants (B-17)
- confidentiality, drug tests, medical care records (A-23)
- drug tests, treatment program records (A-21)
- medical records (B-55)
- mental health records (C-35 to 37)
- congenital deformities (B-13)

d

- dependence on drugs-alcohol (C-27)
- detoxification (C-7, D-5, D-23)
- discharge summary, medical records (B-51)
- Draw-A-Person test (C-53)
- drug tests, court-ordered, not consented to (A-15)
- infant (A-9, B-9)
- out-of-court, consented to, (A-17)
- out-of-court, not consented to (A-19)
- probable cause hearings (A-15 to 19)
- when to order (A-25)
- DSM III-R, Chart, Dependence and Abuse (C-29)
- chart, organic mental syndromes-psychoactive substances (C-31)
- use, abuse & dependence (C-27)

e

- "early intervention" programs (E-24)
- Education for the Handicapped Act (E-23)
- examination of laboratory personnel (A-31)
- neonatal nurse (B-66)
- neonatologist (B-66)

- psychiatrist (C-44)
- psychologist (C-44)

f

- father's role in drug transmission (B-29)
- fetal alcohol effects (B-25)
- fetal alcohol syndrome (B-19)
- fetus, vulnerability during gestation (B-15)

g

- GC/MS (Gas Chromatography/Mass Spectrometry) (A-5)

h

- hair, drug test (A-10)
- Halstead Reitan test (C-54)
- head circumference, small (B-11)
- HIV and drug use
 - adolescents (B-41)
 - pregnant women (B-45)
- House-Tree-Person test (C-55)

i

- in-home services (E-11)
- infant, apnea monitor (B-18)
 - cocaine reactions (B-17)
 - congenital deformities (B-13)
 - drug tests (B-9)
 - intoxication symptoms (B-5)
 - Meconium test (A-9, B-9)
 - neurobehavioral exams (B-27, C-19, C-62)
 - Sudden Infant Death Syndrome (B-18)
 - symptoms of drug exposure (B-11)
 - withdrawal symptoms (B-5)
- in-patient treatment (D-7 to 11)
- intoxication, adult symptoms (A-36)
 - infant symptoms (B-5)

j

Joint Commission on Accreditation of Hospitals Organization (C-14)

k

Kaufman Assessment for Children (C-55)

kinship placement (E-13)

l

laboratory personnel and procedures, court examination (A-31)

laboratory reports, medical records (B-52)

m

meconium, infant drug test (A-9, B-9)

medical records, confidentiality (B-55)

- what to ask for (B-51)

mental health assessments, adolescents (C-23, C-60)

- checklist, child-developmental (C-42)

- children (C-19)

- eighteen month follow-up (C-7)

- full assessment (C-11 to 17, C-49)

- guidance by court (C-11)

- infants (C-19, C-62)

- questions to psychologist, psychiatrist (C-11)

- screening (C-9, C-48)

- standards of practice (C-14)

- when to schedule (C-7, C-41)

mental health, early identification (C-15)

mental health records, confidentiality (C-35 to 38)

mental health screening (C-9, C-48)

mental status interview (C-13)

methadone maintenance (D-11, D-23)

Microcephaly (B-19)

"Minnesota Model" treatment (D-9)

Minnesota Multiphasic Personality Inventory (C-56)

n

Narcotics Anonymous (D-15, E-19)
neonatologist, examination of (B-66)
neonatal nurse, examination of (B-66)
neurobehavioral exams, infant (B-27, C-19, C-62)

o

“one-stop-shopping” treatment (D-25)
order, case management (F-3)
- child’s physical exam (F-9)
- drug screen (F-5)
- drug/alcohol treatment (F-17)
- drug/alcohol treatment, priority for pregnant woman (F-18)
- infant needs assessment (F-8)
- infant neurobehavioral assessment (F-7)
- mental health screening (F-10)
- multiple services (F-13)
- neurobehavioral assessment (F-7)
- visitation (F-16)
out-patient treatment (D-7 to 11)

p

passive ingestion (A-13)
- breast milk, infant (B-31)
- smoke, child (B-33)
PL 96-272 (E-5, E-9)
play therapy (C-21)
pregnant woman - fetus, court’s use of medical records (B-47)
- health problems (B-45)
- records (B-47)
- treatment (D-21 to 27)
premature birth (B-11)
progress notes, medical records (B-51)
psychoactive substance use disorder (C-31)

psychiatric assessment, when appropriate (C-13 to 15)
psychological tests, when appropriate (C-17)
psychiatrist, examination (C-44)
psychologist, examination (C-44)
psychological tests, list of commonly-administered tests (C-51)

r

"reasonable efforts" (E-5)
relapse (D-13)
residential community treatment (D-7)
risk assessment (E-7)
Rorschach test (C-57)

s

saliva, drug test (A-10)
sexually transmitted diseases (STDs) and drug use
- adolescents (B-41)
- pregnant women (B-45)
social service programs, federally funded (E-31)
Sudden Infant Death Syndrome (B-18)

t

teenagers, health issues (B-41)
- drug-alcohol use (B-41)
- mental health (C-23, C-60)
- treatment (D-39)
teratogenic drugs, effect on fetus (B-13 to 15, D-21 to 24)
Thematic Apperception Test (C-57)
toxicologist, examination (A-34)
treatment, adolescents (D-39)
- alcohol (D-9)
- checklist (D-44)
- child victims of adult substance users (D-37, E-23)
- cocaine, amphetamines (D-10)

- cultural minorities (D-29)
 - defined (D-5)
 - drug-exposed infants (B-5, D-33, E-23)
 - drug-exposed toddlers (D-35, E-23)
 - environments (D-7, E-22)
 - fetus (D-21)
 - heroin (D-11)
 - list of local facilities (to be completed) (D-43)
 - pregnant women (D-21 to 27)
 - women (D-19)
- Twelve-Step programs (D-9)

W

- Wechsler Intelligence Test for Children (C-58)
- for Adults (C-58)
- withdrawal, adult symptoms (A-36)
- infant symptoms (B-5)

U

- urine drug screen, confirmation (A-5)
- duration of detectability (A-4)
 - EMIT (A-3)
 - evasions (A-7)
 - frequency (A-25, A-29)
 - "look-alike" substances (A-11)
 - limitations (A-4)
 - model order (A-29)
 - "negative" (A-7)
 - "positive" (A-5)

V

- visitation, parent and child (E-15, E-42)

MAIN IDEA INDEX

Main Idea Index

Drug Tests

Urine toxicology screens are the most commonly used drug tests A-3

A **positive urine drug screen** means that very recently (probably within the past 2-5 days) enough illegal drugs (or "look alike" substances) were ingested to register above the cut-off level on the test A-5

A **negative urine drug screen** may mean only that within the past 2-5 days a person did not ingest enough of the tested drug to register above the cut-off level on the test A-7

Other testing media for drugs include blood, meconium, hair, breath and saliva A-9

Certain **foods, prescription drugs** or over-the-counter drugs can register on a drug test as positive for an illegal drug A-11

Passive and indirect ingestion can cause positive drug tests A-13

Drug tests that are **court-ordered** and not consented to have **fourth amendment** issues that may require a probable cause hearing A-15

Most **drug tests** that are **consented to** out of court (for example, as part of a medical exam) are not unreasonable searches or seizures. A-17

Results of out-of-court **drug tests** of parents or **infants** (e.g., as part of a medical exam) that were **not consented to** be the parent may require a probable cause hearing A-19

Results of **drug tests** performed in drug or alcohol **treatment programs** that receive federal support can probably be disclosed. A-21

Results of **drug tests** that were part of **medical care**, or that arose in some other way outside of a federally-supported drug or alcohol treatment "program" will be governed by state confidentiality laws and evidentiary privileges. A-23

Drug tests are most effectively ordered when there is independent evidence pointing toward the probability of both drug use and **inadequate parenting** A-25

Medical Assessments

Infant; Toddler

Infants with drugs or alcohol in their systems may be **intoxicated or in withdrawal** from the substance at birth B-5

Urine screens, blood tests, or meconium tests may indicate whether drugs or alcohol currently are in the newborn's system B-9

Five symptoms which often occur together when a newborn has been exposed to drugs or alcohol in the womb are the following:

1. abruptio placenta
2. premature birth
3. low birth weight
4. small head circumference
5. abnormal neurobehavioral responses B-11

Maternal drug use during pregnancy may **damage** any part of the **infant's body**, including the organs, central nervous system, skeletal structure and muscles B-13

Infants identified as **cocaine-exposed** may require a specific kind of care if the are born with:

1. high respiratory rate
2. elevated heart rate
3. depressed interactive reactions B-17

Fetal Alcohol Syndrome (FAS) is a group of symptoms that occur together in response to maternal alcohol ingestion. It can be clinically identified as an entity. The syndrome includes:

1. growth deficiency and microcephaly
2. minor physical anomalies
3. central nervous system dysfunction B-19

Fetal Alcohol Effects (FAE) is a term applied to a collection of adverse pregnancy outcomes which are caused by perinatal alcohol use but which do not appear as an entire clinically identifiable syndrome B-25

Neurobehavioral impairment can be assessed in infancy in a way that is helpful to the court B-27

Recent medical research demonstrates that **cocaine can bind to human spermatozoa**. Implications of the father's physical responsibility for fetal drug exposure may become clearer in the next few years B-29

Drug and alcohol ingestion in infants can occur through **breast milk** B-31

Child; Teen

Drug ingestion in children can occur through **passive exposure** to smoke . . B-33

Accidental ingestion of drugs or alcohol by children occurs frequently . . . B-37

Adults who use drugs or alcohol can be prone to violence, including the **physical abuse** of children in their care B-39

Adolescent drug use is often accompanied by **sexually transmitted diseases** and (increasingly) HIV B-41

Pregnant Woman - Fetus

Certain **health problems** frequently accompany substance use and must be included in comprehensive care for the pregnant woman. They include:

1. sexually transmitted diseases
2. HIV positive status
3. pneumonia and tuberculosis
4. hepatitis and cellulitis
5. cirrhosis
6. poor nutrition B-45

Medical assessments of a pregnant woman are used by physicians -- and sometimes by courts -- to corroborate a history of drug or alcohol use B-47

Records

Two kinds of **medical records** are full of information:

1. the "progress notes"; and
2. the laboratory reports B-51

Local law governs the manner in which **confidentiality** is waived and medical records are obtained. B-55

Mental Health Assessments

Kinds Of Assessments

Early signs to the court of possible drug or alcohol problems in the family may occur through:

1. allegations in the petition
2. admission of drug use
3. positive drug test
4. prior family or criminal court record indicating drug or alcohol use
5. appearance of intoxication or severe withdrawal C-5

To best assess the impact of alcohol and drugs on a family, as soon as local law permits, the court should order :	
1. mental health screens for substance-using adults; and	
2. full mental health assessments for family members who are free of drugs	C-7
When drug or alcohol use is suspected, an immediate screening by a psychologist or psychiatrist is advised to rule out other causes of dysfunction . . .	C-9
Psychologists and psychiatrists require specific questions from the court in order to offer accurate information on how parental substance use may be threatening a child and contributing to an unstable family environment.. . . .	C-11
At the heart of a psychiatric or psychological assessment is a mental status interview during which the behavior and appearance of the person is closely observed	C-13
A psychiatrist can explore physiological bases for substance use and mental illness and suggest neurological or other tests, as well as prescribe medicine	C-15
Tests , usually administered by a psychologist , can measure intellectual-cognitive functioning in a way that gives insight into behavior. Tests can also describe personality	C-17
The problems caused by family drug and alcohol use can be assessed in children from birth to adulthood	C-19
An individual teenager's drug and alcohol use needs to be examined as part of a web of social problems, including family, peers, and the community . .	C-23

Interpretation Of Reports (DSM III-R)

To a mental health professional, the ability to parent may be tied to the kind and extent of use, abuse, or dependence on drugs or alcohol.	C-27
The screening report will indicate whether drugs or alcohol are causing a current mental dysfunction	C-31

Records

Evidentiary privileges protecting confidentiality between patients and mental health professionals generally are waived when mental health assessments are either consented to or court-ordered	C-35
Reports of mental health assessments completed prior to the court process -- or contemporaneous with the court process, but undertaken for a different purpose -- probably will be subject to restrictions raised by evidentiary privilege between patient and mental health professionals.	C-37

Treatment

Adults, Generally

"Treatment" consists of medical, psychological, and social services, the goal of which is to free a person from dependence on psychoactive substances D-5

Treatment environments for adults are usually one of three kinds:

1. in-patient
2. out-patient, or
3. residential community D-7

The **dominant type of substance used** (e.g. alcohol, cocaine, heroin) may require particular treatment strategies that are only available in specific programs D-9

Relapse is a predictable element in treatment. D-13

Aftercare counseling and social support can help a person avoid or delay relapse when primary care is over. D-15

Women, Minorities

Women may not respond well to treatment programs shared with men . . . D-19

Drug and alcohol treatment for the **mother and fetus** dramatically affects the fetus' chances for survival and health. D-21

The **medical goals for treatment of the fetus** may vary from abstinence to medication, depending on the substances ingested by the mother D-23

Drug and alcohol treatment for a pregnant woman must not be isolated from **other services** that she requires, including :

1. prenatal medical care
2. natal medical care
3. parenting classes
4. counseling on coping with violence and abuse
5. connection with public benefits
6. vital treatment links like child care and transportation D-25

Cultural minorities may not recover in treatment programs designed to serve the dominant culture D-29

Child, Teen

The **caretaker** of a substance-exposed newborn requires **training** D-33

Substance-exposed toddlers often will require **special education** to overcome learning and behavioral deficits. D-35

Treatment for **child victims** of adult drug abusers should include:

1. protection from further abuse, and
2. reversal of emotional and cognitive impairment. D-37

Adolescent treatment issues are tied to larger social issues that may require a variety of counseling techniques. D-39

Social Service

Reasonable Efforts

Both federal and state law require that the government make “**reasonable efforts**” to keep a family together. E-5

Prior to making placement decisions based (at least partially) on the social worker’s recommendation, the court should inquire **how risk** to the child from the parents’ drug and alcohol use was **assessed** E-7

The **agency’s case plan** for the child may be the most significant document in the case, meriting the court’s close scrutiny E-9

In-home services protect against out-of-home placement E-11

Resources within the **extended family** protect against out-of-family placement E-13

Facilitating **visitation** between family members during out-of-home placement is a responsibility shared by the social service agency and the parents. E-15

Community Resources

Resources in the wider **community** are necessary to maintain family placements. E-19

Implementing **drug and alcohol treatment** for the adults can be the “reasonable efforts” that bring about successful reunion of the family. E-21

Children suffering the effects of in-utero or environmentally-acquired drug or alcohol exposure may have access to greater resources if they are classified as “**handicapped**” E-23

Effective **case management** is required in drug-alcohol cases E-27

A. DRUG TESTS

DRUG TESTS

Urine Drug Screens	A-3
Other Tests (Blood, Meconium, Hair, Breath, Saliva)	A-9
“Look Alike” Substances	A-11
Passive Ingestion	A-13
Fourth Amendment Issues	A-15
Obtaining Drug Test Records	A-21
When To Order Drug Tests	A-25

Appendix

Order for Drug Screen	A-29
Examination of Laboratory Personnel	A-31
Examination of Toxicologist or Chemist.....	A-34
Drug Chart	A-36
End Notes.....	A-37

Urine toxicology screens are the most commonly used drug tests

In order to sharpen its inquiry, the court will wish to be familiar with:

1. the *medium* tested (urine, blood, meconium)
 2. the *scope* of the test (drugs that the test covers)
 3. the *manufacturer* of the test (in case there are questions about the test's specifications)
 4. the *testing environment* (laboratory, hospital, jail, clinic—in case testing personnel need to be called to the court)
-

A. EMIT Urine Screen

Urine is the usual testing medium for drug screens.

Obtaining urine samples is generally considered to be less intrusive than obtaining blood samples.

EMIT, an immunoassay test manufactured by Syva Co., is the most widely-used drug screen.

The EMIT samples can be obtained in the field (that is, outside of a laboratory setting)

The samples are easy to process by personnel who need not have a college degree.

B. Choice of Drugs

Only certain drugs are chosen to be tested in a urine toxicology screen. The court can make the choice, or the laboratory can make the choice.

If the laboratory chooses the drugs to be tested, they will usually be the four or five most popular street drugs.

C. Amount Required to Register

The drugs must:

1. have been used *recently* enough to register on the test, and
2. must be present in *high enough amounts* to be above the minimum parameter of the test as set in the calibrated sample.

This is the "cut-off" level, above which a test is considered "positive" and below which it is considered "negative".

D. Limitations

Evidence Problem!

A urine screen cannot show:

1. that the person is a chronic user
2. how much of the drug was ingested
3. precisely when the drug was taken
4. that an illegal substance was ingested (some legal drugs and food can mimic some illegal drugs)
5. that the drug was intentionally ingested (passive absorption is a possibility)
6. that the person is *not* a drug user (There is a high possibility of false negatives on the EMIT test)

E. Time Drugs Stay in Urine

DURATION OF DRUG DETECTABILITY IN URINE	
chart adapted from Dubowski, <i>Drug Use Testing</i> , 11 Nova L.Rev. 415, 530 (1987)	
	Days
Amphetamines	1- 3
Barbiturates	
Short-acting	1- 3
Intermediate-acting	2- 4
Long-acting	7-21
Benzodiazepines	3-10
Cannanbinoids (marijuana,hash,etc.)	2-21
Cocaine metabolites	2-5
Ethyl alcohol	1/2-1
Lysergic acid diethylamide (LSD)	1
Methadone	2-3
Methaqualone	2-7
Opiates (heroin, opium, etc.)	1-3
Phencyclidine (PCP)	3-8
Propoxyphene	1/4-2

A positive urine drug screen means that very recently (probably within the past 2-5 days) enough illegal drugs (or "look alike" substances) were ingested to register above the cut-off level on the test

Prior to making any decisions (such as out-of-home placement for the child, or an increased schedule of testing for the adult) based upon a positive test, the court should assure that the positive results have been *confirmed*.

A. Confirm Positive Results

EMIT has at least a 5% chance to register as a *false positive*.^{11,17} Some commentators place the rate of false positives much higher.¹⁵

The weight of scientific opinion, as well as the recommendation of the manufacturer, is that positive results should be re-tested by another method.^{6,11}

The usual method of *re-testing* is GC/MS (Gas Chromatography/Mass Spectrometry). When performed correctly by well-trained personnel it is highly accurate.

B. Family vs. Criminal Cases

Evidence Problem!

In some jurisdictions positive results of urine toxicology screens are not reconfirmed by another method—they are simply re-tested again by the same method.

While this procedure does not pass scrutiny of the scientific community, it has passed scrutiny of certain appeals courts on different facts (e.g. in criminal cases involving discipline, contempt, parole revocation, etc.)³

The issue for family court judges is whether decisions which have far-reaching implications and give rise to constitutional issues (like the separation of a child from the family with possible future loss of parenting rights) should be based on a positive drug screen that has not been properly confirmed.

A negative urine drug screen may mean only that within the past 2-5 days a person did not ingest enough of the tested drug to register above the cut-off level on the test.

If the court looks at a drug test as one of many indicators of drug use, other indicia of drug use are more likely to be brought before the court.

Other indicia may include:

1. admissions of drug use
2. medical histories (physicians often obtain their most accurate information from oral medical histories)
3. testimony of witnesses
4. a *pattern* of positive results from regularly scheduled drug tests (twice a week) over a longer period of time

A. False Negatives

The possibility for *false negatives* in the EMIT test is very high because the cut-off level (the artificial line above which the drug registers as positive, and below which it registers as negative) has been set high in order to reduce the incidents of false positives.

Some commentators place the rate of false negatives as high as 50%.¹⁵

B. Evasions

Evidence Problem!

Drug tests are easy to evade:

1. drink a lot of water
2. adulterate urine with another substance like liquid soap, vinegar, soft drink, etc.
3. hide a clean urine sample on the body for substitution
4. appear late for drug test (so there is more time to reduce level of toxins)

Evasions can be foreclosed if tests are strictly scheduled at least twice a week, the sample is taken un-

der observation, and it is tested for Ph, temperature and gravity.

C. The Court's Order

Drug use can be overlooked if the court fails to specify testing for the particular drugs known to be preferred by the person tested.

If the court is simply casting a wide net, then testing for the four or five most common street drugs may have to do. [see model order, p.A-29]

:

Other testing media for drugs include blood, meconium, hair, breath, and saliva.

If alcohol is the suspected substance, the court will wish to order a blood (or breath) test.

If drug-exposure of a newborn is at issue, the court may look for results of a meconium test (as well as a urine screen).

For most other substances, a urine screen is the best testing medium.

A. Blood

Blood is a suitable medium for testing alcohol consumption.

Alcohol dissipates quickly and can best be isolated in blood or breath.

Blood also yields accurate results for drugs.

Taking a blood sample is considered to be more intrusive than urine testing because the body must be invaded to obtain the sample.

B. Meconium

Meconium is an infant's first stool after birth.

Meconium has proved to be a reliable medium to analyze fetal drug ingestion over many months of pregnancy.^{9,10}

A recent study indicates that a stool sample may be gathered from the diapers of a full term infant up to three days after birth.¹⁰ A pre-term infant can be tested up to two weeks.

While currently there are not many laboratories that perform the radioimmunoassay test, soon there will be available a meconium conversion kit that will make the test cost effective in any laboratory.

C. Hair

Hair has been determined to be an unreliable medium for testing drugs. 55 Fed.Reg. 23985 (June 6, 1990)

Hair can give a retrospective look at drug use over several months.

Reliability is affected by cutting, dyes, permanents, straighteners, etc.

Dark, thick hair holds drugs much longer than light, fine hair, creating the potential for racial discrimination.

D. Breath

Breath tests are a useful way to screen for alcohol consumption.

E. Saliva

There is scientific controversy about the reliability of saliva tests.

Certain foods, prescription drugs, or over-the-counter drugs can register on a drug test as positive for an illegal drug.

If the court receives a plea that a positive drug screen was caused by a legal substance, the court may wish to place the burden on defense counsel to produce a doctor's prescription, and/or a credible witness.

Given a prescription, a toxicologist can ascertain whether the substance could cause a positive reading.

Poppy seed ingestion can mimic opiates. Both **heroin** and poppy seeds have a similar morphine base.

"Nyquil", and related prescription drugs can register positive for **amphetamines**.

Anti-inflammatory drugs can mimic **marijuana**.

"Nalfon" and related prescription drugs derived from fenoprofen may register as positive for **amphetamines, barbiturates, benzodiazepines, and methaqualone**.

Medical literature does not indicate substances currently on the market that mimic **cocaine**. However, newspapers have reported that cocoa tea, sold in Latino grocery stores, has caused urine samples to test positive for cocaine.

Passive and indirect ingestion can cause positive drug tests

An infant or small child can absorb drugs through

- a smoke-filled room
- breast milk

When that claim is made, or the facts substantiated, the court should order

1. a home study
 2. review of parenting capabilities
 3. recommendation for alternate parenting arrangements
-

Evidence Problem!

Sitting in a smoke-filled room in a "crack house" for hours might cause enough absorption of cocaine to register positive in a urine drug screen.

Infants have been shown to suffer seizures from absorption of cocaine through breast milk.

At least one study connected low birth weight to a mother's *passive* exposure to tobacco daily for at least two hours a day.⁸

Drug tests that are *court-ordered* and not consented to have fourth amendment issues that may require a probable cause hearing.

The court may face this issue at any time in the proceeding from initial hearing through disposition and review.

The question is whether a mere allegation of drug use (in the petition, or from the social worker, for example) is a sufficient basis to order a drug test.

The court's solution may be to hold a probable cause hearing on the issue of drug-alcohol use (which would be separate from a probable cause hearing on the issue of neglect-abuse).

A. Search and Seizure

The presumption that a drug or alcohol test is an **unreasonable search or seizure** may be overcome by showing a significant need for the information, *Schmerber v. Cal.*, 384 U.S. 757 (1966).

Neglect and abuse laws form a strong public policy basis for overcoming constitutional protections for privacy.

In a probable cause hearing the court may inquire whether drugs or alcohol were taken at or near the time of the incident—or whether a pattern of misusing drugs or alcohol exists with these adults.

B. Drug Use and Neglect Distinguished

Evidence Problem!

A probable cause inquiry into the likelihood of drug or alcohol ingestion is not the same as a probable cause inquiry into the likelihood of neglect or abuse.

Ingestion of drugs does not inevitably lead to child abuse or neglect.

C. Parent-Child Consent Distinguished

Adults may refuse to consent to a drug test of themselves, in which case the court may determine that a probable cause hearing is required.

If the court decides that there is probable cause, and orders a drug test, and the adults refuse to participate, the court will decide what sanctions are appropriate.

After the court has jurisdiction over the case, in most states the judge may order any tests for the **child** that are congruent with necessary medical care.

A court order would override the parents' refusal to consent to a drug test of the child.

Most drug tests that are consented to *out of court* (for example, as part of a medical exam) are not unreasonable searches or seizures.

To invoke the Fourth Amendment, the person tested would have to show:

1. a higher degree of government involvement than would be the case in most hospitals or laboratories.

E. g. *Blum v Yaretsky*, 457 U.S. 991 (1982); *Rendell-Baker v. Kohn*, 457 U.S. 803 (1982).

However, consult your state's constitution for additional privacy protections

2. lack of informed consent.

E. g. *Feliciano v. City of Cleveland*, 661 F.Supp. 578 N.D. Ohio 1987); *U.S. v. Williams*, 754 F.2d 672 (6th Cir. 1985).

A. Consent to Hospital Test

Evidence Problem!

Lack of informed consent is a possibility, since drug tests may be taken in hospitals without specific notice to the patient.

The patient may have signed a blanket consent for any necessary health-related tests or the test may have been taken because the patient fell into the "high risk" category in the hospital's protocol

"High risk" may be identified by social as well as medical factors. The social factors may equate more with poverty than with drug use.

E.g., no fixed address
family or criminal court record
unkempt appearance

In a hospital, consent is considered only to have medical implications (e.g. what care does the pregnant woman and her newborn infant need?)

The social implications of consent are rarely explained (e.g., if the test is positive, the woman may be reported to the child protection agency. Ultimately her child could be taken away from her)

B. Objections are Rare

Objections on the basis of informed consent are rarely raised.

This may be because:

1. tests performed prior to, or not pursuant to, a court order are rarely brought into neglect proceedings; or
2. there is seldom enough government involvement to bring the Fourth Amendment into issue; or
3. it tends not to be to the ultimate advantage of the tested person to raise the issue (strategy of cooperation).

Results of out-of-court drug tests of parents or infants (e.g., as part of a medical exam) that were not consented to by the parent may require a probable cause hearing.

A hospital may be able to establish a compelling medical reason to drug test an infant over the objection of the parent.

The court may wish to put that compelling reason on the record through a probable cause hearing.

Parents who specifically objected to a drug test of themselves are entitled to a probable cause hearing if the government seeks to admit the results of such a test.

A. Fourth Amendment

Not all drug tests are entitled to Fourth Amendment protections.

A privacy interest exists only where the Fourth Amendment has been extended to the state through the Fourteenth Amendment due process clause (this requires substantial government involvement), or where the state has established its own privacy protections.

B. Infant Drug Tests

If parents refuse to consent to drug tests of their infant prior to court jurisdiction over the family, a physician might be able to override the withholding of consent if the test is necessary for emergency, life-sustaining measures.

In most cases the hospital would treat the infant's drug test as conceded when the parent agreed by signing the hospital's admission form that all health-supporting, life-sustaining measures could be taken.

Such a position might be open to challenge on the basis of lack of informed consent, if Fourth Amendment protections apply.

C. Parents' Drug Tests

If consent of the parents to a drug test for themselves were sought and consent were refused—and if such a drug test had been taken despite the refusal—the parent might be entitled to a probable cause hearing prior to admission of those results in a neglect proceeding.

Results of drug tests performed in drug or alcohol treatment programs that receive federal support can probably be disclosed.

The court will base its inquiry into confidentiality of drug and alcohol treatment records from programs receiving federal support upon two federal laws:

1. **Drug Abuse Office and Treatment Act of 1972, 42 U.S.C. sec. 290ee-3; and**
2. **Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act of 1970, 42 U.S.C. sec. 290dd-3.**

A. Steps for Ordering Drug Records

Regulations describe procedures for compelling disclosure. 42 C.F.R 63 (1990) et seq.

Step 1: Determine if the state has stricter prohibitions against disclosure than do the federal laws.

State laws are not preempted by the federal laws. sec.2.20.

State laws must be followed if they are stricter.

Step 2: Determine if the drug test record originates in a "program" as defined in the law. sec. 2.11.

Step 3: Determine if disclosure is warranted, or whether there are other effective ways of obtaining the information. sec.2.64 (d)(1)

Step 4: Assure that adequate notice has been given to both the person tested and the holder of the record.

Step 5: Assure that both the person tested and the record holder have an opportunity to file written responses and to appear in person to argue their positions. sec.2.64(b) (c).

Step 6: Assure that the drug test results are not disclosed to a non-party.

The court should consider requiring in-chambers arguments and sealed records, sec. 2.64 (e)

B. Disclosure Standard

The standard for disclosure will be: whether the confidential information is **“necessary to protect against an existing threat to life or serious bodily injury, including circumstances which constitute suspected child abuse and neglect...”** sec. 2.63(a)(1).

The court will balance “the public interest and the need for disclosure” against “the injury to the patient, to the physician-patient relationship and to the treatment services.” sec. 2.64(d)(2), 2.65(d)(4).

Results of drug tests that were part of medical care, or that arose in some other way outside of a federally-supported drug or alcohol treatment “program” will be governed by state confidentiality laws and evidentiary privileges.

For any confidentiality issues that lay outside the parameters of a federally-supported drug treatment “program”, the court will turn to its own state laws.

Many state laws permit waiver of confidentiality laws and evidentiary privileges where proof of child abuse or neglect is at issue.

Drug tests are most effectively ordered when there is independent evidence pointing toward the probability of both drug use and inadequate parenting

The court needs to find a nexus between drug use and poor parenting.

As to drug use, the court may wish to:

- 1. take testimony on the record (a probable cause hearing is one way to do this); or**
- 2. obtain consents; and**
- 3. order further drug tests under carefully controlled conditions (see model order, p. A-29)**

As to poor parenting, the court may wish to:

- 1. order a home study**
- 2. order a needs assessment for significant family members**

A. Drug Tests are Screens

One urine drug test of an adult, unconfirmed by another method of testing, is nearly without value.

A series of drug tests, two or three times a week, under careful laboratory conditions can reveal current patterns of adult drug use.

B. Independent Evidence

Independent evidence should be more than an unsubstantiated allegation in a petition.

Evidence might include:

- 1. confirmation of a positive urine toxicology by another more reliable method (e.g. GC/MS)**
- 2. admission**
- 3. drug or psychological history**
- 4. testimony of witnesses**

At the initial hearing, in lieu of consent, a probable cause hearing on the issue of drug use may establish a record sufficient to support the order for a drug test.

C. Infant Drug Tests

If the parents' drug use is known or the court has evidence of the probability of parental drug use, and a petition is before the court within 24 hours of birth, the court may consider an order for meconium or urine testing.

Even a 24 hour time delay may produce a negative drug test in a drug-exposed infant.

If parental drug use was suspected, the hospital may have drug-tested the infant. The court may request the results.

Appendix

Appendix

Order for Drug Screen	A-29
Examination of Laboratory Personnel	A-31
Examination of Toxicologist or Chemist	A-34
Drug Chart	A-36
End Notes	A-37

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR DRUG SCREEN

A. Drugs to be tested shall include at least the following:¹

_____ amphetamines	_____ lysergic acid
_____ barbiturates	_____ methadone
_____ benzodiazepines	_____ methaqualone
_____ cannabinoids	_____ opiates
_____ cocaine metabolites	_____ phencyclidine
_____ ethyl alcohol	_____ propoxyphene
_____ others (describe) _____	
_____ choice of common street drugs to be determined by the laboratory	

¹ (Note: most labs test for three or four popular street drugs. Additional drugs of concern to the court must be specified).

B. _____ Positive tests to be confirmed by a different method.

C. Tests shall occur according to the following schedule:²

_____ scheduled
_____ twice a week
_____ at two or three day intervals
_____ other (describe) _____
_____ random
_____ on one to twenty-four hour telephone notice
_____ on one to two days' notice
_____ other (describe) _____
_____ today only

² (Note: Drugs dissipate quickly. Twice weekly or random short notice is required to catch most drug use)

D. The drug screen shall be performed:

_____ by the following agency (name) _____

_____ by a facility arranged by (agency) _____

E. (Name of person to be tested) _____ is ordered to appear
for the first test:

_____ on (date) _____

_____ as scheduled by the laboratory

_____ as arranged by (name of person or agency):

JUDGE

EXAMINATION OF LABORATORY PERSONNEL

How EMIT screens urine What kind of test is the EMIT urine screen?

[A: Immunoassay]

How does an immunoassay test detect drugs?

[A: antibodies that react only with a particular drug attach themselves to the drug if it is present in the urine. The more drugs present, the greater the chemical response. The standard is a calibrator which has the amount of drug determined to be the detectable limit. If the sample is equal to or higher than the calibrator's, it is positive]

Can the EMIT test measure the amount of drugs in the urine?

[A: No. the EMIT test only indicates if drugs are detectable]

Accuracy of EMIT process How accurate is the EMIT field test?

Are you relying on company literature when you make that estimation?

What is the percentage of *false positives*?

How can one determine if there has been a false positive?

[A: re-test by another method]

What is the percentage of *false negatives*?

Why are there more false negatives than false positives?

[A: The detection level is set quite high to avoid false positives]

- Re-test for false positives** What is the most accurate way to re-test for false positives?
- [A: Gas chromatography/mass spectrometry]
- Does your laboratory re-test all positives?
- What method does your laboratory use to re-test?
- Obtaining the sample** Describe the intake process in your laboratory, prior to obtaining the urine sample.
- Is a person searched prior to giving a sample?
- [A: If so, describe the search]
- Is a person accompanied by laboratory personnel while giving a urine sample?
- Is a person observed while giving a urine sample?
- [A: If so, how is that observation accomplished? Do laboratory personnel record their observations in a book?]
- Chain of custody** How long does the urine sample remain in the possession of the person being tested?
- To whom is the sample passed?
- Is receipt of the sample recorded in a book? Who records it?
- Who takes possession of the sample next?
- Is that recorded in a book? Who records it?
- Is the sample now in the testing laboratory?
- How long does it remain in the laboratory before it is tested?
- Who has access to the sample before it is tested?
- When are the tested results entered into a book?
- Where is the sample placed after it is tested?
- How long are samples kept?

Examination of laboratory personnel, p.3

**Process for
scheduling tests**

How are regularly-scheduled tests arranged with the person to be tested?

Does a person receive a letter, or are arrangements made at the laboratory?

Do you set up a schedule for testing, or do you simply follow the court's or employer's instructions?

[If you set it up, what are the guidelines for frequency of testing_____ (name drug of concern to court in this case)

If a person does not appear on the day and at the time indicated, how is that recorded in your files?

Will you test a person who appears on a different day?

How much delay will you tolerate?

Is the court informed when there has been delay?

What are the intake procedures for persons who come to the laboratory more than once?

How are the above factors different for *random* tests?

How is a person notified that a random test is scheduled?

How much delay do you tolerate in cases of random testing?

Test-dodging

In your experience is it difficult to alter a urine sample?

What are common techniques for altering samples?

What are common techniques for switching samples?

When that occurs, what do you do with that information?

EXAMINATION OF TOXICOLOGIST OR CHEMIST

Detectability of drugs in urine

Why is there a difference between the length of time that different drugs stay in the urine?

What is the length of time that the following drugs can be detected in urine?

[select those of interest to the court]

cocaine, or cocaine metabolites?

opiates?

PCP?

amphetamines?

barbiturates?

cannabinoids (marijuana)?

Do urine screens indicate the amount of drugs in the urine?

Can you tell from a urine screen when the drug was ingested?

Can you tell from the urine screen whether a person is a chronic user of drugs?

Can you distinguish legal from illegal substances?

What legal substances might register on a urine screen as positive?

Is it possible for an infant to passively ingest drugs through smoke?

Can you cite the court to any statistics or literature that backs up your statement?

Is it possible for an infant to passively ingest drugs through breast milk?

Are you familiar with medical literature which establishes that phenomenon?

Is it possible for an adult to passively ingest drugs?

If so, what are circumstances under which that might occur?

Can you cite any statistics or literature that backs up that idea?

Examination of toxicologist, cont.,p.2

Blood Tests Why is blood, more often than urine, used to test alcohol?

Is blood also a good medium in which to test for drugs?

What are the limitations of blood tests?

What is the most frequent method of testing for drugs or alcohol in blood?

Is accuracy in a test more a function of the kind of test used, or of the medium being tested?

Meconium Tests Can you explain to the court what meconium is?

[A: the infant's first stool]

What can drug tests of meconium reveal that urine or blood tests cannot?

How is meconium tested?

Does meconium testing take particular skill?

How expensive is it?

[how does that compare to the cost of urine testing?]

Hair Tests What advantages would there be to testing hair?

What are the drawback to testing hair?

What is the method used for testing hair?

Overall, would you recommend hair testing as accurate?

Saliva Tests For what drugs or alcohol would it be appropriate to use saliva as the testing medium?

What is the accuracy of saliva tests?

Appendix
Drug Chart

Chart adapted from U.S. Dept. of Justice, Drug Enforcement Administration, Drugs of Abuse, 1989 Edition, pp. 30-31

DRUGS	TRADE NAME	ROUTE OF ADMINISTRATION	EFFECT
NARCOTICS			
Opium	Dover's powder, Paregoric Parepectolin	oral, smoked	high: euphoria, drowsy, respiratory depression, constricted pupils, nausea
Morphine	Morphine, MS-Contin, Roxanol, Roxanol-SR	oral, smoked, injected	
Codeine	Codeine added to: Tylenol, Empirin, Robitussin A-C, Fiorinal	oral, injected	
Heroin	Diacetylmorphine, Horse, Smack	injected, sniffed, smoked	
Hydromorphone	Dilaudid	oral, injected	withdrawal: watery eyes, runny nose, lost appetite, irritable, tremors, panic, cramps, nausea, chills, sweating
Meperidine (Pethidine)	Demerol, Mepergan	oral, injected	
Methadone	Dolophine, Methadone, Methadose	oral, injected	
Other Narcotics	Numorphan, Percodan, Percocet, Tylox, Tussionex, Fentanyl, Darvon, Lamotil, Talwin	oral, injected	
DEPRESSANTS			
Chloral Hydrate	Noctec	oral	high: slurred speech, disoriented drunken behavior
Barbituates	Amytal, Butisol, Fiorinal, Lotusate, Nembutal, Seconal, Tuinal, Phenobarbital	oral	
Benzodiazepines	Ativan, Dalmane, Diazepam, Librium, Xanax, Serax, Valium, Tranxene, Verstran, Versed, Halcion, Paxipam, Restoril	oral	withdrawal: anxiety, insomnia, tremors, delirium, convulsions, death
Methaqualone	Quaalude	oral	
Glutethimide	Doriden	oral	
Other Depressants	Equanil, Miltown, Noludar, Placidyl, Valmid	oral	
STIMULANTS			
Cocaine	Coke, Flake, Snow, Crack	sniffed, smoked, injected	high: alert, excited, euphoric, high pulse, high blood pressure, insomnia, lost appetite
Amphetamines	Biphedamine, Delcobese, Obetrol, Desoxyn, Dexedrine	oral, injected	
Phenmetrazine	Preludin	oral, injected	withdrawal: apathy, deep sleep, irritable, depressed, disoriented
Methylphenidate	Ritalin	oral, injected	
Other Stimulants	Adipex, Cylert, Didrex, Lonamin, Mefilat, Plegine, Sanorex, Tenuate, Tepanil, Prelu-2	oral, injected	
HALLUCINOGENS			
LSD	Acid, Microdot	oral	high: illusions, hallucinations, poor time and distance perception
Mescaline & Peyote	Mexc, Buttons, Cactus	oral	
Amphetamine Variants	2, 5-DMA, PMA, STP, MDA, MDMA, TMA, DOM, DOB	oral, injected	withdrawal: no syndrome reported
Phencyclidine	PCP, Angel Dust, Hog	smoked, oral, injected	
Phencyclidine Analogues	PCE, PCPy, TCP	smoked, oral, injected	
Other Hallucinogens	Bufotenine, Ibogaine, DMT, DET, Psilocybin	smoked, oral, injected, sniffed	
CANNABIS			
Marijuana	Pot, Grass, Acapulco Gold, Reefer, Sinsemilla, Thai Sticks	smoked, oral	high: euphoria, relaxed inhibitions, increased appetite, disoriented
Tetrahydro- cannabinol	THC, Marinol	smoked, oral	
Hashish	Hash	smoked, oral	withdrawal: (sometimes) hyperactive, insomnia, decreased appetite
Hashish Oil	Hash Oil	smoked, oral	

END NOTES

MEDICAL and SCIENTIFIC LITERATURE

1. Chasnoff, I., *Drug Use and Women: Establishing a Standard of Care*: Annals of N.Y. Academy of Sci., 1989, Vol.9, No.4, p.291.
2. Bateman & Heagarty, *Passive Freebase Cocaine ('Crack') Inhalation by Infants and Toddlers*, 1989 American Journal of Diseases in Children, Vol. 143, p.25-27.
3. Bureau of Justice Assistance, *American Probation and Parole Association's Drug Testing Guidelines and Practices for Adult Probation and Parole Agencies* (Monograph No. NCJ 129199), July 1991.
4. Chasnoff, I., et al., *The Prevalence of Illicit Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Penellas County, Florida*: New Eng.J. of Med. April 26, 1990, Vol. 322, No.17, pp.1202-1206.
5. Cone & Johnson, *Contact Highs and Urinary Cannabinoid Excretion after Passive Exposure to Marijuana Smoke*, (Sept. 1986) Vol. 40, No.3, p.247.
6. Dubowski, *Drug-use Testing*, 11 Nova L.Rev. 415 (1987).
7. Fannellaro, et al., *Advisability of Substance Abuse Testing in Parents who Severely Maltreat their Children: the Issue of Drug Testing before the Juvenile/Family Courts*. 1988 Bulletin of the American Academy of Psychiatry and the Law, vol.16,pp.217-223.
8. Martin & Bracken, *Association of Low Birth Weight with Passive Smoke Exposure in Pregnancy*, 1986 Am J. of Epidemiology, Vol. 124, No.4, pp 633-642.
9. Ostrea, et al, *A New Method for the Rapid Isolation and Detection of Drugs in the Stools (Meconium) of Drug-Dependent Infants*, Annals of N.Y. Academy of Sci., 1989, Vol. 562, p.372.
10. Ostrea, et al., *Drug Screening of Newborns by Meconium Analysis: A Large-Scale, Prospective, Epidemiologic Study*, 1992 Pediatrics, Vol. 89, No.1, pp.107-113.
11. Syva, Co., *Frequently Asked Questions About Syva and Drug Abuse Testing*, (pamphlet available upon request from Syva Co., (800) 227-8994

LEGAL LITERATURE

12. Dale, *Constitutional Analysis of Proposals to Establish a Mandatory Public Employee Drug-Testing Program*, Congressional Research Service Report to Congress, April 12, 1988.
13. *Drug Testing for Federal Employees before the Subcommittee on Gov't Operations of the House Committee on the Post Office and Civil Service*, 100th Cong., 1st Sess. (1987)
14. Dubowski, *Drug-use Testing: Scientific Perspectives*, 11 Nova L.Rev.415 (1987).

15. Greenblatt, *Urine Drug Testing*, 23 New England L.Rev.651, No.3 (1988-89).
16. Moss, *Legal Issues: Drug Testing of Post-Partum Women and Newborns as the Basis for Civil and Criminal Proceedings*, Clearinghouse Review, Feb. 1989.
17. *Proficiency Standards for Drug Testing Laboratories, Hearings before a Subcommittee on Government Operations, U.S. House of Representatives*. 100th Cong., 1st Sess., June 10 and 11, 1989.
18. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality and the Right of Privacy*, 104 Harv.L.Rev.1419 (1991).
19. Zeese, *Drug Testing: Legal Manual*, Clark Boardman, 1991.

CASES

- Blum v. Yaretsky*, 457 U.S. 991 (1982) [4th Amendment]
- In re Fletcher*, 141 Misc.2d 333, 533 N.Y.S.2d 241 (Fam.Ct.1988) [Nexus between test and neglect]
- Jones v. U.S.*, No. 86-31 (D.C. Ct. App.1988) [confirmation of test]
- Lahey v. Kelly*, N.Y. 2d 135 (N.Y. Ct. App. 1987) [confirmation of test]
- Nat.Treasury Employees Union v. Von Raab*, 489 U.S. 602 (1989) [4th Amend.]
- Rendell-Baker v. Kohn*, 457 U.S. 803 (1982). [4th Amend.]
- Schmerber v. Cal.*, 384 U.S. 757 (1966) [4th Amend.]
- Skinner v. Railway Labor Executives Ass.*, 489 U.S. 602 (1989) [4th Amend.]

B. MEDICAL

MEDICAL ASSESSMENTS

Infant; Toddler

Intoxication and Withdrawal	B-5
Drug Tests	B-9
Other Exposure Signs	B-11
Congenital Deformities	B-13
Cocaine Reactions	B-17
Alcohol Reactions	B-19
Neurobehavioral Tests	B-27
Role of Father	B-29
Passive Ingestion	B-31

Child; Teen

Accidental Ingestion	B-37
Adult-Inflicted Abuse	B-39
Teen Health Issues	B-41

Pregnant Woman - Fetus

Health Issues	B-45
Court Use of Medical Evidence	B-47

Records

Interpreting Medical Records	B-51
Obtaining Medical Records	B-55

Appendix

Checklist: Medical, Newborn	B-59
Order for Neurobehavioral/Developmental Assessment	B-63
Order for Child's Physical Exam	B-65
Examination of Neonatologist or Neonatal Nurse	B-66
End Notes	B-73

Infant; Toddler

Infant; Toddler

Intoxication and Withdrawal	B-5
Drug Tests	B-9
Other Exposure Signs	B-11
Congenital Deformities	B-13
Cocaine Reactions	B-17
Alcohol Reactions	B-19
Neurobehavioral Tests	B-27
Role of Father	B-29
Passive Ingestion	B-31

Infants with drugs or alcohol in their systems may be intoxicated or in withdrawal from the substance at birth.

The court may find evidence of intoxication or withdrawal in the progress notes and laboratory reports of the infant's medical records.

A. Exposure Symptoms

Fetuses exposed to substances that cross the placenta ("teratogenic" substances) will respond in a manner much like that of the mother who ingests the substances.²¹

Physical symptoms of intoxication or withdrawal in the newborn may be similar to those experienced by the adults.

The symptoms may last longer, because it is more difficult for the infant to expel toxins.

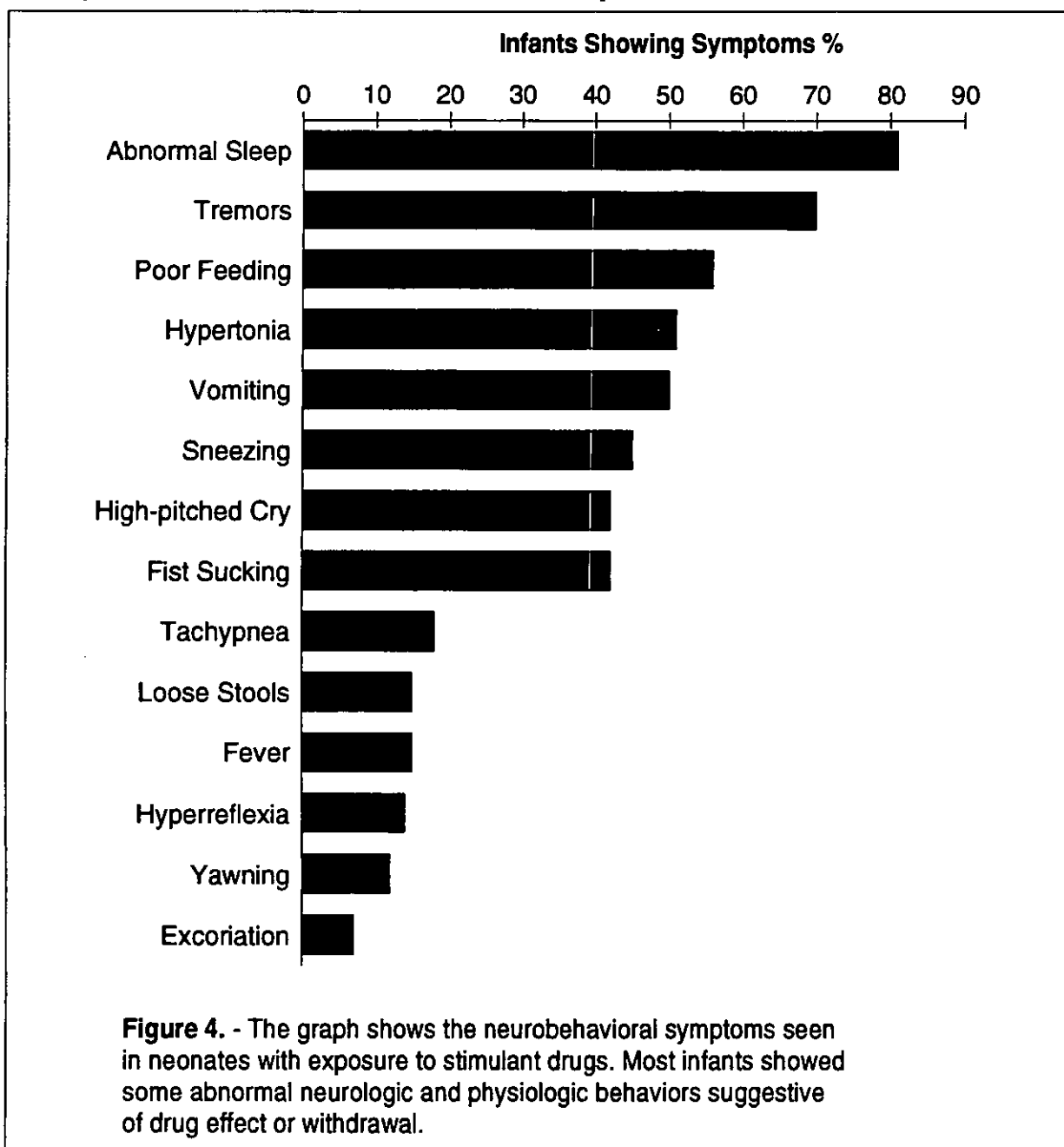
Typical reactions that might occur for any toxic substance ingested include:¹³

- a high-pitched cry**
- sweating**
- sneezing, runny nose**
- irritability**
- hyperactivity**
- tremulousness, startles**
- frantic sucking, yawning**
- fever**
- skin abrasions on knees, toes, elbows, nose**
- hypertonicity (stiff muscle tone)**
- vomiting**
- diarrhea**
- respiratory distress**
- dehydration**
- hypothermia**
- poor feeding patterns**
- irregular sleeping patterns**
- apnea (sudden cessation of breathing)**

In extreme cases infants may have seizures.

Because newborns lose so much weight at this period, it may take quite a while to bring them back to their birth weight.¹³

Graph from U.of Cal. Medical Center, San Diego in: Dixon, *Effects of Transplacental Exposure to Cocaine and Methamphetamine on the Neonate*, 1989 West J Med, Vol.150, p.440



B. Medical Records

Medical records will indicate whether:

1. A specific diagnosis of drug-exposure was made
2. A positive urine screen or meconium test exists
3. The infant exhibited signs and symptoms of intoxication or withdrawal
4. Any therapeutic drugs were administered
5. Laboratory tests indicate "companion" problems like HIV positive status.

The conservative (and newer) approach to treatment of infants for withdrawal symptoms is abstinence with supportive techniques like swaddling and holding.⁵⁶

Traditional more aggressive therapy includes administration of:¹³

Paregoric (improves sucking)

Diazepam (suppresses a number of withdrawal symptoms)

Phenobarbital (sedates infant)

Evidence Problem!

If medical records indicate the presence of any of these therapies, the court may inquire—even in the absence of a positive drug screen—whether the infant was thought to be withdrawing from drugs.

Urine screens, blood tests, or meconium tests may indicate whether drugs or alcohol are currently in the newborn's system.

**The court will wish to take a cautious approach to drug tests, aware of the limitations of both a "positive" or a "negative" result. [See pp. A-3 to A-8]
Corroborating evidence should be sought.**

A. Positives; Negatives

A **"positive" urine screen** does not indicate the quantity of drugs taken or number of times drugs were ingested during the pregnancy. A confirmed positive only indicates that shortly before the birth the mother, and therefore the fetus, probably had drugs in their systems.

A **"negative" urine screen** for an infant may indicate only that in the last day or two before labor the mother did not ingest enough drugs to register above the rather high cut-off limit on the test.

Most drugs, or their metabolites, can be found in the urine only for a short period of time after they have been ingested.

For example, the usual time limit for tracing cocaine is 72 hours after ingestion. [for other examples, see p. A-4]

B. Meconium; Blood; Breath

An infant *meconium* test will indicate a drug history over weeks, or even months.⁵³

Meconium is the first stool produced by the infant after birth.

Meconium can be gathered from diapers during the first 3 days after birth in a full term infant and up to two weeks in a pre-term infant.⁵²

Meconium tests may have to be ordered. Until recently the test had to be done by radioimmunoassay. Now, however, a kit is available that will convert meconium to a substance that can be tested like a urine sample.

Alcohol is best measured in blood or breath. Alcohol stays in the blood stream for an extremely short time—often only four or five hours.

Therefore, it is not common to find alcohol in infant blood samples.

C. Substance Use Histories

Evidence Problem!

Carefully gathered medical histories, and even the use of self-reporting psychosocial questionnaires, have proved to be more effective ways to analyze drug-alcohol use than drug tests.^{12, 39}

Five symptoms which often occur together when a newborn has been exposed to drugs or alcohol in the womb are the following:

- 1. Abruptio Placenta**
A rupture of the placenta, precipitating either an abortion or premature delivery
- 2. Premature Birth**
Less than 37 weeks gestation
- 3. Low Birth Weight**
Less than 2500 grams
- 4. Small Head Circumference**
Less than 33 centimeters
- 5. Abnormal Neurobehavioral Responses**
Hyperactivity or depressed responses, heightened irritability, trembling, seizures, etc.

The court may find evidence of each of these factors in the infant's medical records.⁴² Hospital personnel should be able to respond readily to questions concerning the birth.

If the court wishes closer inquiry into the extent of impairment, infant neurological assessments can be ordered. Commonly used techniques include the Brazelton Neonatal Behavioral Assessment Scale and the Bayley Scales of Infant Development. [see p C-19,20; C-62]

Evidence Problem!

Each of these symptoms can have a cause different than drug or alcohol exposure.

Even when all of these factors occur together there may be a medical explanation different than perinatal substance abuse.

However, a physician seeing these five symptoms together would definitely investigate drug or alcohol exposure.

Maternal drug use during pregnancy may damage any part of the infant's body, including the organs, central nervous system, skeletal structure and muscles.

While it is important to the court to understand the nature of the infant's impairment so that services can be provided, it may be futile to attempt to establish a direct cause and effect relationship between substance use and impairment, unless there are:

- 1. a positive drug or alcohol screen, [see pp. A-5, A-9, B-9] and/or**
- 2. five signs of drug or alcohol exposure [see p. B-11] and/or**
- 3. signs of intoxication or withdrawal [see p. B-5]**

A. Causes of Deformities

Evidence Problem!

There may be no positive drug screen.

There may be no symptoms of intoxication or withdrawal.

Nevertheless, the court's inquiry may lead to the discovery that there are malformations of the infant's body.

One explanation for such congenital defects may be maternal use of drugs during the pregnancy. **Obviously, there might be other explanations as well.**

Other diseases, accidents, genetic factors, etc. may be the source of damage.

Studies have shown low infant birth weight to result from the the *mother's passive exposure to tobacco smoke* more than two hours a day.⁴⁶

Prospective research may indicate a male role in fetal damage.^{60, 66.}

B. Unpredictability

Where there is a dose-response relationship, there is a small degree of predictability.

Alcohol has a dose-response relationship, for example. If a woman drinks more than a moderate amount continuously throughout her pregnancy, it can be predicted that the infant will be symptomatic^{63, 64}, [see pp. B-19 to B-25] although the kind and extent of impairment cannot be predicted.

With most teratogenic drugs (drugs that cross the placenta and directly affect the fetus) however, kind and extent of impairment to the fetus cannot be predicted.

Factors which affect this unpredictability may include:²¹

- kind of drugs
- amount of drugs taken at any one time
- route of administration
- frequency of drug use
- point of fetal development at which drug was taken
- genetic base for mother and infant
- health of mother

A recent study indicates a possible correlation between small head circumference in cocaine-exposed infants and poor cognitive abilities.¹¹

This correlation has been observed in alcohol-exposed infants as well.^{63, 64}

C. Fetal Vulnerability

Fetal Vulnerability During Gestation	
based on Cook, et al., <i>Alcohol, Tobacco and Other Drugs May Harm the Unborn</i> , 1990 NIDA publication (ADM)90-1711	
blastocyst stage <i>relatively resistant</i>	
1 week	growing & dividing egg
embryonic stage <i>congenital deformities</i>	
15 - 25 days	central nervous system differentiated
20 - 30 days	skeleton, limb buds, muscles
24 - 40 days	eyes, heart, lower limbs
60 days	other body organs
fetal stage <i>intrauterine growth retardation</i>	
8 weeks - birth	neurological development weight gain

C. Kinds of Deformities

Congenital anomalies that have appeared after perinatal drug use include those affecting:^{17, 36}

- urogenital areas
- limbs (reduction and deformity)
- bowels
- kidneys
- liver
- heart
- cerebral infarctions
- eyes
- ears
- facial dysmorphology

Infants identified as *cocaine*-exposed may require a specific kind of care if they are born with:

1. High Respiratory Rate
2. Elevated Heart Rate
3. Depressed Interactive Reactions¹⁶

The court may wish to order a thorough needs assessment of the cocaine-exposed infant, so as to make a well-informed placement decision and provide other services.

A. Early Symptoms

The cocaine-exposed infant may exhibit any of the characteristics of **intoxication or withdrawal** that other substances cause [see p. B-5]

In addition, as a consequence of the over-stimulation caused by cocaine ingestion, **heart rates and respiratory rates** may rise (as they also do in cocaine-intoxicated adults).

Depressed interactive abilities are a consequence of over-stimulation from the cocaine. They represent an instinct on the part of the infant to withdraw from further stimulation.

A cocaine-exposed infant may seek sleep, or may turn away from a person trying to engage the infant's attention.

If the person persists, the infant may express sudden rage. Characteristically, the infant moves abruptly from one emotional state to another.

Infants exposed to **amphetamines** and other stimulants may follow the same pattern as cocaine-exposed infants.

B. Other Post Birth Problems

Certain post-birth problems can make the court's placement decision difficult. These include:

1. **loss of weight after birth**

This can occur from feeding problems, diarrhea, vomiting, etc. If the infant was under-weight at birth and premature, post-birth loss of weight can be life-threatening.

2. **need for an apnea monitor**

3. **vulnerability to Sudden Infant Death Syndrome (SIDS)**

Although many deaths of drug-exposed infants are attributed to SIDS, this may be a catch-all category indicating that these infants are vulnerable to a great variety of problems: seizures, apnea, heart failures, accidents, etc. ⁸

4. **potential for seizures**

5. **irritability and lack of affectionate response to caregivers** ^{35, 56}

C. Caregiver Training

The caregiver primarily must be able to focus on the infant's needs (rather than her own) and be **trained in swaddling, holding and feeding techniques.**

Fetal alcohol syndrome (FAS) is a group of symptoms that occur together in response to maternal alcohol ingestion. It can be clinically identified as an entity. The syndrome includes:

1. Growth Deficiency and Microcephaly

Microcephaly refers to very small cranial capacity

2. Minor Physical Anomalies

These are known as “dysmorphic” characteristics: flat mid-face, thin upper lip, epicanthal fold to eyes, etc.

3. Central Nervous System Dysfunction ⁶³

Where FAS has been diagnosed, the court will wish to order the child services agency to develop a needs assessment and case plan.

The agency's report should include:

- 1. Immediate treatment needs**
- 2. Congenital problems that may require long-term or life-long care.**
- 3. Placement recommendations.**
- 4. Plans for aid to caregivers, including connection with programs for the handicapped (SSI, etc.)**

A. Appearance

The physical anomalies in the faces of children with FAS make them very easy to identify. Those characteristics often include:

- small head circumference
- flattened midface
- sunken nasal bridge
- flattened and elongated philtrum (groove between nose and lip)
- epicanthal fold on eyelids
- thin upper lip
- short nose
- low placed ears

B. Other Characteristics

Medical records may show the following notations for infants with FAS:

- Weak suck. Long latency to first suck.
- Low Apgar score. Need for ventilatory resuscitation.
- Heart rate abnormalities
- Slow habituation to stimulation on the Brazelton scale.
- Tremors, hand-to-mouth activity, head turns to the left.
- Non-alert wake state.

C. Long-term Impairment

A child with FAS has serious, long-term impairment. While certain characteristics—like facial anomalies—may improve with maturity, other characteristics, like mental retardation, are life-long problems.

There is a dose-response relationship between alcohol ingestion and severity of impairment.

There is also a relationship between the severity of the facial dysmorphology and the extent of organic damage.

For example, children with the most obvious facial defects are also those with the lowest I.Q.

Children with the most obvious facial defects and growth deficiency in infancy have the poorest prognosis for later performance.

In addition to the characteristics which are part of the FAS syndrome, there are defects which *often* occur in such children:

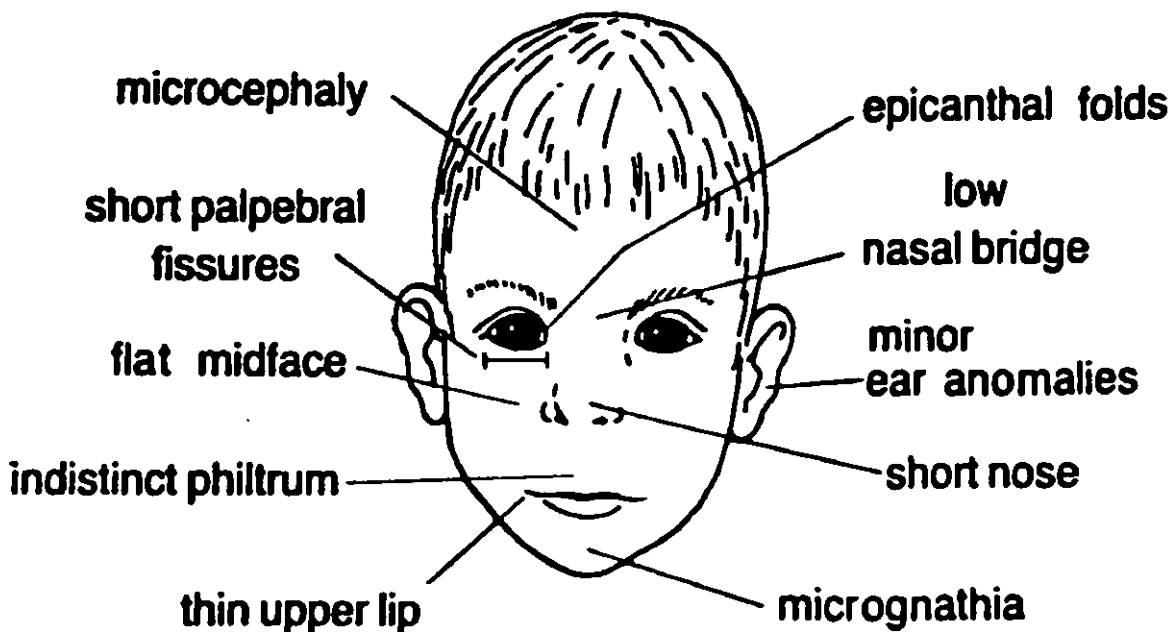
30-40% of FAS children have heart defects

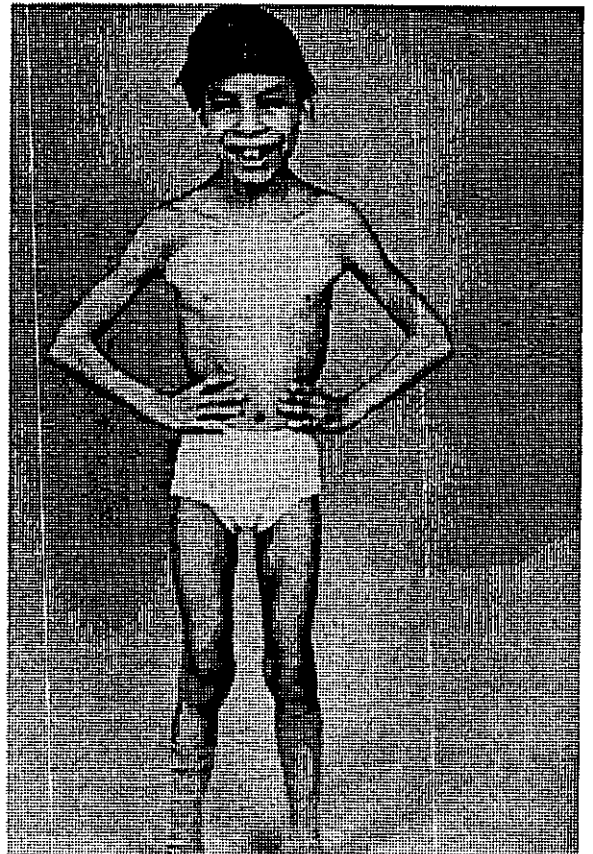
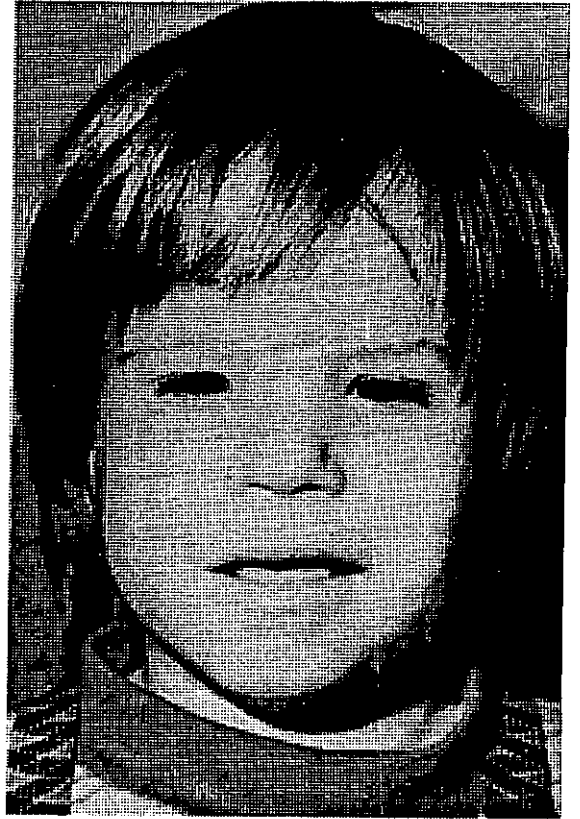
In one very thorough study, the average I.Q. was 65, although the range varied from a low of 15 to a high of 105.⁶⁵

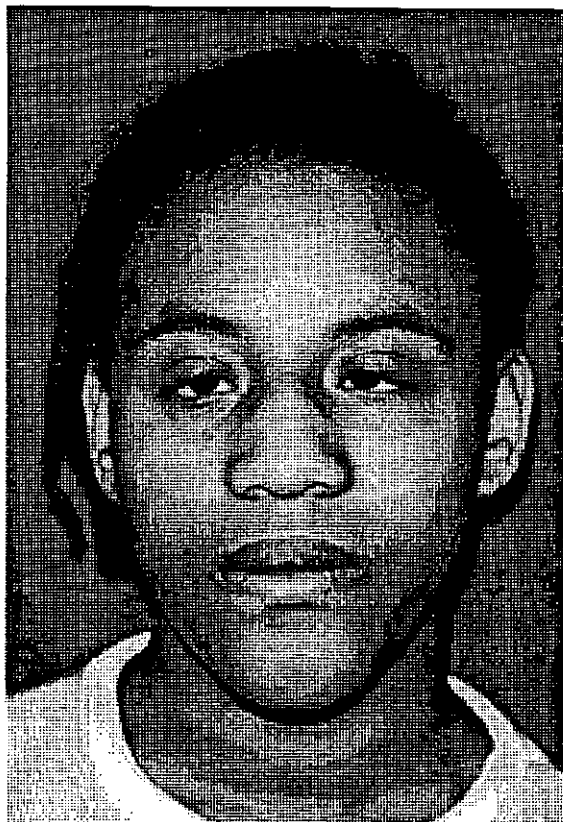
FAS has been found to be the most frequent cause of mental retardation through substance exposure in the Western world.

Pictures and graphs illustrating fetal alcohol syndrome from Streissguth, *A Manual on Adolescents and Adults with Fetal Alcohol Syndrome*, 1986, U.Of Wash., and *Psychological and Behavioral Effects in Children Prenatally Exposed to Alcohol*, 1985 Alcohol World, Vol.10, No.1, pp.7-10.

FACIES IN FETAL ALCOHOL SYNDROME







Fetal Alcohol Effects (FAE) is a term applied to a collection of adverse pregnancy outcomes which are caused by perinatal alcohol use but which do not appear as an entire, clinically identifiable syndrome.⁶³

The court will wish to order a needs assessment from the child services agency. The report should:

- 1. distinguish between FAS and FAE in this child.**
 - 2. describe immediate treatment needs**
 - 3. project the child's long term needs**
 - 4. offer a plan to help the caregiver meet those needs**
-

A. Relation to FAS

FAE may include any (but not all) of the characteristics found in the three categories of FAS.⁶³ Those three categories are:

1. Growth deficiency and microcephaly
2. Minor physical anomalies
3. Central nervous system dysfunction.

B. Not a Syndrome

Evidence Problem!

Because Fetal Alcohol Effects do not amount to a clinically-recognized syndrome, each factor would have to be proved to:

- a. exist in the child, and
- b. harm the child

In addition, the court usually would wish to have corroborating evidence of the mother's alcohol use.

Neurobehavioral impairment can be assessed in infancy in a way that is helpful to the court

Early assessment may help the court to make placement decisions and develop a case plan that will connect the child with benefits for the handicapped.

The court should:

1. inquire of the social worker and counsel whether any assessments have been completed
 2. if assessments have been completed, ask to see the medical records or report that contains the results
 3. if no assessments have been performed, consider an order for assessments
-

A. Brazelton Test

The Brazelton Neonatal Behavioral Assessment Scale [see annotation, p. C-62]

Neonatologists and pediatricians are using this scale more and more frequently.

The Brazelton Scale is administered between the third and thirtieth day after birth. It takes from 1/2 to 3/4 of an hour to administer. It tests 26 behavioral responses and 20 reflexes.

The tester poses simple events for the infant to respond to. For example

- a sound to determine if the infant will turn her head toward it.
- a blanket lightly placed on the infant's face to see if he will try to remove it (normal reaction) or simply fall asleep (as cocaine-stimulated babies may do).

A baby who performs poorly is considered to be at high risk: a helpful analysis for the court to guide future planning.

B. Bayley Scales

The Bayley Scales of Infant Development

[See annotation, p. C-62]

The Bayley Scales are a highly structured set of tasks often performed at regular monthly milestones over the first two years of life.

The infant-toddler scores are compared to normally-developing peers.

The Bayley Scales measure progress over time.

C. Three Month Follow-Up

Evidence Problem!

Certain problems do not become evident until from 10 days to several months after birth.

All infant problems cannot be known at the earliest stages of the case.

Parties should return to court approximately three months after the birth of a drug or alcohol-exposed infant to take actions based on results from all of the tests.

Recent medical research demonstrates that cocaine can bind to human spermatozoa. Implications of the father's physical responsibility for fetal drug- exposure may become clearer in the next few years.

As the court oversees a plan to reunify the family, the importance of the father's responsibility and the centrality of the father's role may be stressed.

More than 10 years ago medical researchers using animal studies were able to show that drugs could alter chromosomes.⁶⁰

In 1991 researchers finally demonstrated that human sperm could actually contain cocaine. That raised the possibility that "sperm may act as a vector to transport cocaine into an ovum."⁶⁶

This latest discovery does not amount to a certainty that the father can be responsible for drug effects on his child.

It does, however, give an opportunity for the court to stress the equal responsibility of parents toward their children.

Drug and alcohol ingestion in infants can occur through *breast milk*.

The court is most likely to encounter this phenomenon either as an argument put forth as a defense to a charge of intentional administration of drugs to an infant, or as a statement of fact from the hospital.

The court may wish to review the placement decision in light of the implication that the caregiver continues drug or alcohol use.

Women who are known to continue their drug or alcohol ingestion post-natally are discouraged by the medical community from breast feeding their infants.

The phenomenon of drug-ingestion through milk has been noted for both alcohol and cocaine.¹⁰

Effects of breast milk ingestion can be life-threatening. One case of cocaine ingestion, for example, caused vomiting, diarrhea, heightened heart and respiratory rate, dilated pupils, tremulousness, etc.

Drug ingestion in children can occur through *passive exposure to smoke*.

The court may wish to review the placement decision for any child whose caregivers assert that reactions to cocaine occurred in the child as a result of passive exposure to smoke.

The agency's report to the court should include:

1. results of a home visit, that includes careful inspection of the home environment
2. description of the responsible caregiver
3. description of services that the agency has offered—and will now offer—to the family
4. estimation of the safety of the child
5. description of alternative caregiving arrangements

Passive inhalation of smoke by children has been increasingly occurring, according to reports by emergency room physicians.⁹

Children reported have ranged from infancy to two years old.

Symptoms reported range from drowsiness and lethargy, to seizures.

An implication in passive-inhalation cases usually would be that the child was improperly supervised.

Child; Teen

Child; Teen

Accidental Ingestion.	B-37
Adult-Inflicted Abuse	B-39
Teen Health Issues	B-41

Accidental ingestion of drugs or alcohol by children occurs frequently. ^{27, 55}

The court may wish to reconsider its placement order, if the accidental ingestion occurred in the child's home, or while the child was in the care of the court-designated adult.

The agency's report to the court should include:

- 1. results of a home visit with careful inspection of environment.**
- 2. description of the services that the agency has offered, and will now offer**
- 3. description of the responsible caregiver**
- 4. estimation of the safety of the child.**
- 5. description of alternate caregiving arrangements.**

Claims of accidental ingestion of drugs have become so common lately, that various descriptive terms have been developed, such as "environmentally acquired" drugs, and "morning-after syndrome."

Children who wander around homes after parties, while the adults sleep, not uncommonly pick up cocaine, alcohol and other substances and eat or drink them.

Reactions in children relate to the amount ingested. They can of course be very severe, including seizures, heightened heart and respiratory rates, vomiting, etc.

Adults who use drugs or alcohol can be prone to violence, including the physical abuse of children in their care.

When children who suffer physical abuse are before the court, the judge may wish to order:

- 1. mental health (including substance use) assessment of the caretaking adult [see pp. C-9 to 14];**
 - 2. home study to determine risk to child [see p. E-7] and**
 - 3. medical and psychological assessment of child [see pp. C-19 to 21].**
-

A. Drugs, Alcohol and Violence

Children of substance-users are likely to witness violence (especially against their mother² and to be the victims of violence.⁶⁷

Certain drugs can be the specific cause of aggressiveness and violence.⁷

For example, cocaine, methamphetamine, and PCP cause anxiety, fearfulness, hallucinations, paranoia, and physical aggressiveness.

Other drugs indirectly trigger violence.⁷

For example, alcohol causes organic brain damage, sleep deprivation, and suppression of inhibitions.

Alcohol is implicated 30-40% of the time in child sexual abuse.^{29, 44}

Many times the search for drugs and alcohol drives the consumer into a subculture where violence is pervasive.

B. Medical Assessment

All cases of violence to children will raise the court's concern about adult substance use.

The court may ask for mental health assessments of the entire family, including the child victims.

Specifically, sexual abuse will raise suspicion of alcohol use, in that the connection has been made in several medical studies.

Cracked ribs, head injuries, and other trauma to the body may indicate the need for adult drug assessments, particularly cocaine, methamphetamine, and PCP. The court should always be alert to dual diagnosis issues (mental illness plus substance use).

Adolescent drug use is often accompanied by sexually transmitted diseases and (increasingly) HIV.

The court may wish to order a needs assessment report, including:

- 1. results of a complete physical exam**
 - 2. A case plan that includes**
 - a) regular medical check-ups**
 - b) counseling on health, sexual behavior and drug-alcohol use**
 - c) stable living arrangements**
 - d) career and education goals**
-

A. STDs, HIV and Drugs

The court will wish to pay particular attention to other health "markers" of substance use, which can contribute to a poor outcome for the child.

Teen substance use should be approached as a holistic problem, requiring close medical attention and counseling.

Medical research shows a high correlation between sexually transmitted diseases, HIV and substance use.

The exchange of drugs for sex has become common among crack-cocaine users in the inner city.³³

Medical studies also show that youth with multiple sex partners are **less likely to use condoms** than those with three or fewer partners a year.^{22, 31}

Sexual activity also appears to increase with crack-cocaine use.³¹

This has contributed to a great rise in gonorrhea, syphilis and other STDs.

A high rate of HIV infection in adolescence can be deduced from statistics of AIDS among young adults.

These statistics are drawn from military recruits, job corps applicants, infected infants of teen mothers, and youth shelter entrants.³⁴

It is now thought that there is approximately a nine year latency period for the human immunodeficiency virus.

Heterosexual spread of AIDS is a greater factor among teens than among adults.

B. Holistic Health Response

Evidence Problem!

Social habits among teens may include sexual behavior that is *not* correlated to drug use. The two behaviors are not inevitably tied together.

The presence of sexually transmitted diseases and HIV are cause for the court to be alarmed about the health and well-being of the teens under its jurisdiction.

These markers will make the court *alert* to any substance use, pending further evidence.

Pregnant Woman; Fetus

Pregnant Woman; Fetus

Health Issues B-45

Court Use of Medical Evidence B-47

Certain health problems frequently accompany substance use and must be included in comprehensive care for the pregnant woman.¹⁴ They include:

1. Sexually transmitted diseases
2. HIV positive status
3. Pneumonia and tuberculosis
4. Hepatitis and cellulitis
5. Cirrhosis
6. Poor nutrition

The court will wish to assure that any debilitating diseases are treated and assessed for their impact on family life.

Particularly with HIV, the court may wish to order the agency to prepare a case plan for the child that considers the mother's availability for caregiving.

A. Diseases Described

Sexually transmitted diseases frequently appear when there is cocaine use. They can be a consequence of a lifestyle that involves trading sexual favors for drugs.

The **human immunodeficiency virus** occurs both as a consequence of IV drug use, and of sexual activity. **Pneumonia** can be one of the first of many problems that appear when the immune system is weakened.

Hepatitis and **cellulitis** can be signs of IV drug use.

Cirrhosis can be a consequence of heavy alcohol ingestion.

Tuberculosis and other diseases that attack bodies that are weakened from lack of nutrition, sleep and medical care are not uncommon.

B. Effect on Fetus

All of these diseases, and others, have implications for the newborn.

At the very least, they make gestation and birth more difficult and dangerous.

At their worst, they cross the placental barrier, or infect the fetus during birth, becoming part of the child's natal burdens. (e.g. syphilis, HIV)

HIV, of course, threatens to leave the newborn without a mother.

These facts lead to the conclusion that comprehensive health care for the mother is vital to the health and survival of the newborn, as well.

Medical assessments of a pregnant woman are used by physicians—and sometimes by courts—to corroborate a history of drug or alcohol use.

The connection between health problems and drug-alcohol use may be unfamiliar to a judge. The court may wish to require that a medical expert demonstrate the connection.

A. Medical Perspectives

Physicians will often look at cumulative evidence to determine substance use in a pregnant woman:¹⁴

1. occurrence of diseases that are companions to drug use.
2. physical appearance of exhaustion, dilated or shrunk pupils, abscesses or track marks, or runny nose.
3. a medical history of births that includes a number of miscarriages, abruptio placenta or drug-exposed babies.

Physicians will also tend to look more suspiciously at drug tests than do the courts: drug tests may indicate very recent drug use, but not chronic use [see p. A-4]

B. Legal Perspective

Evidence Problem!

The court will be aware of the constitutional problems inherent in assuming drug use based on a "profile."

Health, mental health, and social work professionals will often use a "profile" for their judgments—and many factors in the "profile" also may be factors for poverty (e.g. untidy appearance, criminal or family court history, etc.)

These "profiles" often appear in hospital drug-testing protocols and in social science literature.

Despite the problems inherent in "profile" judgments, there are aspects of these professional observations that may be worth the court's attention.

Records

Records

Interpreting Medical Records..... B-51

Obtaining Medical Records B-55

Two kinds of medical records are full of information:

- 1. The Progress Notes**
- 2. The Laboratory Reports**

The court will wish to see more than the "Discharge Summary." The "Progress Notes" (i.e. narrative portion of the records) and laboratory reports may yield the most crucial information. ⁴²

The court may wish to instruct counsel to pull specific information out of the progress notes and laboratory reports for the court's inspection.

A. Discharge Summary

Frequently, in response to a request for medical records, the records clerk will ask if more than the "discharge summary" is required.

The "discharge summary" gives the status of the patient at the time of release. It may refer to the course of treatment, but not in detail.

The "discharge summary" cannot be counted on to include information that the court may think is vital.

B. Progress Notes

Most helpful to the court will often be the **progress notes**. Whenever a physician, nurse or other health professional visits a patient in the hospital, a short description of the patient's progress is put into the record.

That description may contain facts about an infant that may add up to a diagnosis of substance exposure, even when the physician has not explicitly identified that.

For example, the judge may learn that Phenobarbital was used to sedate the trembling, sweating infant (frequently a treatment for withdrawal)

Or that the infant has had constant gastro-intestinal upsets (possible withdrawal) and is a premature, low birth weight baby.

The progress notes may not be all in one place but rather scattered throughout the record. They are usually distinctive because they are written in narrative form.

C. Laboratory Reports

The **laboratory reports** will contain results of drug screens and blood tests. These may be indicative of substance exposure, yet not be included in the discharge summary.

The physician will usually check off which factors were analyzed, indicating whether the report was positive or negative.

Typical Laboratory Reports, from ABA/SJI Judicial Training Manual. *Drugs, Alcohol and Families*

Local law governs the manner in which confidentiality is waived and medical records are obtained. ⁴³

The court will wish to check local statutes and court rules to govern cases that do not involve information from drug and alcohol programs.

A. General Medical

Most states have made legal provision for waiving confidentiality of records over the objection of the parents where neglect or abuse is at issue and good cause, or the need for the records, can be demonstrated.

B. Drug-Alcohol Treatment

To the extent that an argument can be made that the person is receiving not general medical care but drug and alcohol treatment, attention may shift to two federal laws:

Drug Abuse Office and Treatment Act of 1972, 42
U.S.C. sec.290ee-3; and

Comprehensive Alcohol Abuse and Alcoholism Prevention,
Treatment and Rehabilitation Act of 1970, 42
U.S.C. sec.290dd-3

Regulations implementing these laws set up particular procedures for waiving the confidentiality of records in order to:

“protect against an existing threat to life or serious bodily injury, including circumstances which constitute suspected child abuse and neglect”

However, in order to reach applicability of the federal laws, counsel must prove that the treatment is part of a “program” for drug and alcohol treatment.

It is unclear whether or not the neonatal ward in a hospital would fall under the rather narrow parameters of a drug and alcohol treatment “program”.

(Steps for obtaining records under the two federal laws cited are found on pages A-21)

Appendix

Appendix

Checklist: Medical, Newborn	B-59
Order for Neurobehavioral/Developmental Assessment	B-63
Order for Child's Physical Exam	B-65
Examination Of Neonatologist Or Neonatal Nurse	B-66
End Notes	B-73

NEWBORN MEDICAL CHECKLIST

	yes	comment
Urine or meconium screen		
positive		
confirmed by other method		
implicated drugs		
Five signs of potential exposure (look for 2 or 3 occurring together)		
abruptio placentae		
premature birth (less than 37 weeks)		
low birth weight (less than 2500 grams)		
small head circumference (less than 33 centimeters)		
abnormal neurobehavioral responses		
Intoxication or withdrawal		
high pitched cry		
sweating		
sneezing		
runny nose		
irritability		
hyperactivity		
tremulousness		
startles		
frantic sucking		
frequent yawning		
fever		
skin abrasions on knees, toes, elbows, nose		

Appendix
Newborn Checklist

	yes	Checklist, Newborn, cont. comment
vomiting		
diarrhea		
respiratory distress		
dehydration		
hypothermia		
poor feeding patterns		
irregular sleeping patterns		
apnea		
seizures		
Three medicines that may indicate treatment for drug exposure (check progress notes, medical records)		
paregoric		
diazepam		
phenobarbital		
Congenital anomalies		
urogenital areas		
limbs		
bowels		
kidneys		
liver		
heart		
cerebral infarctions		
eyes		
ears		
facial dysmorphology		

	yes	Checklist, Newborn, cont. comment
Cocaine (and amphetamine) reactions (in addition to, or instead of, the above)		
high respiratory rate		
elevated heart rate		
depressed interactive abilities		
Fetal Alcohol Syndrome (factors that must occur together)		
growth deficiency		
microcephaly (small cranial capacity)		
“dysmorphic” facial characteristics (any or all of these)		
flat mid-face		
thin upper lip		
epicanthal fold to eyelid		
sunken nasal bridge		
faint philtrum (groove between nose and lip)		
low-placed ears		
central nervous system dysfunction		
Fetal Alcohol Effects Any—but not all— four FAS categories:		
growth deficiency		
microcephaly		
“dysmorphic” facial characteristics		
central nervous system dysfunction		

	Checklist, Newborn, cont.	
	yes	comment
Other alcohol-related problems		
weak suck		
heart rate abnormalities		
slow habituation to stimulation		
tremors		
non-alert wake state		
Neurological Tests		
Apgar Score (0-4 is poor; top score is 10)		
 Brazelton Neonatal Behavioral Assessment Scale		
 Bayley Scales of Infant Development		

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR INFANT NEUROBEHAVIORAL/DEVELOPMENTAL ASSESSMENT

A. A neurobehavioral/developmental assessment shall be administered to (infant's name) _____ for the purpose of assessing infant impairments and deciding on therapeutic and early intervention strategies.

B. The test(s) shall be performed at:

_____ hospital (name) _____
_____ other facility _____
_____ facility to be chosen by test giver
_____ facility to be chosen by social service agency
_____ other arrangement (describe) _____

C. Test(s) shall be performed by:

_____ physician (name) _____
_____ other professional (name and profession) _____
_____ as decided by testing facility
_____ as decided by social worker
_____ as decided by (name, profession) _____

D. Test(s) shall include:

_____ Brazelton Neonatal Behavioral Assessment Scale
_____ Bayley Scales of Infant Development
_____ other: _____
_____ as decided by test-giver

E. Results of test(s) shall be sent to: _____

Court shall receive results by (date) _____

JUDGE

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR INFANT NEEDS ASSESSMENT

A. A needs assessment report shall be prepared for (infant's name): _____

The report shall be prepared by (agency) _____

B. The court is particularly concerned about effects arising from:

- _____ cocaine exposure
- _____ alcohol exposure
- _____ narcotic (opioid) exposure
- _____ inhalant exposure
- _____ polydrug exposure
- _____ other exposure (describe) _____

C. The needs assessment shall address:

- _____ apnea monitor
- _____ vulnerability to SIDS
- _____ potential for seizures
- _____ cerebral palsy
- _____ heart irregularities
- _____ congenital deformities
- _____ HIV/AIDS
- _____ other (describe) _____

D. The report shall assess:

- _____ physical therapy requirements for the next year
- _____ recommended early intervention programs
- _____ projected long-term needs
- _____ other (describe) _____

E. The report shall describe how the agency plans to meet the child's needs.

J U D G E

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR CHILD'S PHYSICAL EXAM

Child (name) _____ shall be examined at:

- _____ public-funded hospital or clinic
- _____ facility chosen by social service agency
- _____ facility chosen by examining physician
- _____ other (describe) _____

Particular attention shall be given to:

- _____ physical trauma
- _____ congenital defects
- _____ drug-alcohol reactions
- _____ any deformities or impairments for which early inter-
vention is recommended
- _____ other (describe) _____

Reports of the examination shall be submitted to _____

The court shall receive the results by (date) _____

JUDGE

EXAMINATION OF NEONATOLOGIST OR NEONATAL NURSE

Intoxication or withdrawal

Did the infant exhibit signs of intoxication?

What were those signs?

Did the infant exhibit signs of withdrawal?

What were those signs?

[alternate questions]

Did you note any of the following signs or symptoms in the infant?

high pitched cry
sweating
sneezing
runny nose
irritability
hyperactivity
trembling
startles
frantic sucking
voracious yawning
fever
skin abrasions on the infant's extremities
hypertonicity
vomiting
diarrhea
respiratory distress
dehydration
hypothermia
poor feeding patterns
irregular sleeping patterns
apnea
seizures

Are these abnormal responses for a newborn infant?

What do you believe to be the cause of these symptoms?

Were any of the following medicines administered to the infant: paregoric; diazepam, phenobarbital.

For what purpose were these medicines administered?

Neonatal exam., cont.

Infant drug tests Were any drug screens or tests performed on this infant?

Was the test performed on urine?
blood? meconium? other?

Was the test positive for any substances?

What substances were those?

Were the positive results confirmed?

What method was used to confirm them?

What do the positive results of the tests indicate to you?

How recently would the mother have had to use these
drugs, for them to be present in the infant's sample?

**Five symptoms of infant
drug exposure** Was the infant's birth precipitated by the mother's *ruptured
placenta*?

Was the infant born *prematurely*?

How many weeks gestation?
[37 weeks or more is full gestation]

How many centimeters was the infant's *head circumference* at birth?
[33 centimeters or more would be normal]

**neurobehavioral
assessments** Did you note any abnormal or unusual *neurobehavioral re-
sponses*?

What were they?

(For example, was infant: trembling?
Hyperactive? Seizures?)

Did you perform any infant development assessments?

Which one(s) did you use?

Will you give us an example or two of the assessment tech-
niques and the infant's response?

Neonatal exam., cont.

What is this infant's overall score on that scale?

How does that compare to that of a normal infant?

What do these behaviors suggest to you about:

infant's fetal development?

infant development?

causes?

Major body damage Did you find any impairment of the infant's organs?

What were they?

Skeletal structure?

What were they?

Muscles?

What were they?

Are there any congenital anomalies that have been discovered in:

urogenital areas?

reduction or deformity of limbs?

bowels?

kidney?

liver?

heart?

eyes?

ears?

cerebral infarctions?

facial dysmorphology?

How are those congenital anomalies manifested?

cocaine-specific problems Was this infant's respiratory rate normal or high?

Was this infant's heart rate normal or high?

How does the infant respond to stimuli?

(For example, being talked to, light, noise, being held?)

Neonatal exam., cont.

Is this infant's response to stimuli normal?

If not, what have you determined to be the cause of these problems?

After birth, did this infant lose weight?

How much?

Is that typical of a healthy infant?

Will the infant need an apnea monitor?

Why?

How does one operate an apnea monitor?

Is there any potential for seizures?

How must the caregiver respond to an infant with seizures?

Is the infant likely to be irritable?

Crying?

Screaming?

Compared to a healthy infant, how difficult do you believe it will be to care for this infant?

Would you say that the infant has any vulnerability to Sudden Infant Death Syndrome?

What is SIDS?

alcohol specific problems Have you noted any growth deficiency in this infant?

What is that?

Are there any indications of microcephaly?

What is that?

Does the infant exhibit physical anomalies?

low nasal bridge?
flat mid face?
thin upper lip?
indistinct philtrum?
epicanthal folds to eyelids?
low nasal bridge?
short nose?
low placed ears?
micrognathia?

Is there any central nervous system dysfunction?

Please describe

Any defects of the heart?

What are they?

Have you noted any of the following?

weak suck
low Apgar score
Please explain what that means
heart rate abnormalities
slow habituation to stimulation
tremors
head turns to left
hand-to-mouth activity
non-alert wake state?

Have you diagnosed Fetal Alcohol Syndrome?

If not, have you diagnosed Fetal Alcohol Effects?

Will you explain what is the difference between them?

Overall Evaluation Is this infant ready for discharge?

If not, why not?

What are the infant's immediate treatment needs for the next three months?

What are the infant's treatment needs likely to be over the next year?

Have you had any opportunity to observe the infant's family interacting with (him/her)?

Are you recommending that the infant be discharged to the family?

Have your observations influenced your view?

Please explain.

END NOTES

1. Amaro, et al., *Drug Use Among Adolescent Mothers: Profile at Risk*, 1989 Pediatrics, Vol. 84, pp 144-151
2. Amaro, et al., 1990 *Violence During Pregnancy and Substance Use*, Am J. Public Health, vol. 80, pp.575-579.
3. American Academy of Pediatrics, Comm.on Substance Abuse, *Drug Exposed Infants*: Pediatrics, Oct. 1990, Vol. 86, No.4, p.639-642.
4. American Academy of Pediatrics, *Neonatal Drug Withdrawal*, 1983 Pediatrics, 895-907
5. American Medical Association, Law and Medicine, Board of Trustees Report, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, Journal of the American Medical Association (JAMA) Nov. 28, 1990, Vol. 264, No.20, p. 2663-2670.
6. Bandstra & Burkett, *Maternal-Fetal and Neonatal Effects of In Utero Cocaine Exposure*, 1991 Seminars in Perinatology, Vol.15, No.4, pp 288-301.
7. Bays, *Substance Abuse and Child Abuse*, 1990 Pediatrics Clinics of North America, Vol. 37, No.4, p.881-904.
8. Bass, et al., *Death-scene Investigation in Sudden Infant Death*, 1986 New Eng. J. of Med., Vol. 315, No.2, p.100-105.
9. Bateman & Heagarty, *Passive Freebase Cocaine ("Crack") Inhalation by Infants and Toddlers*, Jan. 1989 American Journal of Diseases in Children, Vol. 143, p.25-27.
10. Chasnoff, *Cocaine Intoxication in a Breast Fed Infant*: 1987 Pediatrics, Vol. 80, No. 6, p.836-838.
11. Chasnoff, et al.: *Cocaine/Polydrug Use in Pregnancy: Two-Year Follow-Up*. 1992 Pediatrics, Vol. 89, No.2, 284-289.
12. Chasnoff: *Drug Use and Women: Establishing a Standard of Care*, 1989 Annals of N.Y. Academy of Science, Vol. 562, 208-210.
13. Chasnoff, *Newborn Infants with Drug Withdrawal Symptoms*, 1988 Pediatrics in Review, Vol. 9, No. 9, p. 273-277.
14. Chasnoff, *Perinatal Effects of Cocaine*, May 1987 Contemporary OB/GYN, pp163-179.
15. Chasnoff, *Prenatal Drug Exposure: Effects on Neonatal and Infant Growth and Development*: 1986 Neurobehavioral Toxicology and Teratology, Vol. 8, p.357.
16. Chasnoff, et al., *Temporal Pattern of Cocaine Use in Pregnancy*, 1989 JAMA, Vol. 261, No. 12, p.1741-1744.

17. Chavez, et al.: *Maternal Cocaine Use During Early Pregnancy as a Risk Factor for Congenital Urogenital Anomalies*, 1989 JAMA, Vol. 262, No.6, p.795
18. Chavkin, *Drug Addiction and Pregnancy: Policy Crossroads*, 1990 Am.J. Public Health, Vol 80, No 4, pp 483-487.
19. Chouteau, et al.: *The Effect of Cocaine Abuse on Birth Weight and Gestational Age*, 1988 Obstetrics and Gynecology, Vol. 72, No.3, Part 1, p. 351-354.
20. Connolly & Marshall, *Drug Addiction, Pregnancy and Childbirth: Legal Issues for the Medical and Social Services Communities*, Drug-Exposed Infants and their Families: Coordinating Responses of the Legal, Medical and Child Protection Systems, ABA Monograph 1990.
21. Cook, et al.: *Alcohol, Tobacco and other Drugs May Harm the Unborn*, 1990 OSAP, DHHS Pub. (ADM) 90-1711.
22. DiClemente et al., *Determinants of Condom Use Among Junior High School Students in a Minority, Inner-City School District*, 1992 Pediatrics, Vol. 89, No.2, pp 197-202.
23. Dixon: *Effects of Transplacental Exposure to Cocaine and Methamphetamine on the Neonate*, West J. Med. 1989, Vol. 150, 436-442.
24. Doberczak, et al., *One-Year Follow-Up of Infants with Abstinence-Associated Seizures*, 1988 Arch Neurol, Vol.45, pp.649-653.
25. Edelin, et al., *Methadone Maintenance in Pregnancy: Consequences to Care and Outcome*, 1988 Obstetrics and Gynecology, Vol. 71, No.3, pp 399-404.
26. English & Henry, *Legal Issues Affecting Drug-Exposed Infants*, Youth Law News, Vol. XI, No. 1, p. 1 (1990).
27. Ernst & Sanders, *Unexpected Cocaine Intoxication Presenting as Seizures in Children*, 1989 Annals of Emergency Medicine, Vol 18, No.7, p.774-776.
28. Falloon, et al., *Human Immunodeficiency Virus Infection in Children*, 1989 J. of Pediatrics, Vol 114, No.1, pp 1-30.
29. Finklehor, *A Sourcebook on Child Sexual Abuse*, Beverly Hills, Sage Publications, 1986.
30. Finnegan & Wapner, *Narcotics Addiction in Pregnancy*, in *Drug Use in Pregnancy*, ed. Lea and Febiger, 1987, pp 203-222.
31. Fullilove, et al., *Risk of Sexually Transmitted Disease among Black Adolescent Crack Users in Oakland and San Francisco, Calif.*, 1990 JAMA, Vol. 263, No.6, pp 851-855.
32. Gallagher, *Prenatal Invasions and Interventions*, 10 Harv. Women's L.J. 9 (1987)
33. Goldsmith, *Sex Tied to Drugs = STD Spread*, 1988 JAMA, Vol 260, No.14, p 2009.
34. Hein, *Adolescent Acquired Immunodeficiency Syndrome*, 1990 Am.J. of Diseases in Children, Vol 144, pp 46-48.

35. Howard, et al.: *The Development of Young Children of Substance-Abusing Parents: Insights from Seven Years of Intervention and Research*, June, 1989 Zero to Three, p. 8-12
36. Jones & Lopez: *Component Report on Drug Abuse*, Public Health Service Report on the Content of Prenatal Care, 1990 Vol. II, Chapter 16, p.273.
37. Kaltenbach & Finnegan, *Perinatal and Developmental Outcome of Infants Exposed to Methadone In-Utero*, 1987 Neurotoxicology and Teratology, Vol.9, No.9, pp.311-313.
38. Kandall & Gaines, *Maternal Substance Use and Subsequent Sudden Infant Death Syndrome (SIDS) in Offspring*, 1991 Neurotoxicology and Teratology, Vol.13, pp.235-240.
39. Kemper: *Self-Administered Questionnaire for Structured Psychosocial Screening in Pediatrics*, 1992 Pediatrics, Vol. 89, No.3, 433-436.
40. Khoury, et al.: *Does Maternal Cigarette Smoking During Pregnancy Cause Cleft Lip and Palate in Offspring?* 1989 American Journal of Diseases in Children, Vol 143, p 333-337.
41. Larsen, *Creating Common Goals for the Medical, Legal and Child Protection Communities*, in Drug-Exposed Infants and their Families: Coordinating Responses of the Legal, Medical and Child Protection Systems, ABA Monograph, 1990.
42. Larsen, et al., *Medical Evidence in Cases of Intrauterine Drug and Alcohol Exposure*, 18 Pepperdine L.Rev. 279 (1991).
43. Larsen & Horowitz, *Judicial Primer on Drug and Alcohol Issues in Family Cases*, 1991 American Bar Association.
44. Leonard & Jacob, *Alcohol, Alcoholism and Family Violence*, at pp.386-406 in Van Hasselt, et al., *Handbook of Family Violence*, N.Y., Plenum Press, 1988.
45. MacGregor, et al.: *Cocaine Use During Pregnancy: Adverse Perinatal Outcome*, 1987 American Journal of Obstetrics and Gynecology, Vol 157, No 3, p 686-690.
46. Martin & Bracken: *Association of Low Birthweight with Passive Smoke Exposure in Pregnancy*, 1986 Am.J. of Epidemiology, Vol. 124, No.4, 633-642.
47. Moss, *Substance Abuse During Pregnancy*, 13 Harv.Women's L.J. 278 (1990)
48. Office for Treatment Improvement, *Treatment Improvement Protocol Statements (TIPS): Pregnant, Substance-Using Women*, 1991 (Draft).
49. Office of National Drug Control Policy, *Understanding Drug Treatment*, White Paper, June 1990.
50. Oro & Dixon: *Perinatal Cocaine and Methamphetamine Exposure: Maternal and Neonatal Correlates*, 1987 Journal of Pediatrics, Vol.111, No. 4, p.571-578
51. Orr, et al., *Factors Associated with Condom Use Among Sexually Active Female Adolescents*, 1992 J. of Pediatrics, Vol. 120, No.2, Part 1, pp 311-317.

52. Ostrea, et al., *Drug Screening of Newborns by Meconium Analysis: A Large-Scale, Prospective Epidemiologic Study*, 1992 Pediatrics, Vol. 89, No.1, pp 107-113.
53. Ostrea, et al., *A New Method for the Rapid Isolation and Detection of Drugs in the Stools (Meconium) of Drug-Dependent Infants*, Annals of N.Y. Academy of Science, 1989, Vol.562, p.372.
54. Regan, et al., *Infants of Drug Addicts: At Risk for Child Abuse, Neglect, and Placement in Foster Care*, 1987 Neurotoxicology and Teratology, Vol.9, pp.315-319.
55. Rivkin & Gilmore, *Generalized Seizures in an Infant due to Environmentally Acquired Cocaine*, 1989 Pediatrics, Vol. 84, No. 6, p.1100-1102.
56. Schneider, et al: *Infants Exposed to Cocaine in Utero: Implications for Developmental Assessment and Intervention*, Inf Young Children, July 1989.
57. Schneider & Chasnoff: *Cocaine Abuse During Pregnancy: its Effects on Infant Motor Development—a Clinical Perspective* 1987 Topics in Acute Care and Trauma Rehabilitation, Vol. 2, No. 1 p.59-69.
58. Shannon, et al., *Cocaine Exposure in Pediatrics*, April 1988 American Journal of Diseases in Children Vol. 142, p. 385 [abstract]
59. Silver, et al., *Addiction in Pregnancy: High Risk Intrapartum Management and Outcome*, 1987 J. of Perinatology, Vol VII, No 3, pp 178-184.
60. Soyka & Joffe, 1980 *Male Mediated Drug Effects on Offspring*, Drug and Chemical Risks to the Fetus and Newborn, A. Liss, Inc. p. 49-66.
61. Streissguth, et al.: *A Manual on Adolescents and Adults with Fetal Alcohol Syndrome with Special Reference to American Indians*, University of Washington, 2nd Ed., 1988.
62. Streissguth, et al.: *Fetal Alcohol Syndrome in Adolescents and Adults*, 1991 JAMA, Vol. 265, No. 15, p.1961-1967
63. Streissguth, et al.: *A Natural History of the Fetal Alcohol Syndrome*, Fall 1985 Alcohol Health and Research World, Vol. 10, No.1, p.6-12.
64. Streissguth, et al.: *Neurobehavioral Dose-Response Effects of Prenatal Alcohol Exposure in Humans from Infancy to Adulthood*, 1989 annals of N.Y. Academy of Science, Vol. 562, p. 145-157.
65. Streissguth & LaDue: *Psychological and Behavioral Effects in Children Prenatally Exposed to Alcohol*, Fall 1985 Alcohol Health and Research World, Vol. 10, No. 1, p.6-12.
66. Yazigi, et al. *Demonstration of Specific Binding of Cocaine to Human Spermatozoa*, 1991 JAMA, Vol 266, No.14, p.1956-1959.
67. Zuckerman & Bresnahan, *Developmental and Behavioral Consequences of Prenatal Drug and Alcohol Exposure*, 1991 Pediatric Clinics of North America, vol.38, pp.1387-1406.

68. Zuckerman & Frank, "*Crack-Kids*" Not Broken, 1992 Pediatrics, Vol.89, No.2, 337-339.
69. Zuckerman, et al: *Effects of Maternal Marijuana and Cocaine Use on Fetal Growth*, N.Eng.J.Med. 1989 Vol. 320, No.12, p.762-768.

CASES

- Cox v. Ct. of Common Pleas*, 537 N.E. 2d 721 (Ohio App.1988) [no jurisdiction over fetus possible]
- Dept. of Soc.Serv.on behalf of Mark S. v. Felicia B.*, 543 NYS 2d 637 (Fam.Ct.1989) [duty towards child exists at fetal stage but ripens to cause of action at birth]
- Dept. of Soc.Serv. v. Nash*, 419 N.W.2d 1 (Mich.App.1987) [Infant's drug-exposed characteristics plus mother's prior neglect record sufficient for jurisdiction]
- In the Matter of Baby X*, 293 N.W. 2d 736 (Mich.Ap.1980) [prenatal conduct of mother may be considered along with drug withdrawal symptoms to establish jurisdiction]
- In the Matter of "Male" R*, 422 NYS 2d 819 (Kings Cty.Fam.Ct., 1979) [based on mother's past drug record, newborn child was in imminent danger of abuse from mother]
- In the Matter of Stefanel Tyesha C.*, 556 NYS 2d 280 (A.D.1 Dept.1990) [newborn's positive toxicology combined with mother's confession of prenatal drug use and failure to enrol in treatment program is sufficient to show neglect]
- In re Ruiz*, 500 N.E.2d 935 (Ohio Com.Pl.1986) [In her perinatal drug abuse, mother abused "child" by creating a substantial risk to the newborn's health]
- In re Troy D.*, 263 Cal Rptr 869 (Cal.App.4 Dist.1989) [mother's prenatal behavior can be considered after birth of drug-exposed child]
- In re Vanessa F.*, 351 NYS 2d 337 (1974) [Newborn with drug withdrawal symptoms is, prima facie, a neglected child]
- Matter of Damien H.*, N.Y.L.JJ. 1/6//92 at 26, Col.3 (Fam.Ct., King County)
- Matter of Fletcher*, 141 Misc.2d 333, 533 NYS 2d 241 (Fam.Ct.1988) [prenatal drug use can only be a factor in neglect if there is a direct connection to child's health and safety]
- Matter of Smith*, 128 Mich.2d 976, 492 N.W.2d 331 (Fam.Ct.1985) [mother who misused alcohol during pregnancy created imminent danger to child]
- State v. Gray*, 62 Ohio St.3d 514 (1992) [drug exposure prior to birth does not amount to "child endangerment" under Ohio law]

C. MENTAL HEALTH

MENTAL HEALTH ASSESSMENTS

Kinds Of Assessments

Court Identification of Substance Use	C-5
When to Schedule Assessments	C-7
Mental Health Screening.....	C-9
Court Guidance to Mental Health Professionals.....	C-11
Full Mental Status Assessment (Psychiatric, Psychological.....	C-13
Psychiatric Assessment.....	C-15
Psychological Tests.....	C-17
Infant-Child Mental Health Assessments	C-19
Adolescent Mental Health Issues	C-23

Interpretation Of Reports (DSM III-R)

Use, Abuse, and Dependence	C-27
Impact of Substances on Central Nervous System	C-31

Records

Obtaining, With Consent or Court Order	C-35
Obtaining, Without Consent	C-37

Appendix

Checklist: Scheduling Family Assessments	C-41
Checklist: Child, Developmental	C-42
Examination Of Psychologist, Psychiatrist.....	C-44
Order for Mental Health Screening.....	C-48
Order for Full Mental Health Assessment.....	C-49
Lists of Commonly Administered Tests	C-51
Annotations of Specific Tests	C-53
End Notes	C-63

Kinds of Assessments

Kinds of Assessments

Court Identification of Substance Use C-5

When to Schedule Assessments C-7

Mental Health Screening C-9

Court Guidance to Mental Health Professionals C-11

Full Mental Status Assessment (Psychiatric, Psychological) . . C-13

Psychiatric Assessment C-15

Psychological Tests C-17

Infant-Child Mental Health Assessments C-19

Adolescent Mental Health Issues C-23

Early signs to the court of possible drug or alcohol problems in the family may occur through:

1. Allegation in the Petition
2. Admission of Drug Use
3. Positive Drug Test
4. Prior Family or Criminal Court Record Indicating Drug or Alcohol Use
5. Appearance of Intoxication or Severe Withdrawal

The court usually will want to demand cumulative evidence of drug use (e.g. appearance of intoxication plus a history of giving birth to drug-exposed infants).

Evidence Problem!

There is a fine line between mental health danger signals and distress caused by poverty and physical illness.

Characteristics of intoxication like slurred speech and unsteady gait also can be signs of nervous disorders and other diseases.

To best assess the impact of alcohol and drugs on a family, as soon as local law permits, the court should order:

- 1. Mental health screens for substance-using adults [See p. C-9]; and**
- 2. Full mental health assessments for family members who are free of drugs [See pp. C-13 to 21].**

The court need not postpone evaluations for other family members until substance-using members are free of drugs. The more information the court has, the better will be its early decisions.

A. Initial Assessments

For persons whose screenings indicate drug or alcohol use and/or whose drug tests are positive, schedule as soon as possible after two consecutive negative drug tests.

The purpose of the bridging regimen is to clean toxins out of the person's system so that the most useful and complete mental health assessment can be provided to the court.

If drug tests continue to be positive, the mental health assessments should be postponed until there are two consecutive negative results.

Motivation for the adult to comply with the mental health assessments may depend on the extent to which the assessments are tied to the court's child placement decision.

B. Eighteen Month Follow-Up

When the child has been placed outside the home or extended family, federal (and therefore state) law requires an inquiry within 18 months after the child came into care to determine why reunification has not occurred. PL 96-272

Certain states require an earlier review to make permanent placement decisions.

At the permanent placement review, if reunification is still the preferred option, the court may profit from an assessment of the adult's prospects for overcoming drug and alcohol-caused dysfunction and providing a nurturing, stable home for the child.

The court may wish to pose the following kinds of questions for the mental health professional:

1. What place do drugs and alcohol currently have in this person's life?
2. Is this person currently in treatment?
3. What is the treatment director's prognosis for recovery?
4. Is care for and nurture of the child important to this adult?
5. Is this person currently capable of caring for and nurturing the child?
6. Does this person provide a healthy drug and alcohol-free environment in which the child can grow?
7. Are there other resources beyond the family on which the child can depend?

When drug or alcohol use is suspected, an immediate screening by a psychologist or psychiatrist is advised to rule out other causes of dysfunction.

The screening order should require the mental health professional to:

“rule out or assess for any current drug-alcohol problems (psychoactive substance induced mental disorders) or any long-term drug-alcohol problems (psychoactive substance use disorders) as well as any predisposing factors or complications associated with these disorders. [consult DSM III-R classifications]”

[See model order, p. C-48]

Full mental health evaluations cannot occur if the person is intoxicated. Drugs and alcohol impair judgment and test-taking skills [See p. C-7, for regimen to clear toxins from body.]

A mental health screening, however, can provide the court with information crucial to child placement decisions.

The suggested wording for the order directs the psychologist or psychiatrist to assess the person's current relationship with drug and alcohol, evaluate any addictions, and comment on the problems it is causing, including mental complications.

Psychological and psychiatric assessments require specific questions from the court in order to yield accurate information on how parental substance use may be threatening a child and contributing to an unstable family environment.

The court's order may include such questions as:

- 1. To what extent are drugs or alcohol interfering with the parenting abilities and tasks of this person?**
- 2. How possible is it that the child's safety will be threatened if the child is left in the exclusive care of this adult?**
- 3. What course of mental health treatment, and drug-alcohol treatment, would be required to restore health and stability to this person?**
- 4. Is this child receiving the care and nurture required for a healthy and stable childhood?**
- 5. What degree of closeness to the parent is it in the child's best interests to maintain during attempts to treat and stabilize this family?**

The reason that the court must guide the mental health professional, is that psychiatric and psychological assessments cast a wide net.

They are meant to warn of a great variety of problems from psychopathic behavior and schizophrenia on the one hand to stress or impaired intellectual functioning on the other.

To further complicate matters, many psychological tests have a number of ways to be analyzed and scored.

If the psychologist does not know what the court wants to know, the choice of tests and the choice of interpretive scales will be left up to chance and the tester's instincts.

Focusing the search on drug and alcohol use (even if that is not the exclusive goal) makes the task efficient and the report helpful. The tester will then be looking for distinctions between mental illness, poverty, cultural differences, and actual misuse of drugs or alcohol.

At the heart of a psychiatric or psychological assessment is a mental status assessment during which the behavior and appearance of the person is closely observed.

There is frequent correlation between mental disorders and substance use. The psychologist or psychiatrist is trained to explore that nexus. However, the court must include questions in the court order that specifically focus on that issue.

A. Mental Status

Typically, the subjects covered in a mental status interview include:¹⁹

- identifying data
- consideration of the referral question
- current status of the referred problem
- history of the present illness
- previous psychiatric and medical illnesses
- personal social history
- history of physical and sexual abuse
- history of substance abuse
- school history
- peer relationships
- sociopathy
- family history
- mental illness in the family
- developmental history (including learning disabilities and neurological problems)

The part of the interview that assesses mental **status**, usually includes analysis of:

- general appearance
- motoric behavior
- attitude
- mood
- affect
- speech
- perceptual disorders
- thought content
- thought process

- level of consciousness
- long-term memory
- recent memory
- short-term memory . concentration and calculation
- information and intelligence
- judgment
- insight

B. Standards of Practice

The Joint Commission on Accreditation of Hospitals Organization has developed standards of practice for psychologists and psychiatrists who serve drug-alcohol dependent persons in hospitals or clinics.¹⁸

There are no separate standards for forensic psychologists and psychiatrists. Therefore, these standards come close to being the benchmark for treating professionals.

The standards require that a psychiatric and psychological assessment include:

1. a systematic mental status examination with special emphasis on immediate recall and recent and remote memory.
2. a determination of current and past psychiatric/psychological abnormality.
3. a determination of the degree of danger to self or others; and
4. a neuropsychological assessment if indicated by the psychiatric/psychological assessment.

Special emphasis is placed on cognitive functioning, including any learning impairment that might influence diagnosis and treatment.

A psychiatrist can explore physiological bases for substance use and mental illness and suggest neurological or other tests, as well as prescribe medicine.

If the court suspects that medical management of this person may be required, a psychiatric assessment can be useful.

Dual diagnosis (substance use and mental illness) is a common problem in certain populations.

Other issues that frequently arise in substance-using families that may require medical management include children that are hyperactive, have neurological damage, or parents that are mentally ill.

Tests, usually administered by a psychologist, can measure intellectual-cognitive functioning in a way that gives insight into behavior. Tests can also describe personality.

The court order should indicate that an assessment of drug and alcohol use is of high concern to the court. [See model order, p. C-49]

Tests may reveal factors relating to substance use that are denied or unrecognized by the person tested, and that would not be apparent during an interview.

Some tests of intellectual-cognitive functioning require the psychologist to rule out substance use as a factor that is impairing intellectual functioning [see MMPI annotation, p.C-56]

For example, delusion on the part of the person being tested may be caused by schizophrenia or may be caused by a psychoactive substance.

In addition, the underlying reference for mental health professionals, *The Diagnostic and Statistical Manual*, (Third Edition, Revised), has a number of ways to reveal behavior of substance-using persons. [see p. C-27 to C-31]

However, for most tests to yield information on substance use, a psychologist requires to know that substance use is a concern of the court so that appropriate interpretive keys can be used.

The problems caused by family drug and alcohol use can be assessed in children from birth to adulthood.

Assessments of infants and small children can be very helpful to the court in selected cases.

For example, the court may examine the Apgar scores of newborns and order neurobehavioral assessments for those suspected of drug-exposure.

The court will wish to specify the specific concerns to be addressed by the infant's physician or a child psychologist.

A. Infants

Neurobehavioral problems and developmental delays can be assessed from birth through two years with tests of motor response, visual and auditory response, muscle tone, and so forth.

Infant tests usually are administered by physicians, or by other trained professionals in association with a physician.

i. Apgar

At birth, and at five minutes after birth, an infant receives an Apgar Score from one (poor) to ten (excellent) that accounts for heart rate, skin tone, motor responses, muscle tone and respiration.

The Apgar Score is in the infant's medical records.

The Apgar Score predicts neonatal distress, rather than future development. However, a low score (0-4) indicates an infant at risk for developmental delays.¹⁴

ii. Brazelton

When drug or alcohol exposure is suspected, or developmental delays are evident, the Brazelton Neonatal Behavioral Assessment may be administered. The neonate responds to visual, auditory and other sensual stimuli in a series of simple tasks. [see annotation, p.C-62]

The Brazelton Assessment measures the newborn's ability to adjust to the new environment. It also measures the newborn's ability to interact with parents or other adults.⁵

A 1989 study found correlation between mothers' depression rating on the Minnesota Multiphasic Personality Inventory and a low developmental score for infants on the Brazelton Assessment, indicating how maternal characteristics may affect the infants' progress.¹³

The Brazelton Scale indicates current functioning more than it predicts future development.^{5,9}

iii. Bayley

An assessment that measures progress at various milestones in the infant's life are the Bayley Scales of Infant Development. At specified intervals the child's mental, motor and behavioral responses are analyzed for their relationship to normally developed children of their age. Assessments can continue until the age of two. [see annotation, p. C-62]

While the Bayley Scales cannot actually predict future development, they can point to areas of risk and suggest potential for future delays.^{4,14}

B. Toddlers

Play therapy has a respected history and can be a valuable tool to recognize social-environmental problems that the child may have, as well as individual physical progress.

A sandbox may be the environment, and dolls or figurines the props.

Play therapy calls on the intuitive and creative skills of the child psychologist, who must have specific training for this kind of analysis.

A skilled therapist can develop reports helpful to the court by observing a family together as they interact.

The Kaufman Assessment Battery for Children (K-ABC) can be administered to children as young as two and a half. [see annotation, p. C-55]

C. Children

From the ages of three or four, the variety of assessments expands.[see annotation, p. C-53 to 58]

1. Play therapy
2. Analyses based upon drawing (e.g. Draw-A-Person; House-Person-Tree)
3. Analyses based upon responses to visual and auditory stimuli (e.g. Rorschach, TAT, Bender-Gestalt, K-ABC)
4. Standard intelligence tests (e.g. Weschler)
5. Special tests for neuropsychology (e.g. Halstead-Reitan)
6. Clinical observation of family interactions

Children who are victims of substance-using adults can be identified in a variety of ways.

In addition to identification of physical traumas which they may suffer, play therapy and tests that require responses to pictures can be helpful because they evoke emotions that rise from the child's family history.

Observation by a skilled clinical child psychiatrist or psychologist of the child's interactions with family members is always useful.

The court may wish to specify that the child is to be observed in the the home.

Administration of a substance use assessment [see annotation of CAST p. C-61] will provide direct information on substance use in the family.

An individual teenager's drug and alcohol use needs to be examined as part of a web of social problems, including family, peers, and the community.

The structure of a mental health assessment for teens is similar to that for adults See C-9 to C-17]

In addition, the court will wish to approach teen drug-alcohol use as a holistic problem that requires medical as well as mental health supervision.

The court may wish to order a needs assessment that includes:

- 1. results of a complete physical exam [See Teen Medical, p. B-41]**
 - 2. a case plan that includes**
 - a) regular medical checkups**
 - b) counseling on health, sexual behavior and drug-alcohol use**
 - c) stable living arrangements**
 - d) career and education goals**
-

A. Family Dysfunction

Family problems usually precede drug-alcohol use.

A great majority of young women in treatment for substance use have a history of sexual abuse.¹¹

About half the young men have a history of physical abuse¹¹

Numerous studies of substance-use risk factors for adolescents indicate that family dysfunction is central^{6,5,20,22}

This dysfunction includes parental and sibling substance use, conflict and social deprivation.

If the teenager is to remain involved with the family, analysis and counseling of that family is of central importance.

B. Other Social Factors

Other factors prominently associated with substance use are:

- low attachment to school
- peer interactions
- community tolerance for drugs
- disruptions in living arrangements
- individual characteristics:
 - low self esteem
 - lack of skills
 - psychological disturbances

C. Typical vs. Extreme Use

Teen drug-alcohol use is NOT confined to certain socio-economic or ethnic groups.

Studies indicate that approximately the same percentage of teens at all economic levels, and in all ethnic groups use drugs or alcohol -- although the *kinds* of drugs vary between ethnic groups and between geographical regions.²⁰

A longitudinal study over more than a decade suggests that it is normal for teenagers to *experiment* with drugs.

The frequent users on the one hand, and total abstainers on the other, may be less psychologically balanced teens than those who experiment with drugs.²⁴

Interpretation of Reports

Interpretation of Reports (DSM III-R)

Use, Abuse, and Dependence..... C-35

Impact of Substances on Central Nervous System C-37

To a mental health professional, the ability to parent may be tied to the kind and extent of *use, abuse or dependence* on drugs or alcohol.

If this concept appears in the mental health assessment, the court will want to explore it carefully with the expert. The distinction has not been discussed widely in legal cases.

The expert may be asked to identify the report's position as adhering to, or departing from, DSM-III-R criteria for use, abuse and dependence. [See Examination Protocol, p. C-44]

A. Behavior Criteria

The idea of distinguishing between degrees of harm in using drugs and alcohol, and the vocabulary that expresses the concept, is found in the standard reference for mental health professionals: the *Diagnostic and Statistical Manual of Mental Disorders* (Third Edition - Revised), published by the American Psychiatric Association, 1987. It is known as the DSM-III-R.

Dependence on, and abuse of, drugs or alcohol fall into a DSM-III-R category called psychoactive substance use disorder. This refers to maladaptive behavior associated with more or less regular use of substances.

B. Dependence

The DSM-III-R describes kinds of behavior, for example, being unable to meet school or work commitments, or spending a great deal of time trying to obtain the substance. An accumulation of at least three of the described behaviors over a specified period of time amounts to dependence on the substance.

C. Abuse

Users who do not meet the criteria for dependence, but who use psychoactive substances in two described harmful ways over a specified period of time are classified as **abusers**.

D. Use

Users of psychoactive drugs who do not meet the DSM-III-R criteria for either dependence or abuse might well be described as persons who could fulfill their parenting obligations while using drugs or alcohol.

Chart from *Diagnostic and Statistical Manual*, Third Edition, Revised, American Psychiatric Association, 1987

DSM-III-R

DIAGNOSTIC CRITERIA FOR PSYCHOACTIVE SUBSTANCE DEPENDENCE

A. At least three of the following:

- (1) substance often taken in larger amounts or over a longer period than the person intended
- (2) persistent desire or one or more unsuccessful efforts to cut down or control substance use
- (3) a great deal of time spent in activities necessary to get substance (e.g., theft), taking the substance (e.g. chain smoking), or recovering from its effects
- (4) frequent intoxication or withdrawal symptoms when expected to fulfill major role obligations at work, school or home (e.g. does not go to work because hung over, goes to school or work "high," intoxicated while taking care of his or her children), or when substance use is physically hazardous (e.g., drives when intoxicated)
- (5) important social, occupational, or recreational activities given up or reduced because of substance use
- (6) continued substance use despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by the use of the substance (e.g., keeps using heroin despite family arguments about it, cocaine-induced depression, or having an ulcer made worse by drinking)
- (7) marked tolerance: need for markedly increased amounts of the substance (i.e., at least a 50% increase) in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount.

Note: the following items may not apply to cannabis, hallucinogens, or phencyclidine (PCP)

- (8) characteristic withdrawal symptoms (see specific withdrawal syndromes under Psychoactive Substance-induced Organic Mental Disorders)
- (9) substance often taken to relieve or avoid withdrawal symptoms

B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.

Criteria for Severity of a Psychoactive Substance Dependence

Mild: Few, if any, symptoms in excess of those required to make the diagnosis, and the symptoms result in no more than mild impairment in occupational functioning or in usual social activities or relationships with others.

Moderate: Symptoms or functional impairment between "mild" and "severe."

Severe: Many symptoms in excess of those required to make the diagnosis, and the symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.

In Partial Remission: During the past six months, some use of the substance and some symptoms of dependence.

In Full Remission: During the past six months, either no use of the substance, or use of the substance and no symptoms of dependence.

DIAGNOSTIC CRITERIA FOR PSYCHOACTIVE SUBSTANCE ABUSE

A. A maladaptive pattern of psychoactive substance use indicated by at least one of the following:

- (1) continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of the psychoactive substance
- (2) recurrent use in situations in which use is physically hazardous (e.g., driving while intoxicated)

B. Some symptoms of the disturbance have persisted for a least one month, or have occurred repeatedly over a longer period of time.

C. Never met the criteria for Psychoactive Substance Dependence for this substance.

The screening report will indicate whether drugs or alcohol are causing a current mental dysfunction.

The court's delivery of services to the family will depend on whether the dysfunction is from drug and alcohol use, organic mental impairment, or some other dominant cause (like poverty or cultural adjustment).

Both treatment and the potential for family reunion will be affected by how the impairment is analyzed.

The Diagnostic and Statistical Manual of Mental Disorders (DSM III-R) suggests various schemes for observing psychoactive substance use and distinguishing it from other sorts of mental impairment.

One scheme frequently used in screenings examines the impact of certain of the most popular psychoactive substances directly on the central nervous system

Chart reprinted from the *Diagnostic and Statistical Manual*, Third Edition, Revised, American Psychiatric Association, 1987

ORGANIC MENTAL SYNDROMES ASSOCIATED WITH PSYCHOACTIVE SUBSTANCES							
	Intoxication	Withdrawal	Delirium	Withdrawal Delirium	Delusional Disorder	Mood Disorder	Other Syndromes
Alcohol	*	*		*			1
Amphetamine & related sub- stances	*	*	*		*		
Caffeine	*						
Cannabis	*				*		
Cocaine	*	*	*		*		
Hallucinogen (hallucinosis)	*				*	*	2
Inhalant	*						
Nicotine		*					
Opioid	*	*					
Phencyclidine (PCP) & related substances	*		*		*	*	3
Sedative, hyp- notic, or anxi- olytic	*	*			*		4

1. Alcohol Idiosyncratic Intoxication, Alcohol Hallucinosis, Alcohol Amnesic Disorder, Dementia Associated with Alcoholism.

2. Posthallucinogen Perception Disorder.

3. Phencyclidine (PCP) or Similarly Acting Arylcyclohexylamine Organic Mental Disorder NOS.

4. Sedative, Hypnotic or Anxiolytic Amnesic Disorder.

Records

Records

Obtaining, With Consent or Court-Order. C-35

Obtaining, Without Consent C-37

Evidentiary privileges protecting confidentiality between patients and mental health professionals are generally waived when mental health assessments are either consented to or court-ordered.

After the inception of the case the court should have no difficulty obtaining the results of court-ordered assessments that arise out of the case and pertain to case.

When the examination is court-ordered, the examining psychologist or psychiatrist will explain to the patient that confidentiality is waived. The interview or testing will proceed only if the person agrees to that condition.

Reports of mental health assessments completed prior to the court process—or contemporaneous with the court process, but undertaken for a separate purpose—probably will be subject to restrictions raised by evidentiary privilege between patient and mental health professionals.

The court will wish to consult local statutes and court rules to determine the procedures for waiving evidentiary privileges in cases of neglect and abuse when the information is vital to the case and cannot be obtained in any other way.

A. “Good Cause” Exception

Many states permit these privileges to be waived under certain conditions (for example, “for good cause shown”, or for the “child’s best interests”) where child abuse or neglect is at issue. Consult local law.

B. Drug Treatment Records

If the mental health analysis occurred in the context of a drug treatment program, access to the records is likely to be controlled by two laws:

1. Drug Abuse Office and Treatment Act of 1972, 42 U.S.C. sec. 290ee-3; and
2. Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, 42 U.S.C. sec. 290dd-3.

Regulations describing the procedures for the court to use to compel disclosure are found at 42 C.F.R. 63 (1990) et seq.

The standard for disclosure will be: “whether the confidential information is necessary to protect against an existing threat to life or serious bodily injury, including circumstances which constitute suspected child abuse and neglect...” sec. 2.63(a)(1).

The court will balance “the public interest and the need for disclosure” against “the injury to the patient, to the physician-patient relationship, and to treatment services.”

If the court decides that there is a need for those records, the following steps should be taken:

Step 1: Determine if the state has stricter prohibitions against disclosure than do the federal laws.

State laws are not pre-empted by these federal laws. sec.1.20

State laws must be followed if they are stricter.

Step 2: Determine if the drug test record originates in a "program" as defined in the law. "Program" is defined at:

Step 3: Determine if disclosure is warranted, or whether there are other effective ways of obtaining the information. sec. 2.64.

Step 4: Assure that adequate notice has been given to both the person tested and the holder of the record.

Step 5: Assure that both the person tested and the record holder have an opportunity to file written responses and to appear in person to argue their positions. sec. 2.64 (b)(c).

Step 6: Assure that the mental health reports are not disclosed to a non-party. In-chambers arguments and sealed records should be considered. sec. 2.64 (e)

C. Records Outside a "Program"

Evidence Problem!

The term "program" is narrowly construed in the federal laws. If the mental health records arose with some connection to drug or alcohol treatment, but that treatment was not part of a "program" (for example, it was part of medical care, or occurred at the same time as treatment but in a different place), the mental health records may not be governed by the federal laws.

Instead, those mental health records would be governed by state laws on confidentiality, and be evidentiary privileges.

Appendix

Appendix

Checklist: Scheduling Family Assessments	C-41
Checklist: Child, Developmental	C-42
Examination of Psychiatrist, Psychologist	C-44
Order for Mental Health Screening	C-48
Order for Full Mental Health Assessment	C-49
List of Commonly-Administered Tests	C-51
Annotations of Specific Tests	C-53
End Notes	C-63

CHECKLIST

SCHEDULING FAMILY ASSESSMENTS			
	Screen	Initial Full Assessment	Review Assessment
Adults or Teens	Psychiatric or psychological screen for anyone who appears to be involved with drugs or alcohol	Psychiatric or psychological assessment for (1) persons who are not currently drug or alcohol involved, and (2) drug or alcohol-involved persons who are currently detoxed (two consecutive negative tests)	(1) prior to reunion with child; and (2) one year after reunion with child, if still under court jurisdiction
Child	(any infant tests below)	(1) Bayley Scales [p. C-62] (2) C.A.S.T. [p. C-61] (3) play therapy (4) Halsted-Reitan [p. C-54] (5) drawing assessments [p. C-53, 55]	prior to reunion with family
Infant	(1) Apgar Score [p. C-19] (2) Brazelton Neonatal Behavioral Assessment [p. C-62]	Bayley Scales [p. C-62]	(1) 3 months after drug-exposed birth to pick up latent problems (2) continue Bayley Scales

CHECKLIST

CHILD: DEVELOPMENTAL

(based on work by J. Howard, M.D. and Carol Cole. See p. D-35)

COMMON CHARACTERISTICS OF SUBSTANCE-EXPOSED TODDLERS

	yes	comment
I.Q. low-average or below		
awkward body movements		
difficulty paying attention		
difficulty concentrating		
speech, language delays		
insufficient adult attachments		
indiscriminate adult attachments		
sudden mood swings		
play has little fantasy		
play has much scattering, throwing		
restless, disruptive (hyperactive)		
cannot easily make choices		
difficulty switching attention between activities		
poor growth		
small head		
other:		
other:		
other:		

Child Developmental Checklist, p. 2

	yes	comment
Mental Health Assessments		
clinical observations of child at play		
clinical observations of child with family		
clinical observations of of child in home		
results of intelligence tests		
name:		
name:		
name:		
results of neurobehavioral tests		
Bayley Scales		
Halstead Reitan		
Other		

Examination by the Court

PSYCHOLOGIST or PSYCHIATRIST

Process Approximately how long did you talk to [this person]?

Did you have information at hand in addition to the information that this person gave you?

[If so] what information was that?

Mental Status Did you analyze [this person's] mental status?

Did you find any unusual features in:

General appearance?

Level of activity?

Attitude?

Mood?

Affect?

Speech?

Perception?

Thought content?

Thought process?

Level of consciousness?

Memory?

Concentration?

Information and Intelligence?

Judgment?

Insight?

Examination of psychologist, psychiatrist, p. 2

[If so, to any of these]:

Did you think that this unusual characteristic could be caused by use of a psychoactive substance?

Personal History Did you take a personal history of [this person]?

Did you discuss [this person's] history of use of psychoactive substances?

Has there been such use?

Does [this person] claim current use of such substances?

[If so] what are those substances?

What is the extent of use?

Use, Abuse and Dependence Is the *Diagnostic Statistical Manual*, Third Edition, Revised, a standard reference in your field?

Are you familiar with DSM-III-R distinction between "use, abuse and dependence"?

What are the characteristics of "Dependence" on a psychoactive substance in the DSM-III-R?

Which of those characteristics does [this person] display?

Do those characteristics amount to "Dependence" on the substance according to the DSM-III-R?

What are the characteristics of "Abuse" in the DSM-III-R?

Does this person display those characteristics?

Did you adhere to the criteria in the DSM-III-R in your analysis of [this person]?

[If no] Why not?

Examination of psychologist, psychiatrist, p. 3

Did you bring other criteria to bear on [this person] in your analysis?

[If so] what are they?

Based upon your analysis do you believe that [this person] is either dependent upon or abusing drugs or alcohol?

**Organic Mental
Disorders**

Did you see any signs of *intoxication* in [this person]?

[If so] What were those signs?

Did you see any signs of *withdrawal* in [this person]?

[If so] what were those signs?

Did you see any signs of *delirium*? *Delusional disorder*?
Mood disorder?

[If so] What where those signs?

[If so: does this disorder indicate that [this person's] central nervous system was directly affected by a psychoactive drug, or alcohol?]

Medical Management
(particularly for psychiatrist)

Is there a question of *dual diagnosis* for mental disorder *and* substance use for this person?

[If so, what treatment do you recommend?]

[If so, is it likely that this person should be in the care of a physician?]

Are there other neurological tests that should be undertaken for this person?

[If so, what are they?]

Are there other physical assessments that should be undertaken for this person?

[If so, what are they?]

Examination by psychologist, psychiatrist, p. 4

Psychological Tests
(particularly for psychologist)

What tests did you administer?

[For each test, ask]:

What does this test measure?

Does this test yield any information about potential drug or alcohol use in [this person?]

[If so] What is that?

Does this test yield any information about the parenting abilities of [this person?]

Does this test yield any information about how well these people function as a family?

Does this test yield any other information bearing on this person's ability to relate to and care for the child?

Expert Opinion

In your professional opinion, based upon your analysis of [this person], do you believe that drugs or alcohol are interfering with this person's ability to parent?

In your professional opinion, what course of mental health treatment, and drug-alcohol treatment would be required to restore health and stability to this person?

Will the child be safe if left in the exclusive and unsupervised care of [this person]?

What degree of closeness to the parent is it in the child's best interests to maintain during attempts to treat and stabilize this family?

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR MENTAL HEALTH SCREENING

(person)_____ is to participate in a mental health screening.

The screening is to be performed by (agency) _____

The screening psychologist or psychiatrist is to **rule out or assess for any current drug-alcohol problems (psychoactive substance induced mental disorders) or any long term drug-alcohol problems (psychoactive substance use disorders) as well as any pre-disposing factors or complications associated with these disorders [consult DSM III-R classifications].**

The screening:

_____ is scheduled on (date)_____

_____ will be scheduled for the earliest available date by (person or agency)_____

Social information is to be provided to the screening psychologist or psychiatrist by (agency or social worker) _____ prior to the screening appointment.

A written report of the screening results is to be provided to the court by (date, time)

The mental health screening is to be paid for by (person or agency):

JUDGE

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR FULL MENTAL HEALTH ASSESSMENT

(Name of person) _____ shall participate in a full mental health assessment.

The full mental health assessment shall include:

- _____ psychological assessment
- _____ psychiatric assessment
- _____ other (describe) _____

The following questions shall be addressed by the mental health professionals:

- _____ **To what extent are drugs or alcohol interfering with the parenting abilities and tasks of this person?**
- _____ **Is this child receiving the care and nurture required for a healthy and stable childhood?**
- _____ **Is it possible that the child's safety will be threatened if the child is left in the exclusive care of this adult?**
- _____ **What course of mental health treatment, and drug-alcohol treatment, would be required to restore health and stability to this person?**
- _____ **What degree of closeness to the parent is it in the child's best interests to maintain during attempts to treat and stabilize this family?**
- _____ **Other (describe)** _____

- _____ **Other (describe)** _____

Order for Full Mental Health Assessment, p.2

The mental health assessments shall be performed by:

_____ mental health professionals, or agency (describe)

_____ mental health professionals as arranged by (name of
agency) _____

A report by each examining mental health professional shall be provided to the court by
(date) _____

These assessments shall be paid for by _____

JUDGE

LIST OF COMMONLY-ADMINISTERED PSYCHOLOGICAL TESTS

(Tests with asterisks are annotated at the end of the list)

Intelligence Tests and Developmental Scales

AAMD Adaptive Behavior Scale, 1974 Revision
AAMD Adaptive Behavior Scale—Public School Version
Bayley Scales of Infant Development
Bruininks-Oseretsky Test of Motor Proficiency
*Draw A Person Test [p. C-53]
*Kaufman Assessment Battery for Children (K-ABC) [p. C-55]
Leiter International Performance Scale
McCarthy Scale of Children's Abilities
Peabody Picture Vocabulary Test
Stanford-Binet Intelligence Scale, Fourth Edition
Vineland Adaptive Behavior Scales
*Wechsler Adult Intelligence Scale—Revised (WAIS-R) [p. C-58]
*Wechsler Intelligence Scale for Children—Revised (WISC-R) [p. C-58]
Wechsler Preschool and Primary Scale of Intelligence - Revised (WPPSI-R)
Goodenough-Harris Drawing Test
Raven's Progressive Matrices (RPM)

Multiple-Aptitude Batteries

Differential Aptitude Test (DAT)
USES General Aptitude Test Battery (GATB)

Psychomotor (Occupational) Tests

Purdue Pegboard

Neuropsychological Tests

*Bender-Gestalt [p. C-53]
Benton Revised Visual Retention Test
*Halstead-Reitan Neuropsychological Test Battery [p. C-54]
Luria-Nebraska Neuropsychological Battery
Memory for Designs Test

Assessment of Learning Disabilities

Auditory Discrimination Tests
Goldman-Fristoe-Woodcock Test of Auditory Discrimination
Illinois Test of Psycholinguistic Abilities, Revised Edition

Individual Achievement Tests

Peabody Individual Achievement Test
Wide Range Achievement Test - Revised (WRAT-R)
Woodcock-Johnson Psycho-Educational Battery—Revised, Public School

Self-Report Personality Inventories

Clinical Analysis Questionnaire
High School Personality Questionnaire
*Minnesota Multiphasic Personality Inventory (MMPI-2) [p. C-56]
Mooney Problem Checklist
Sixteen Personality Factor Questionnaire (16PF)

Measures of Interests, Values, and Attitudes

Career Assessment Inventory
Kuder Preference Record—Vocational
Self-Directed Search (SDS)
Strong-Campbell Interest Inventory form of the Strong Vocational Interest Blank (SVIB-SCII)
Children's Apperception Test
Holtzman Inkblot Technique
*House-Tree-Person Test [p. C-55]
Incomplete Sentences Task
Roberts Apperception Test for Children
*Rorschach [p. C-57]
Rotter Incomplete Sentences Blank
*Thematic Apperception Test (TAT) [p. C-57]

Drug and Alcohol Assessments

*Addiction Severity Index [p. C-59]
*The Adolescent Assessment/Referral System [p. C-60]
*The Child of a Substance Abuser Screening Test (CAST) [p. C-61]

Infant Neurobehavioral Tests

*Brazelton Neonatal Behavioral Assessment Scale [p. C-62]
*Bayley Scales of Infant Development [p. C-62]

Brief Annotation of Ten Psychological Tests

Summarized from: *Major Psychological Assessment Instruments*, ed.C. Newmark, Allyn & Bacon, Inc., 1985

A. The Bender-Gestalt Test

(Summarized from an essay by A. Canter)

This test can be used to assess visual-motor behavior. It is highly sensitive to subtle impairments of perceptual motor functions. It consists of cards containing nine different designs.

There are a number of different scoring methods which allow the test to be used in particular ways. For example, one scale measures psychopathology.

Liabilities of this test are that there is no single scoring method, that the results may depend somewhat on the test-taker's artistic ability, and there is insufficient validation of the test to make a firm connection to personality dynamics.

B. The Draw-A-Person Test (DAP)

(Summarized from an essay by L. Handler)

Depending on the interpretive scale used, this test can analyze conflict and anxiety; or alternatively it can be used more impressionistically.

The DAP provides the following benefits:

1. it is simple: easy to take and easy to administer
2. it does not require external stimuli (test paraphernalia)
3. it yields information about test-taker's self-concept
4. it has few age or intelligence limits
5. it is welcomed by non-verbal, inhibited test-takers
6. it is useful for test-takers who are guarded, evasive
7. it is a good springboard for discussion of special conflict areas
8. it is sensitive to psychopathology
9. it is useful for indicating sexual disorders

C. The Halstead-Reitan Neuropsychological Test Battery

(Summarized from an essay by J. Barth and S. Macciouhi)

This test is intended for neurologically impaired test-takers. It evaluates cognitive, behavioral and psychological strengths and weaknesses, and determines their relationship to cerebral functioning. There is a version for adults, and for children 5 to 9 years, and 9 to 15 years.

The tasks are generally in the form of a manual response to the tester's actions or instructions. Following are examples of tasks.

1. category test (test-taker looks at shapes projected on a screen and pulls a corresponding lever)
2. speech-sound perception (sounds of nonsense words are matched to the printed version)
3. seashore rhythm test (the sequence of recorded rhythms are recognized)
4. tactual performance (the blind folded test taker feels objects and recognizes their shapes)
5. finger oscillation (test-taker taps a mechanical lever)
6. trail-making (circles are connected with lines)
7. aphasia screening (test-taker follows simple commands requiring receptive and expressive language)
8. sensory-perception (test-taker guesses shapes and sounds)

D. House-Tree-Person Test

(Summarized from an essay by E. Hammer)

This test intends to give the tester insight into the test taker's inner view of self and environment.

The tester is quite free to make associations and bring intuition and creativity to bear. Some of the following elements may be considered:

1. House: interpretation may provide a portrait that reveals fantasy, ego, reality contact, accessibility and problems. For example:

roof = fantasy
walls = ego; strength of personality
door = direct contact with the environment
windows = secondary interaction with environment
chimney = possible phallic response
smoke = emotional turbulence

2. Tree

trunk = basic strength of personality
roots = hold upon reality
branches = perceived resources for seeking satisfaction from the environment

3. Person: provides a self-portrait

E. The Kaufman Assessment Battery for Children (K-ABC)

(Summarized from an essay by A. Kaufman, R. Kamphaus, and N. Kaufman)

This test measures a child's ability to solve problems. It measures both sequential processing (ability to arrive at a solution by putting the component parts of a problem in serial order) and simultaneous processing (the ability to synthesize information).

The test also permits an overall estimate of the child's previous learning. It can be administered to ages 2 1/2 through 12 1/2.

The tester performs certain tasks using as props such things as hand movements and pictures. The child interprets these. Examples of tasks are:

1. magic window (rotating pictures)
2. face recognition
3. hand movements (copied by child)
4. gestalt closure (child fills in gaps in inkblot)
5. number recall (child repeats number sequences)
6. triangles
7. word order
8. matrix analogies (child selects designs)
9. spatial memory (child recalls location of pictures)
10. photo series (child arranges photos to show an event)

F. Minnesota Multiphasic Personality Inventory (MMPI)

(summarized from essay by C. Newmark)

This test attempts an objective personality assessment. It measures responses in ten clinical areas:

1. hypochondriasis
2. depression
3. hysteria
4. psychopathic deviate
5. masculinity - femininity
6. paranoia
7. psychasthenia (anxiety, indecisiveness, concentration
obsession - compulsion, etc.)
8. schizophrenia
9. hypomania (energy level)
10. social introversion-extroversion

Some of the interpretive scales (for scoring the test) attempt to distinguish alcoholism. For the most part substance abuse is discussed as if it were a single personality trait. Certain clusters of factors tend to emerge as associated with drug use: impulsivity, social non-conformance, rejection of traditional values, and poor judgment.

G. The Rorschach

(Summarized from essay by P. Erdberg)

The Rorschach is a personality test. It uses ten inkblots, some of which are monochromatic, and some of which are colored. For each inkblot the tester interprets the following elements:

1. how much of the blot was needed to produce a response
2. color perception in test-taker's description
3. human movement in description
4. animal movement in description
5. inanimate movement in description
6. shading in description
7. texture in description
8. depth or dimensionality in description
9. amount of achromatic color in description
10. rational vs. emotional perception
11. blend of factors in description
12. perceptual accuracy
13. self-focus of viewer
14. active v. passive factors
15. organizational perception
16. responsiveness to emotions (affect) based on response to colors
17. substantive content

H. Thematic Apperception Test (TAT)

(Summarized from essay by R. Dana)

This test differs from the Rorschach in providing less ambiguous stimuli and clearer structure. It allows the test taker to exercise some control by deciding how to tell the story.

Thirty-one cards with pictures on them are shown. They include such scenes as a boy playing a violin, a country scene, a huddled child, and an adolescent boy with a rifle.

It is more difficult to administer than the Rorschach, because it requires the interpreter to be intuitive and creative. There are parameters for interpretation, but little is imposed.

The test attempts to measure:

1. affects
2. feelings
3. emotions
4. personality defenses and mechanisms
5. interpersonal and object relations
6. sexual thoughts and behavior
7. outlook, attitudes and beliefs.

I. The Wechsler Intelligence Scale for Children - Revised

(Summarized from an essay by A. LaGreca and S. Stringer)

This test can be used to assess intelligence ages 4 to adulthood. There are variations to administer to each age group. The test uses both a verbal scale and a performance scale.

It seems best suited for children in the middle range of development. For gifted children, or those with developmental delays, mental retardation, or severe visual or motor handicaps, the Stanford-Binet may be the better instrument.

Categories measured include:

1. Verbal Scale
 - a. information (30 questions)
 - b. similarities (17 pairs)
 - c. arithmetic
 - d. vocabulary
 - e. comprehension (problem situations)
 - f. digit span (repeat digit series forward and backward)
2. Performance Scale
 - a. picture completion
 - b. picture arrangement
 - c. block design
 - d. object assembly
 - e. coding
 - f. mazes

J. Weschler Adult Intelligence Scale - Revised

(Summarized from an essay by A. House and M. Lewis)

This is the adult variation of the Weschler Scale. It calls for completion of a wide variety of tasks in both the verbal and performance area. Most of the categories tested are similar to those used for children, but at a suitably advanced level. The tester alternates between the verbal and performance scale in order to stimulate the interest of the test-taker

Brief Annotation of Three Drug-Alcohol Assessments

A. Addiction Severity Index

This test was developed by support from the National Institute on Drug Abuse and the Veterans Administration.

It is administered as a *structured interview* that covers seven areas:

1. medical history
2. employment and support history
3. alcohol use
4. drug use
5. legal history
6. family and social history
7. psychiatric history

The test taker is to answer the substance use questions from experience during the last thirty days. These question deal with issues like:

1. multiple substance use
2. dominant drugs used
3. success at abstinence
4. overdoses and delirium tremens
5. treatment history
6. detoxification history

Questions from other categories also relate to a drug or alcohol lifestyle. For example criminal or family court violations, marital discord, failure to hold down a job, and mental illness—all of which can interact with substance use.

The answers are drawn from a five-point scale ranging from "0 = not at all" to "5 = extremely." In adding up the scores, the test giver includes a confidence factor indicating the degree of doubt the test giver has about the test taker's veracity.

B. Adolescent Assessment/Referral System

Developed by the National Institute for Drug Abuse, this is a three-part self-report analysis of the adolescent's life style and involvement with drugs. The goal is to connect the child with appropriate services.

Step 1: This is a Problem Oriented Screening Instrument for Teenagers (POSIT). It consists of 139 yes/no items that are randomly mixed. Areas addressed include:

1. substance use/abuse
2. physical health
3. mental health
4. family relations
5. peer relations
6. educational status
7. vocational status
8. social skills
9. leisure and recreation
10. aggressive behavior and delinquency

Step 2: Client Personal History Questionnaire (CPHQ) This section inquires about basic information: school performance, demographics, juvenile justice history, health care, mental health history, etc. In addition it includes a list of 40 stressful life events to be checked off if they have occurred in the teenager's life.

Step 3: Comprehensive Assessment Battery (CAB). These are validated pre-existing instruments and interview procedures, including in-depth reports on such areas as physical health, mental health and delinquency. This section is only pursued to the extent that there are particular areas of concern arising out of Steps 1 and 2.

C. Child of a Substance Abuser Screening Test (CAST)

Currently in use at Children's National Medical Center in Washington D.C., CAST was adopted from work by John W. Jones, PhD, as published by Family Recovery Press, 1982.

The test is administered by an adult to a child in a structured interview. The child answers 30 questions Yes or No, taking the time needed to answer.

The questions focus on life events (parental fighting), emotions ("did you ever feel responsible"... "guilty"... "caught in the middle"), physical well-being ("did you ever have a stomach ache because"... "feel nervous when"...) and environment ("did you ever wish your home could be more like other homes"... "did you ever take over any chores that used to be done by your parent"...)

A "yes" answer to six or more of the items suggests that the responsible adult is chemically dependent.

Brief Annotation of Two Infant Neurobehavioral Assessments

A. Bayley Scales of Infant Development

[See Model Order, p. B-63]

The Bayley Scales measure an infant's development during the first two years of life at specific monthly milestones. Those monthly milestones are:

1. three months
2. six months
3. one year
4. eighteen months
5. twenty-four months

The individual's progress is compared to that of normally-developing infants.

It measures both *mental* and *psychomotor* development and allows for a behavioral assessment based upon the prior two categories.

It is administered as a "highly structured set of tasks which focus the child on one activity at a time and allows for a great deal of examiner and caretaker intervention to help regulate the child's behavior".⁴ At least one physician who uses the scales feels that the highly-structured aspect of the scales may suggest that actual performance in daily life falls below the Bayley measurement.⁷

B. The Brazelton Neonatal Behavioral Assessment Scales

[See Model Order, p. B-63]

The Brazelton assessment provides an early warning system for drug or alcohol-exposed newborns. The assessment can be performed between the 4th and 30th days after the birth of the child.

The physician provides visual (e.g. a light) and auditory (e.g. a bell, clapping hands) and sensual (a blanket lightly touching the face) stimuli to which the infant responds. The physician also checks for stiffness of muscles, amount of time for responses, ability to move from one state (like sleep) to another (like wakefulness), and so forth. For example, when a blanket is lightly draped on the face, most infants will try to brush it away. Cocaine-exposed infants, however, may simply fall asleep because they prefer to be protected from stimulation.

The seven categories of responses tested are habituation, orientation, motor performance, range of state, regulation of state, autonomic regulation, and reflexes.

Dr. Brazelton states in his manual for the testing procedures that "The newborn's behavior is a reflection of genetic endowments, coupled with the effects of intra-uterine experience. Variability in behavior from day to day may be a reflection of ability to cope with the stresses of labor, delivery and the demands of the new environment."

END NOTES

1. American Psychiatric Association (ed.), *Diagnostic and Statistical Manual*, Third Edition, Revised, 1987.
2. Anastasi, *Psychological Testing*, 6th Edition, MacMillan, N.Y., 1980
3. Bavolek & Henderson, *Child Maltreatment and Alcohol Abuse: Comparisons and Perspectives for Treatment*, Special Issue: Aggression, Family Violence and Chemical Dependency, 1989 *Journal of Chemical Dependency Treatment* 3(1), 165-184.
4. Bayley, *Bayley Scales of Infant Development*, Manual, The Psychological Corp. (19).
5. Brazelton, *Neonatal Behavioral Assessment Scale*, Blackwell Scientific Publications, 2nd Ed.(1984).
6. Brounstein, et al., *Patterns of Substance Use and Delinquency Among Inner City Adolescents*, 1989 Report of the Urban Institute for the U.S. Dept. of Justice Office of Juv. Justice and Delinquency Prevention.
7. Chasnoff, et al., *Cocaine/Polydrug Use in Pregnancy: Two-Year Follow-Up*, 1992 *Pediatrics*, vol.89, No.2, 284-289.
8. Coleman, *Child Physical and Sexual Abuse among Chemically Dependent Individuals*, Special issue: 1987 Chemical Dependency and Intimacy Dysfunction. *Journal of Chemical Dependency Treatment* vol.1, pp. 27-38.
9. Dalgleish & Drew, *The Relationship of Child Abuse Indicators to the Assessment of Perceived Risk and to the Court's Decision to Separate*, 1989 *Child Abuse & Neglect*, vol.1394, pp.491-406.
10. Durkin, *The Use of Therapeutic Day Care to Resolve the Legal Dilemma of Protecting the Rights of Both Children and Parents in Equivocal Cases of Child Abuse and Neglect*, 1986 *Child Care Quarterly* 15(2), 138-140.
11. Farrow, personal communication re: factors that must be addressed in treatment of teens, U.of Wash. School of Medicine, Dept. of Pediatrics, Division of Adolescent Medicine, Mar. 4, 1992.
12. Farrow & Deisher, *A Practical Guide to the Office Assessment of Adolescent Substance Abuse*, 1986 *Pediatric Annals*, Vol.15, No.10, pp 675-684.
13. Freier, et al, *In Utero Drug Exposure: Developmental Follow-up and Maternal-Infant Interaction*, 1991 *Seminars in Perinatology*, Vol. 15, No.4, pp. 310-316.
14. Freier, personal communication re infant neurobehavioral tests, U. of Miami School of Medicine, March 17, 1992.

15. Gabel & Shendledecker, *Parental Substance Abuse and Suspected Child Abuse/Maltreatment Predict Outcome in Children's In-patient Treatment*, 1990 Journal of American Academy of Child and Adolescent Psychiatry, 29(6), p.919-924.
16. Green, *Psychiatric Treatment of Abused Children*, 1978 J. of Am. Academy of Child Psychiatry, Vol.17, pp.356-371.
17. Hawkins, et al., *Delinquents and Drugs: What the Evidence Suggests About Prevention and Treatment Programs*, paper presented to NIDA Technical review on Special Youth Populations, July 16-17, 1986, Rockville, Md.
18. Joint Commission on Accreditation of Hospitals Organization, *Accreditation Manual for Hospitals*, 1992, Alcoholism and Other Drug Dependence Services, p.3.
19. Kaplan & Sadock, *Pocket Book of Clinical Psychiatry*, Williams & Wilkins, Baltimore, Md., 1990
20. Kumpfer, *Prevention of Alcohol and Drug Abuse: A Critical Review of Risk Factors and Prevention Strategies*, in Prevention of Mental Disorders, OSAP Monograph Series 1989.
21. Miller, et al., *Delinquency, Childhood Violence, and the Development of Alcoholism in Women*, Special Issue: Women and Crime, in Crime and Delinquency 35(1), 94-108 (1989).
22. Orr, et al., *Factors Associated with Condom Use Among Sexually- Active Female Adolescents*, 1992 J. of Pediatrics, Vol. 120, No.2, Part I, pp 311-317.
23. Rogeness, et al, *Psychopathology in Abused or Neglected Children*, 1986 J. of Am. Academy of Child Psychiatry, Vol.25, pp.659-665.
24. Shedler & Block, *Adolescent Drug Use and Psychological Health*, 1990 American Psychologist, Vol. 45, No.5, pp 612-630
25. Thomas, *Triple Jeopardy: Child Abuse, Drug Abuse, and the Minority Client*, 1989 Journal of International Violence, Vol.4, pp. 351-355
26. Thompson, *Working with Alcoholic Families in a Child Welfare Agency: the Problem of Underdiagnosis*, 1990 Child Welfare, Vol. 69, pp.464-470.
27. Zuckerman & Bresnahan, *Developmental and Behavioral Consequences of Prenatal Drug and Alcohol Exposure*, 1991 Pediatric Clinics of North America, Vol.38, pp.1387-1406.

D. TREATMENT

TREATMENT

Adults, Generally

Treatment, Defined	D-5
Overview of Treatment Modalities	D-7
Treatment Needs Resulting from Use of Particular Substances	D-9
Relapse	D-13
Aftercare	D-15

Women, Cultural Minorities

Separate Treatment from Men	D-19
Efficacy of Treatment for Pregnant Woman - Fetus	D-21
Detoxification Goals for Pregnant Woman - Fetus	D-23
Pregnant Woman: Need for Multiple Services.	D-25
Cultural Minorities	D-29

Children, Teens

Substance-Exposed Newborns	D-33
Substance-Exposed Toddlers	D-35
Child Victims of Drug Abusers.	D-37
Adolescent Treatment Issues.	D-39

Appendix

Local Treatment Resources (court's notes).	D-43
Order for Drug/Alcohol Treatment.	D-44
Order for Priority Drug Treatment for Pregnant Woman	D-47
End Notes	D-49

Adults

Treatment, Defined	D-5
Overview Of Treatment Modalities	D-7
Treatment Needs Resulting From Use Of Particular Substances	D-9
Relapse	D-13
Aftercare	D-15

“Treatment” consists of medical, psychological, and social services, the goal of which is to free a person from dependence on psychoactive substances.

The court can enhance the opportunity for persons to free themselves from drugs and alcohol by making certain that they are placed in an environment that is conducive to recovery, because it:

- 1. addresses the dominant type of substance used**
 - 2. matches the gender and cultural background of the user as closely as practical**
 - 3. is actual treatment rather than a self-help discussion group or enforced abstinence without services**
-

Incarceration (enforced abstinence) is not treatment.

Detoxification is not treatment. It is the necessary step before treatment which rids the body of toxins and helps ease withdrawal symptoms.¹³

Self-help groups like Alcoholics Anonymous can support treatment, and are excellent aftercare components, but are not in themselves treatment.

Treatment environments for adults are usually one of three kinds: (1) in-patient; (2) out-patient; or (3) residential community.

As a general rule, the more severe the chemical dependency, the more structured and lengthy the treatment program will have to be.

The court should obtain a mental health evaluation that includes a substance use assessment.

Questions it will answer include:

1. what is the dominant drug of choice?
2. what is the degree of commitment to a drug-alcohol lifestyle?

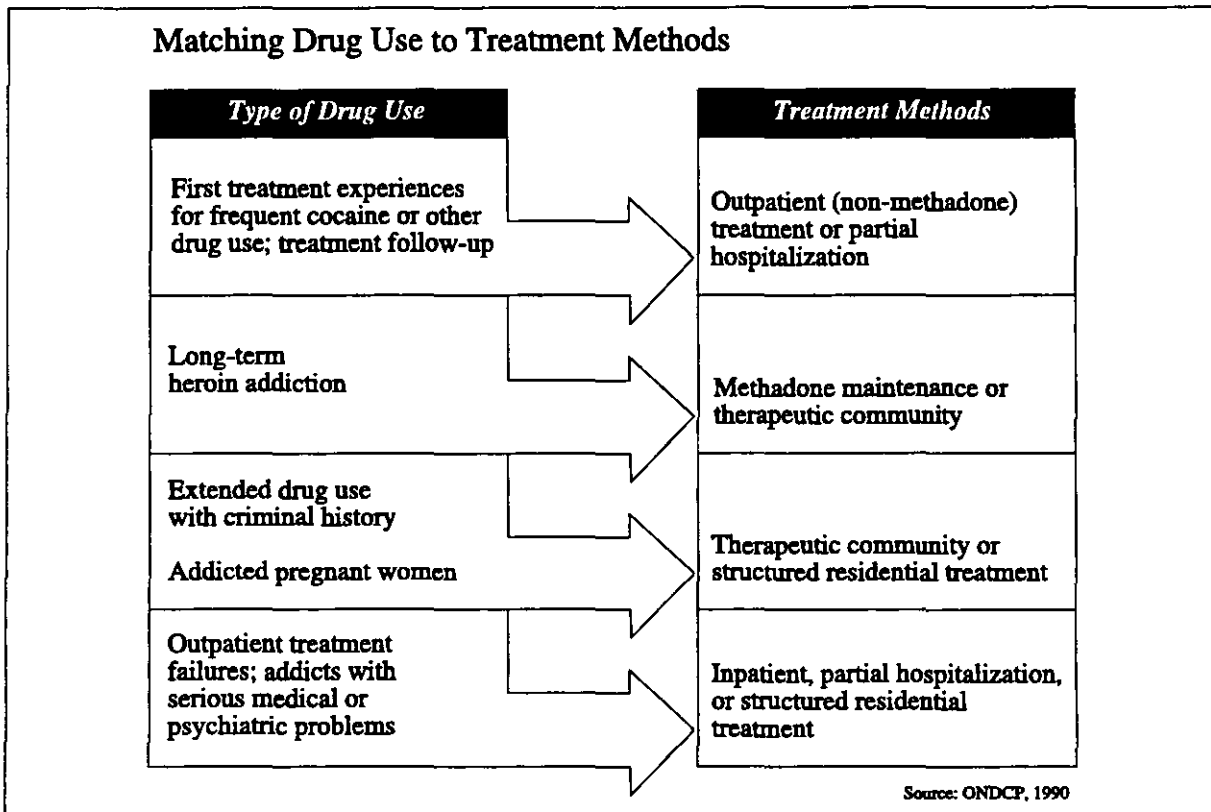


Chart from *Understanding Drug Treatment*, an Office of National Drug Control Policy White Paper, June 1990.

The dominant type of substance used (e.g. alcohol, cocaine, heroin) may require particular treatment strategies that are only available in specific programs

The substance-use assessment that the court has obtained through the mental health evaluation will indicate the adult's dominant drug of choice.

The court may wish to ask for a specific treatment recommendation from the evaluating professional.

A. Alcohol

In-patient short term (three to four weeks) or
In-patient residential (one to six months) may be especially
suited to the alcoholic patient.

This treatment may likely incorporate the "twelve
step" or "Minnesota model".²⁵

Typical components of an alcohol treatment program
are:

1. Detoxification (one to three days).
2. In-patient care (approximately 28 days of intense, confronting psychological therapy)
3. Community support (typically connected to twelve-step Alcoholics Anonymous groups. Lifetime involvement is urged, daily at first.)

The longer-term versions might be more suitable for
those who have been alcoholic for years.

In its short version, this program will often be covered
by insurance because it is time-limited.

The twelve-step in-patient model has been most successful
with men.

Aftercare recommendations usually include attendance at
the twelve-step support group Alcoholics Anonymous.

B. Cocaine-Amphetamines

- i. **In-patient, short-term** treatment may have little efficacy for ingrained cocaine problems, particularly if the patient population is predominantly alcohol-using.
- ii **In-patient, residential.** One to six months in a patient population of predominantly cocaine-users can be efficacious.

The point of longer treatment is to change life styles and attitudes, and to provide vocational training and preparation for re-entering the community.

Two populations that may especially profit from longer term in-patient residential care are pregnant women and adolescents.

Pregnant women can benefit from medical supervision.

Troubled adolescents can benefit from the structure found in this environment.

iii. **Therapeutic communities**

There are many variations on this theme. One is the self-supporting community predominantly staffed by recovered addicts.

Therapy is usually confrontational. The theory is that drug abuse reflects social, educational, and character problems.¹³

Therapeutic communities have demonstrated success among persons with a history of criminal activity, and who have hard-to-heal addictions, like cocaine or PCP.

Four out of five people who *complete* the long program stay drug free several years afterwards. However, the drop-out rate in the early months is high.

These communities seek to teach responsibility and to return members back to the larger community as self-supporting citizens.

Another variation especially suitable for **pregnant women with families** is the community that provides *transitional housing* for families that are trying to break out of old communities and establish a new life style.

Services offered may include vocational training, liaison with the wider community, child-care, and a bridge to a more independent life.

C. Heroin

Widespread heroin use inspired the development of another kind of treatment.

Methadone maintenance is a way to cushion the effects of withdrawal and reduce the criminal search for illegal drugs.

The goal of methadone maintenance is to bridge from heroin use to methadone, and then from methadone to a drug-free life.

- i. **In-patient short term.** If a heroin patient is recommended for methadone maintenance, a period of detoxification is required, and it is best if this is followed by intense counseling.

A short-term in-patient residential program may be ideal for accomplishing these goals.

- ii. **Out-patient methadone maintenance.** This is appropriate for heroin users for whom abstinence is considered impractical.²⁵

The participant reports to a center every day to receive a methadone dose.

Some centers allow patients who are considered to be good risks to take home up to a one month supply of oral methadone.

Court Query

Is the recommended program merely a dispenser of methadone, or does it include drug counseling?

A problem with methadone maintenance can be indefinite dependence on the substance.

- iii. **Longer-term residential programs.** (one to six months, or indefinite) For heroin users who are ready to move toward a goal of abstinence, a **therapeutic community** or long-term residential program may be required to impart the skills and social supports necessary to re-enter society in a different way.

Relapse is a predictable element in treatment.

A family court interested in reunification of the child with the parents may have to come to terms with the parents' potential for relapsing from treatment.

Measured against the child's age and needs, the court will ask:

- 1. How many parental relapses over what period of time can be tolerated?**
 - 2. Can treatment be combined with:**
 - with safe care in the family home?**
 - with frequent visitation?**
 - with child care at the treatment facility?**
 - 3. Can the parent and social worker develop a plan to protect children living at home in the event that the parent relapses?**
-

A difficult concept for courts to accept is that people can relapse in treatment several times, and still be successful, ultimately.

One study indicates that prior treatment experience (which implies relapse) is the most consistent predictor of success in treatment.¹⁶

With certain dependencies—like cocaine—repeated relapse and recovery is the typical, rather than atypical, course of treatment.¹⁰

A prevalent view is that drug abuse is a chronic relapsing disease like diabetes, bipolar mood disorders and arthritis.

There are no permanent cures—only the amelioration of symptoms and prolongation of symptom-free intervals.¹³

A current strategy to combat relapse is to teach patients specific techniques for recognizing its onset and resisting the impulse to use drugs.^{13, 19}

Aftercare counseling and social supports can help a person avoid or delay relapse when primary care is over.

The court can promote healthy family functioning and raise barriers against relapse by assuring continued drug and alcohol counseling and reintegration into the community.¹⁴ The court may wish to require from the family's supervising agency:

- 1. Inclusion of aftercare into the family's case plan**
 - 2. A description of aftercare arrangements recommended by the agency, including:**
 - a. drug and alcohol counseling**
 - b. liaison with community resources**
 - 3. Plans by the agency to facilitate aftercare.**
-

A. Relapse Factors

Studies indicate that the factors most likely to lead to relapse after a primary course of treatment are:

1. family conflict
2. peer pressure to use drugs or alcohol
3. isolation from the community
4. lack of a productive social role
5. lack of a positive alternative recreation
6. negative emotional state (especially depression)

B. Aftercare Programs

Different types of aftercare programs have proved successful, including:

1. family counseling
2. self-help groups (AA, NA, Alanon, Alateen)

3. connection with community volunteers
4. continued connection with treatment professionals
5. connection with a case-manager advocate

Two kinds of successful models are:

1. **free-standing community organizations**, and
2. aftercare that continues as **part of primary care**

Programs that utilizes paraprofessional recovered addicts as role models and liaison with the community have proven especially helpful. ^{14, 15}

C. Success Factors

Evidence Problem!

Social science studies show that less intensive programs (e.g. community referrals for jobs and services) may be just as effective as more intensive programs (daily contact, intensive services)

Factors affecting success in aftercare include:

1. quality of marital relationship
2. socioeconomic status (less success for poor people)
3. distance from aftercare
4. length of time in primary treatment

Women; Cultural Minorities

Women, Cultural Minorities

Separate Treatment From Men	D-19
Efficacy Of Treatment For Pregnant Woman - Fetus	D-21
Detoxification Goals For Pregnant Woman - Fetus	D-23
Pregnant Women: Need For Multiple Services	D-25
Cultural Minorities	D-29

Women may not respond well to treatment programs shared with men

The court may wish to encourage placement of women substance users in women-centered treatment programs.

Court inquiries to the recommending agency might include:

1. whether local treatment programs for women exist
2. If so, whether such programs address the *dominant substance used* and are of appropriate length
3. If so, whether there is space available within a reasonable time (e.g. one month)
4. If no local women-centered treatment programs are available locally within a reasonable period of time, whether there are appropriate programs available outside the community.
5. If so, what are the terms upon which those services could be obtained.

Underlying the substance use of many women are issues of **battering and sexual abuse** by men. ^{13,17}

Among teenage girls in treatment, about 70% report childhood sexual abuse. ⁷

It is difficult for a woman who has been abused and dominated by men to recover in a program where men dominate, and where the treatment strategy is confrontive. ²⁷

Women respond best to therapies that teach how to build positive human relationships.

Drug and alcohol treatment for the mother and fetus dramatically affects the fetus' chances for survival and health

When a substance-using woman is already under the jurisdiction of the court (e.g., as the mother of neglected children, or as an adolescent), and her pregnancy comes to the attention of the court, orders should issue for:

1. prenatal services
2. mental health and substance abuse assessments
3. medical assessment
4. a revision of the case plan to incorporate assessments and treatment

Time is of the essence, as profound damage to the fetus can occur in the earliest stages of pregnancy.⁴

A. Substances Transferred

Substances that can pass through the placenta and cause the fetus to develop abnormally are called "teratogenic".

Substances ingested by the pregnant mother have a high likelihood of passing through the placenta into the fetus.

The placenta does act as a barrier to a few substances. It permits most substances through, but at varying rates.

Because many—perhaps most—substance abusers mix several drugs and alcohol, it is safest for the court to assume that ingested substances will pass into the fetus.

Some drugs pass into the placenta almost immediately. This is the case with crack-cocaine. When crack-cocaine is smoked, the fetus may react in the same way that the pregnant woman reacts, with a slight time delay. The fetus will experience intoxication and withdrawal.

Because the fetus' enzyme system is not as developed as an adult's, drugs which pass the placental barrier may actually be trapped in the fetus' body for many days.

B. Factors Affecting Transfer

Some substances, like alcohol, have a dose-response relationship. This means that damage is related to the quantity and chronicity of the substance consumed.³⁵

Many factors other than quantity and chronicity may affect the outcome of drug usage.⁴

1. some drugs are primarily toxic (e.g. thalidomide, Accutane)
2. others primarily affect only one area of the body
3. the rate of placental transfer differs among drugs and according to the route of administration (whether the drug was smoked, intravenous, oral).
4. some drugs are particularly associated with congenital malformations (alcohol, cocaine) and others more with neurobehavioral deficits (heroin, methadone, marijuana, nicotine).
5. the fetus may have resistance or fragility through its genetic structure

Physicians agree that treatment started at any point in the pregnancy is preferable to no treatment.¹²

C. Fetal Vulnerability

Fetal Vulnerability During Gestation	
based on Cook, et al., <i>Alcohol, Tobacco and Other Drugs May Harm the Unborn</i> , 1990 NIDA publication (ADM)90-1711	
blastocyst stage <i>relatively resistant</i>	
1 week	growing & dividing egg
embryonic stage <i>congenital deformities</i>	
15 - 25 days	central nervous system differentiated
20 - 30 days	skeleton, limb buds, muscles
24 - 40 days	eyes, heart, lower limbs
60 days	other body organs
fetal stage <i>intrauterine growth retardation</i>	
8 weeks - birth	neurological development weight gain

The medical goals of treatment for the fetus may vary from abstinence to medication, depending on the substances ingested by the mother

Any treatment that the court orders for the mother must include a strong medical component and a thorough substance use assessment, so that detoxification will not injure the fetus.^{2, 8, 24}

For certain substances, including cocaine, abstinence can be the goal. Physicians tend to eschew additional medicines, unless it becomes absolutely necessary.

For other substances, most prominently heroin, sudden withdrawal can cause death or severe injury.

Detoxification of Pregnant Woman and Fetus		
substance	care	goal
Alcohol	social support, medication if necessary, during withdrawal	Abstinence
Opiates	switching from opiates to methadone to avoid fetal withdrawal (alternatively, withdrawal with medication)	Methadone Maintenance
Cocaine	close prenatal monitoring, withdrawal; (medication only if absolutely necessary)	Abstinence
Barbiturates (Sedative-hypnotic)	withdrawal medications risky to fetus but may be necessary to prevent seizures	Abstinence

Chart summarizes information found in *Treatment Improvement Protocol Statements (TIPS): Pregnant Substance-Using Women*, Office for Treatment Improvement, ADAMHA, U.S. Dept. of Health and Human Services, 1992.²⁴

Drug and alcohol treatment for a pregnant woman must not be isolated from other services that she requires, including:

- 1. Prenatal Medical Care**
- 2. Natal Medical Care**
- 3. Parenting Classes**
- 4. Counseling on Coping with Violence and Abuse**
- 5. Connection with Public Benefits**
- 6. Vital Treatment Links Like Child Care and Transportation**

The court may wish to ask the social service agency for a descriptive list of local and regional programs that serve substance-using women. For each listed program the report should address:

- 1. whether all necessary services are provided by the program**
- 2. if not, whether the program facilitates access to these services**
- 3. if not, how the agency would propose to facilitate access to necessary services (including scheduling appointments and providing transportation)**
- 4. cost of the program and how costs would be covered**

A. "One Stop Shopping"

Some treatment programs offer all of these services in one place. They are known as "One Stop Shopping."

If one-stop shopping treatment facilities do not exist in your community, a linking agency or case manager can facilitate the connections.

B. Prenatal Medical Care

This not only assures a healthy birth, but strengthens the woman who will face two post-natal tasks: child care and maintaining freedom from drug dependence.

C. Natal Medical Care

For drug-dependent women there must be close medical supervision of labor and delivery. Birthing is often perilous for both infant and mother with complications caused by hazardous drugs, poor nutrition and inadequate prenatal care.³¹

Birth outcomes can be improved in proportion to the length and quality of the treatment that precedes it.⁵

D. Parenting Classes

Instruction in parenting can build on the high motivation for nurturing that brought the pregnant woman into drug and alcohol treatment during her pregnancy.

Treatment providers indicate that the gestation period is a window of opportunity, in that genuine fear and compassion for the child's future may bring a woman into treatment.

Parenting classes provide skills for the care of drug and alcohol-exposed infants. They lay the groundwork for infant safety and bring the child care tasks into realistic perspective for the mother.

E. Counseling on Coping with Violence and Abuse

This instruction is vital in that most chemically-dependent women have been victims of child abuse (including sexual abuse) and often of battering by men.²³

Victims of abuse often become abusers. Women need to be aware of their own potential for child abuse. They need to know how to maintain positive relationships.

It follows that women do not do well in treatment programs that they must share with men.

Group therapy with men too often puts a woman in the traditional position of submission and too often encourages her to exercise old defenses that act as barriers to needed changes.

Women are more likely to recover in groups that they share with other women who have similar problems.

F. Connection to Public Benefits

This is a lifeline for the family after the birth. Without food, housing and child care, a relapse to drug use is nearly inevitable.

A case manager who can act as liaison with the community can be crucial. Women struggling with their own chemical dependency and poverty may very often not have the skill, patience or self-esteem to locate and obtain these services.

Basic public benefits include [See Array of Federal Services, p. E-31]:

1. Aid to Families with Dependent Children (AFDC), including Medicaid
2. Food Stamps
3. Special Supplemental Food Program for Women, Infants and Children (WIC)
4. Low Income Public Housing; Leased Housing Assistance ("Sec.8")

G. Vital Treatment Links like Child Care and Transportation

Treatment is doomed if there are too many domestic impediments to reaching it.

Naturally, many pregnant women are already the primary caretaker for other children. Unless child care can be provided for those children, the woman is not free to attend to her recovery.

Poverty can mean that transportation to treatment and to resources in the community is beyond reach.

Cultural minorities may not recover in treatment programs designed to serve the dominant culture

The court may wish to inquire:

- 1. whether the recommended treatment program includes in its treatment population members of the same cultural minority**
 - 2. whether members of that cultural minority are on the treating staff**
 - 3. whether the treatment program has demonstrated treatment success with that population**
-

A. Why Cultural Sensitivity?

The values, behaviors, and means of communicating within particular cultures can be so different that a treatment strategy designed for one culture may be entirely unsuccessful with another.

Cultural issues have practical significance for treatment outcome.

For example, it may be futile to treat an Hispanic American woman without including her male partner, who typically will exercise authority in her household.

Or, it may be counter-productive for an Asian American individual (whose culture avoids conflict, seeks harmony, and respects elders) to be included in a confrontive group therapy session led by a young person.

B. Availability of Treatment

While development of treatment in the United States has not yet reached such an apex that treatment needs can be met entirely through culturally-appropriate programs, it is important that treatment providers have training in cross-cultural communication.

Minnesota has achieved a high standard of culturally-appropriate treatment, through a combination of strong laws and generous funding.

For example, in Hennepin County separate treatment for Native American women and for African American pregnant women can be obtained virtually on demand.

Children; Teens

Child; Teen

Substance-Exposed Newborns	D-33
Substance-Exposed Toddlers	D-35
Child Victims of Drug Abusers	D-37
Adolescent Treatment Issues	D-39

The caretaker of a substance-exposed newborn requires training

The court's *placement decision* should take into consideration the ability of the caretaker to cope with emergencies, intense routine care, and a cranky infant.

The court should assure that *training* is provided to any caretaker (mother, relative, foster or congregated caregiver). The order could name a case manager to arrange caretaker-infant appointments.

A. Emergency Care

This may include proper operation of an **apnea monitor** (used to monitor breathing because these infants are vulnerable to sudden cessation of breathing) and ability to respond to **seizures**.¹⁵

B. Intense Routine Medical Care

Intense routine medical care may be required if the newborn has any problems that go beyond intoxication or withdrawal.

HIV infection and **cerebral palsy** are examples of common severe problems in drug or alcohol-exposed infants.

Home care for a cranky infant can be challenging. These infants are often unhappy and uncomfortable. They may scream, be inconsolable, hold their bodies rigidly, turn away from the caregiver, and be unable to give affection. They have feeding and sleeping problems.^{15, 29}

Techniques of **swaddling, holding and soothing** must be taught.

Substance-exposed toddlers often will require special education to overcome learning and behavioral deficits

The court's order may specify a case manager who can investigate family preservation services, therapeutic day care, and early intervention programs.

The Education for the Handicapped Act, 20 U.S.C. sec. 1400 et seq. requires states to provide early intervention services for children who indicate developmental delays.

The Act covers children from birth through age eight.

At their option, states may also establish programs for children who are at substantial risk of developmental delay.

Thus, there are a variety of programs funded by the federal government to address the needs of substance-exposed infants. [see Social Services section, p. E-31, et seq.]

**SOME COMMON CHARACTERISTICS OF
SUBSTANCE-EXPOSED TODDLERS**

developed from articles by J. Howard, M.D.;
and congressional testimony by Carol Cole^{3,15}

I.Q. low-average or below
awkward body movements
difficulty concentrating, paying attention
speech, language delays
insufficient, or else indiscriminate, attachments
unpredictable and sudden mood swings
play has little fantasy
play has much scattering, throwing
restless, disruptive (hyperactive)
cannot easily make choices
difficulty switching attention between activities
poor growth, small head

[See checklist, p. C-42]

Treatment for child victims of adult drug abusers should include:

- 1. Protection from further abuse; and**
- 2. Reversal of emotional and cognitive impairment**

The court's immediate concern will be protection of the child.

The court will wish to inquire whether the child is secure from further emotional and physical violence so that treatment can proceed.

- a. Is the child living in a safe environment?**
- b. Is visitation arranged to promote a feeling of security?**

Once the environment is secure, the court can inquire whether the treatment is directed toward the emotional and cognitive impairments identified in the mental health assessment.

A. Characteristic Behavior

Abused children often exhibit these characteristics: ¹¹

- 1. suspicion and mistrust of adults**
- 2. low frustration tolerance**
- 3. impulsivity**
- 4. need for immediate gratification**
- 5. need to exploit, manipulate and control objects**
- 6. expression through motor activity rather than verbalization**
- 7. use of symbols**
- 8. violent fantasies of physical attack (seen in spontaneous play with dolls and puppets)**
- 9. competition in tests of strength and skill (boys)**

Neglected children often exhibit these characteristics: ²⁸

1. cognitive impairment
2. difficulty interrelating with others

B. Barriers to Treatment

Adults often block treatment for their child for the following reasons: ¹¹

1. poor motivation to seek help
2. denial of child's psychological deviation
3. fear of relinquishing special relationship with child
4. competition for dependency gratification
5. fear of child's improvement

C. Factors affecting Treatment Success: ¹¹

The earlier in a child's life that maltreatment begins, the greater the developmental deviations and psychopathology.

Success is more likely if treatment is begun soon after the onset of abuse.

Two years is the average length of time for successful treatment.

Adolescent treatment issues are tied to larger social issues that may require a variety of counseling techniques

The court will wish to order a treatment plan for teens that incorporates family counseling, peer counseling, and individual counseling. [See teen medical issues, p. B-41; and teen mental health issues, p. C-23.]

A. Abuse of Females

The majority of female adolescents in treatment have been sexually abused. Nearly half of the male adolescents have suffered physical abuse.⁷

B. Other Family Conflicts

Other family factors identified as central include conflict, family substance use, and lack of parent-child attachment.
1,14,20,30

Teenagers with these family histories tend to run away, be precociously sexual and delinquent, as well as abuse chemical substances.

C. Therapy Goals

Given this background, treatment counselors must set three therapeutic goals for the adolescent.⁷

- 1. to deal with family re-entry (ideally through family therapy)**
- 2. to understand and resist victimization, and**
- 3. to re-orient social goals so that independent living and vocational skills are developed**

Appendix

Appendix

List of Local Treatment Facilities (blank page) D-43

Order for Drug/Alcohol Treatment D-44

Order for Priority Drug Treatment for Pregnant Woman D-47

End Notes D-49

Local Treatment Facilities

name

kind of patient accepted

telephone; address

**Checklist
TREATMENT**

What are dominant drugs of choice?

Alcohol

If in-patient, is it hospital or clinic?
(see p. D-9)

How many days treatment in addition
to detoxification?

Is there aftercare? (see p. D-15)

If out-patient, is it self-help group only?
(AA) (see p. D-5)

Is other counseling in place?

Are other social supports needed to
make program work? (transportation,
child care, public benefits)
(see p. D-25)

Heroin

Will methadone be part of treatment?
(see p. D-11)

If so, will there be out-patient metha-
done only?

Will there be any counseling available?

If in-patient, is program short term?
(see p. D-7, 11)

How many days, plus detox?

Hospital based?

Is program long term?

How many weeks?

Is it a therapeutic community?
(see p. D-7)

Treatment checklist, cont

Cocaine

Is program long-term? (see p. D-10)

Residential, or all-day out-patient?

How many weeks or months?

Hospital based or therapeutic community?

What are goals of program?

Drug-alcohol counseling?

Vocational rehabilitation?

Are social supports in place? (see p. D-25)

Child care?

Transportation?

Public benefits?

Is there an aftercare program?
(see p. D-15)

Women

Are women treated separately from
men? (see p. D-19)

Is there counseling about battering and
abuse? (see p. D-19, 25)

Are parenting classes available?

May children live with their mothers
during treatment?

If not, is there generous opportunity
for visits?

What percentage of the staff is female?

Pregnant

Is prenatal medical care available?
(see p. D-21 to 27)

Is follow-up pediatric care available?

Cultural minority

What percentage of staff and administration represent the cultural minority?
(see p. D-29)

Is therapy designed to accommodate cultural principles?

Has this program demonstrated success with this cultural minority?

Court:
Division:
County & State:

Case Name:
Case Number
Date:

ORDER FOR DRUG/ALCOHOL TREATMENT

To promote the recovery of this adult, drug/alcohol treatment services shall be obtained as follows:

A. Services shall be facilitated by (social service agency)

B. Services to be investigated shall include:

___ detoxification (name(s) of facility, if known):

___ in-patient, short term (name(s), if known):

___ in-patient, residential (name(s), if known):

___ therapeutic community (name(s), if known):

___ out-patient, counseling (name(s), if known):

C. A report to the court shall be submitted by (agency) _____

_____ no later than (date) _____
describing progress in obtaining drug-alcohol services.

D. Case will be heard again on (date) _____

JUDGE

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR PRIORITY DRUG/ALCOHOL TREATMENT FOR PREGNANT WOMAN

A. (Agency) _____ shall make every effort to facilitate entrance of
(person) _____ into a program with the following attributes:

_____ **for a pregnant woman**

_____ **in-patient**

_____ long-term (6 mo.-1 yr)

_____ mid-length (3 - 6 mo.)

_____ 28 day

_____ **out-patient**

_____ full-day (5 - 7 days a week)

_____ drug-alcohol counseling

_____ **self-support groups**

_____ N.A. or A.A.

_____ **other (describe)** _____

The highest priority is to be given this case, as the health of both the fetus and the mother are at issue.

B. Report shall be made to this court by (date) _____
_____ of the success of efforts to enroll this woman in the above-described treatment program. If sufficient progress has not been made, based upon the court's assessment of the report, the parties will appear before this court on (date) _____ to explain why.

JUDGE

END NOTES

1. Brounstein, et al., *Patterns of Substance Use and Delinquency among Inner City Adolescents*, 1989 Report of the Urban Institute for the U.S. Dept. of Justice Office of Juvenile Justice & Delinquency Prevention.
2. Chavkin, *Mandatory Treatment for Drug Use During Pregnancy*, 1991 JAMA, Vol.266, No.11, pp.1556-1561.
3. Cole, *Testimony on Behalf of Los Angeles Unified School District, before U.S. House of Representatives Select Committee on Children, Youth and Families*, April 27, 1989.
4. Cook, et al., *Alcohol, Tobacco and Other Drugs may Harm the Unborn*, 1990 OSAP, DHHS Pub. (ADM)90-1711.
5. Edelin, et al, *Methadone Maintenance in Pregnancy: Consequences to Care and Outcome*, 1988 Obstetrics and Gynecology, Vol. 71, No.3, 399-404.
6. Education Development Center, Inc., *Effective Treatment for Drug-Involved Offenders: A Review and Synthesis for Judges and Court Personnel*, prepared for State Justice Institute, 1991 (Draft)
7. Farrow, personal communication re: factors that must be addressed in treatment of teens, U.of Wash. School of Medicine, Dept. of Pediatrics, Division of Adolescent Medicine, Mar.4, 1992.
8. Finnegan & Wapner, *Narcotic Addiction in Pregnancy*, in *Drug Use in Pregnancy*, ed. Lea & Febiger, 1987 pp 203-222.
9. Gawain & Ellinwood, *Cocaine and other Stimulants: Actions, Abuse and Treatment*, N.Eng.J.of Med., 1988, Vol.318,No.18, pp.1173-1182.
10. Gawain & Kleber, *Abstinence: Symptomatology and Psychiatric Diagnosis in Cocaine Abusers*, Arch Gen Psychiatry, Feb. 1986, Vol. 43, pp. 107-112.
11. Green, *Psychiatric Treatment of Abused Children*, 1978 J. of Am. Academy of Child Psychiatry, Vol.17,pp.356-371.
12. Halmesmaki, *Alcohol Counselling of 85 Pregnant Problem Drinkers: Effect on Drinking and Fetal Outcome*, Brit J of Obstetrics and Gynecology, Mar. 1988, Vol.95, pp. 243-247.
13. Hatziaandreu, *The Effectiveness of Drug Abuse Treatment: Implications for Controlling AIDS/HIV Infection*, Background Paper No.6 on AIDS-Related Issues, Office of Technology Assessment, U.S.Congress, September 1990
14. Hawkins, *Delinquents and Drugs: What the Evidence Suggests about Prevention and Treatment Programming*, paper presented at NIDA Technical Review on Special Youth Populations, July 16-17, 1986, Rockville, Md.

15. Howard, *The Development of Young Children of Substance-Abusing Parents: Insights from Seven Years of Intervention and Research*, Zero to Three, June 1989, p.8-12.
16. Hubbard, et al., *Drug Abuse Treatment: A National Study of Effectiveness* (Chapel Hill, 1989).
17. Kaltenbach & Finnegan, *Perinatal and Developmental Outcomes of Infants Exposed to Methadone In-Utero*, 1987 *Neurotoxicology and Teratology*, Vol. 13, pp 235-240.
18. Kochman, *Black and White Styles in Conflict*, University of Chicago Press, Chicago, IL, 1981.
19. Kolata, *Experts Finding New Hope on Treating Crack Addicts*, N.Y. Times, Thurs. Aug.24, 1989, p.A1.
20. Kumpfer, *Prevention of Alcohol and Drug Abuse: A Critical Review of Risk Factors and Prevention Strategies*, in *Prevention of Mental Disorders*, OSAP Monograph Series 1989.
21. Marsh & Miller, *Female Clients in Substance Abuse Treatment*, The Int'l J. of the Addictions, 1985 Vol. 20, Nos.6 & 7, p.995.
22. Millman & Sbriglio, *Patterns of Use and Psychopathology in Chronic Marijuana Users*, *Psychiatric Clinics of North America*, 1986 Vol. 9, No.3, 533-544.
23. Mondanaro, *Women: Pregnancy, Children and Addiction*, 1977 *J. of Psychedelic Drugs*, Vol.9, No.1, pp 59-68
24. Office for Treatment Improvement, *Treatment Improvement Protocol Statements (TIPS): Pregnant, Substance-Using Women*, 1991 (Draft)
25. Office of National Drug Control Policy, *Understanding Drug Treatment*, White Paper, June 1990.
26. Office of Substance Abuse Prevention, *Citizen's Alcohol and Other Drug Prevention Directory: Resources for Getting Involved*, DHHS Publication No. (ADM) 90-1657, 1990.
27. Reed, *Developing Women-Sensitive Drug Dependence Treatment Services: Why so Difficult?*, *Journal of Psychoactive Drugs*, 1987 Vol. 19, No.2, pp. 151-161.
28. Rogeness, et al., *Psychopathology in Abused or Neglected Children*, *J. of Am. Academy of Child Psychiatry*, Vol.25, pp.659-665.
29. Schneider, et al., *Infants Exposed to Cocaine in Utero: Implications for Developmental Assessment and Intervention*, *Inf Young Children*, July 1989.
30. Shedler & Block, *Adolescent Drug Use and Psychological Health*, 1990 *American Psychologist*, Vol. 45. No.5, pp 612-630.
31. Silver, et al., *Addiction in Pregnancy: High Risk Intrapartum Management and Outcome*, 1987 *J.of Perinatology*, Vol. VII, No.3, pp178-184.

32. Smith, *Cocaine-Alcohol Abuse: Epidemiological, Diagnostic and Treatment Considerations*, Journal of Psychoactive Drugs, 1986 Vol. 18, No.2, 117-129.
33. Smith, *Heavy Cocaine Use by Adolescents*, Pediatrics, 1989 Vol.83, No.4, 539-542.
34. Stewart & Bennett, *American Cultural Patterns: A Cross-Cultural Perspective*, Intercultural Press, Inc., Chicago, Il, 1991.
35. Streissguth, et al., *Neurobehavioral Dose-Response Effects of Prenatal Alcohol Exposure in Humans from Infancy to Adulthood*, 1989 Annals of N Y Academy of Science, Vol. 562, pp 145-157.
36. Wallace, *Cocaine Dependence Treatment on an Inpatient Detoxification Unit*, Journal of Substance Abuse Treatment, Vol. 4, 1987, pp. 86-92.
37. Wallace, *Psychological and Environmental Determinants of Relapse in Crack Cocaine Smokers*, Journal of Substance Abuse Treatment (1989) Vol.6, pp. 95-106.
38. Weiss & Mirin, *Subtypes of Cocaine Abusers*, Psychiatric Clinics of North America, 1986, Vol. 9, No. 3, pp. 491-501.

E. SOCIAL SERVICES

SOCIAL SERVICES

Reasonable Efforts

Reasonable Efforts Law	E-5
Risk Assessment	E-7
Case Plan	E-9
In-Home Services	E-11
Kinship Placements	E-13
Visitation	E-15

Community Resources

Public Benefits and Other Community Resources	E-19
Drug and Alcohol Treatment	E-21
“Early Intervention”: Infants and Children	E-23
Five Case Management Systems	E-27

Appendix

Array of Services (Federally Funded)	E-31
Protocol for Making Reasonable Efforts in Drug-Related Dependency Cases (Nat. Council on Juv. & Family Court Judges)	E-37
Order for Multiple Services for a Family	E-40
Order for Visitation	E-42
Order for Drug-Alcohol Treatment	E-43
End Notes	E-44

Reasonable Efforts

Reasonable Efforts

Reasonable Efforts Law E-5

Risk Assessment E-7

Case Plan E-9

In-Home Services E-11

Kinship Placements E-13

Visitation E-15

Both federal and state law require that the government make “reasonable efforts” to keep a family together

It is the court’s responsibility to ascertain in each case that the child protection agency has made reasonable efforts to keep the child in the home.

The court will wish to inquire whether the agency has:

- 1. assessed the home with the child’s safety in mind:
was a risk assessment made? how? what was the result?**
- 2. ascertained whether resources could be brought into the home to ease any immediate crises.**
- 3. searched for relatives who could help care for the child either in the parent’s home or the relatives’ home.**
- 4. determined whether resources were available in the wider community to provide medical care, child care, food, shelter, therapy, and skill enhancement.**

A. PL 96-272

The Adoption Assistance and Child Welfare Act of 1980 (PL 96-272; 42 U.S.C. sec.670 et seq.) offers federal foster care payments in each case where the state demonstrates that:

“reasonable efforts will be made (A) prior to the placement of a child in foster care, to prevent or eliminate the need for removal of the child from his home, and (B) to make it possible for the child to return to his home” sec.471(a) (15)

The assumption is that the child’s best interests usually will be served by family care.

B. State Laws

Each state has adopted these requirements into its own law, so that federal funding of foster care programs can be assured.

The court is set up as the ultimate arbiter of whether reasonable efforts have been made.

The court must actually make a finding that reasonable efforts were made.

Prior to making placement decisions based (at least partially) on the social worker's recommendation, the court should inquire how *risk* to the child from the parents' drug and alcohol use was assessed

Any *risk assessment* tool that may have been used by the social worker can be the basis for an exchange between the court and the social worker prior to the court's child placement decision.

A copy of the risk assessment tool should be provided to the court.

The court will wish to inquire whether the drug and alcohol factors in the risk assessment tool are limited to *identification* or whether they address *family functioning*.

If the risk assessment did not reveal family functioning, the court may have to order further agency inquiry into extent of impairment and the family's ability to make use of services.

A. Kinds of Risk Assessments

Most child protection agencies use some form of guided decision-making to arrive at their placement recommendations.

Very often, these decision-making guides are referred to as "risk assessment" tools.

Risk assessment tools currently in use tend to be of two kinds:

1. An "**actuarial**" model that helps the agency determine how serious are the problems in a family and the likelihood that they will become exacerbated.
2. **Matrixes** that guide a social worker's decision-making by isolating factors that seem to be related to harm to children.

None of the risk assessment tools currently in use by state agencies have been validated in long-term studies to determine their ability to accurately identify or predict problems.

Some tools use factors that are drawn from social science studies.

Others are a much looser assemblage of factors that people seem to agree affect safety of the child—like chemical dependency.

B. Court Inquiry

The court will wish to understand how risk assessments were derived in the case currently before it.

1. Was a risk assessment tool used?
2. If so, in what places does it refer to drug and alcohol problems?
3. Are drug and alcohol problems described in terms of the way that they affect family relationships?
4. How are drug and alcohol factors weighted to arrive at a score for the severity of the family's problems?
5. Did the social worker depend entirely on the factors in the risk assessment tool to make a placement recommendation to the court?

If not, what other factors were considered?

6. Is it possible to determine from the risk assessment what services should be offered to the family?

If not, what additional work needs to be done before a case plan can be completed?

The agency's case plan for the child will be the most significant document in the case, meriting the court's close scrutiny

The court may wish to:

- 1. Request a copy of the case plan**
 - 2. Ascertain that the plan includes the parent's treatment goals, description of the recommended treatment facility and the projected length of treatment.**
 - 3. Assure that adequate plans for care of the child during treatment have been made, and that they are described in the case plan.**
 - 4. Require that therapeutic services to the child be included.**
-

A. PL 96-272

Development of a case plan for foster children is a federal (PL 96-272) as well as a state requirement. Federal reimbursement is not to occur unless there is a case plan for each foster child.

The focus of the plan is the child's placement. The goal is to return the child to the family as soon as possible, consistent with the child's best interests. The agency is to make all reasonable efforts to achieve that goal.

CONTENTS OF A CASE PLAN

Adoption Assistance and Child Welfare Act of 1980 PL 96-272, sec. 475 (1); 42 U.S.C. 675

“The term ‘case plan’ means a written document which includes at least the following:

A description of type of home or institution in which a child is to be placed,

including a discussion of the appropriateness of the placement and how the agency which is responsible for the child plans to carry out the judicial determination made with respect to the child in accordance with section 472(a)(1);

and a plan for assuring that the child receives proper care and that services are provided to the parents, child and foster parents in order to improve the conditions in the parents’ home, facilitate return of the child to his own home or the permanent placement of the child, and address the needs of the child while in foster care,

including a discussion of the appropriateness of the services that have been provided to the child under the plan.”

B. Vital Elements

A successful case plan requires:

1. A **social worker** who understands chemical dependency and is willing to use agency resources to help the family recover and reunify.
2. A **family** encouraged to participate in developing treatment goals and supported during the recovery process.
3. **Court** supervision to ascertain that the case plan is realistic, the agency and family are working together, and the child’s interests are paramount.

Appropriate drug or alcohol treatment for the parents is often a condition precedent to reunion of parent and child. For that reason it must be part of the agency’s reasonable efforts, and it must be described in the case plan.

A properly constructed case plan has a continuing life throughout the case. The court can use it at later stages to monitor the family’s progress.

In-home services protect against out-of-home placement

The court may require the agency to offer *intensive in-home services* to supplement the family's parenting resources. The agency's report should include:

1. description of services offered
2. whether services have been accepted
3. whether the parents' drug-alcohol problem permits keeping the child at home, if there are services
4. prospective impact of services on safety of the child
5. cost, and who would bear the cost

Appropriate in-home services often include *family preservation* (a term referring to intensive family counseling and community liaison at least several times a week), homemakers, foster grandparents and baby sitters.. [see Array of Services, p. E-31, et seq.]

In-home services should enhance rather than replace out-of-home services like parenting classes, vocational rehabilitation, child care, respite care and basic survival benefits like AFDC and food stamps.

If a number of different in-home services will be provided rather than one comprehensive family preservation service, the court may wish identify one social service representative who will act as case manager to arrange and monitor appointments.

Resources within the extended family protect against out-of-family placement

The court can require the agency to report on its search for an *appropriate relative* who can either help in the home or assume care for the child.

If a kinship placement is recommended, the agency's report should include:

1. description of the home
 2. explanation of relative-caretaker's ability to parent
 3. description of any known substance use problem in the kinship family
 4. description of the resources the agency will offer to sustain placement
-

The father's family, grandparents, aunts, uncles and siblings should be included in the search.

The standards applied to the relative's home should be the same as those applied to the parent's home.

Resources to be offered to relatives include connection with public benefits and training to manage children with developmental or behavioral disabilities. [see Array of Services p. E-31 et seq.]

Court Query

Can the relative keep the child safe from attempts of a violent parent to withdraw the child?

Facilitating visitation between family members during out-of-home placement is a responsibility shared by the social service agency and the parents

The court's visitation order should provide for:

1. *frequent visits* daily if possible, and at least weekly.
2. *Transportation*, with tokens or vouchers issued as needed.
3. *Reasonable visiting hours* so that the child will not miss school and the parent will not have to choose between visiting a child and keeping a job.

A. Frequent Visits

Once children are removed from their homes, reunion becomes difficult.

The younger the child, the longer parental absences seem.⁵ If the bond between parent and child is to remain strong, visits should occur as frequently as possible, unless it would be in the best interests of the child, as determined by a mental health professional, that visits be infrequent.

A visitation schedule should not be established to suit the convenience of the agency that is arranging it, if to do so would be inconvenient to parent and child and place barriers between them.

B. Safety of Child

Evidence Problem!

Federal law requires that the child be placed in a home in as close proximity to the parent's home as possible. (PL 96-272)

Where families have drug and alcohol problems, competing issues are whether the foster or kinship home must be protected from a violent parent.

Each case will have different facts that affect visitation and accessibility of the child. However, the standard against which the facts are measured should be the central significance of visitation to reunification.

When deviations from the standard of frequent visitation are necessary, findings of fact should support it.

Community Resources

Community Resources

Public Benefits and Other Community Resources	E-19
Drug and Alcohol Treatment	E-21
“Early Intervention”: Infants and Children	E-23
Case Management	E-27

Resources in the wider community are necessary to maintain family placements

The court may require the agency to connect the family with community services.

The agency's report to the court should include:

1. a description of any *emergency assistance* extended to the family.
2. progress in enrolling the family for *public benefits*.
3. progress in enrolling the family in *skills enhancement* courses
4. progress in enrolling the family in drug- alcohol *treatment*, and family *therapy*
5. how the appointments were facilitated (including transportation)
6. the cost of treatment and therapy, and who will bear the cost

A. Kinds of Services

Emergency Services includes cash, goods, medical aid and temporary housing under AFDC; respite care, crisis nurseries for the disabled, food vouchers under WIC and Food Stamps.

Basic Services include AFDC, WIC, food stamps, SSI, Medicaid, disability payments, child care and public housing or Section 8 housing applications.

Skills Enhancement includes parenting classes, Head Start, vocational training, and family counseling.

Very recent studies have shown that when drug-exposed toddlers have been given comprehensive medical and social services they can catch up developmentally with their peers. ²

Drug and Alcohol Services include in-patient or out-patient treatment, connections with self-help groups like Narcotics Anonymous, and individual therapy.

B. Case Management

The court may wish to identify one social service representative who will act as case manager to arrange and monitor appointments in the community.

Over-scheduling adults can be counter-productive. The court may have to determine priorities.

The most efficient methods for delivering comprehensive services are one-stop shopping, or a case management system that coordinates care.¹⁰

Implementing *drug and alcohol treatment* for the adults can be the “reasonable efforts” that bring about successful reunion of the family

The court should require the agency to participate in the search for appropriate treatment. The agency’s report to the court should include:

- 1. a description of the treatment offered**
 - 2. why that treatment is appropriate**
 - 3. projected length of time for treatment**
 - 4. waiting time to enter treatment**
 - 5. cost, and who will bear the cost**
-

A. Agency Intervention

There are several reasons why the assigned family social worker should facilitate drug and alcohol treatment for parents.

The agency is obligated to make reasonable efforts to keep the family together (PL 96-272). Parents who are dependent upon or abusing drugs often cannot care for their children until they receive treatment.

A social worker is trained to connect citizens with community resources.

Parents with on-going drug or alcohol problems often deny those problems. Denial is part of the disease. Asking a person who denies having a problem to find treatment for that problem can be futile.

B. Court Monitoring

Although the social worker or other case manager may facilitate the treatment, the court will wish to monitor the treatment plan to assure that the treatment environment and length of treatment match the needs arising from the type of substance used and the severity of the problem
[see p. D-7 to D-11]

C. Levels of Service

TREATMENT ENVIRONMENTS

based in part on Office of National Drug Control Policy, *Understanding Drug Treatment*, White Paper, June, 1990

in-patient, short-term

detoxification; alcoholic patients; minor drug problems

in-patient, residential (2-6 months)

cocaine and other more difficult addictions (including alcohol); pregnant women

therapeutic communities (4 months to several years)

cocaine, PCP and any other difficult addictions; history of criminal behavior; pregnant women with families

out-patient counseling

intensive, all day every day counseling appropriate for some pregnant women with families; methadone maintenance for heroin addictions; follow-up counseling for people who have been through an in-patient program, or detoxification

self-help groups

These are not treatment providers, merely support groups for people who are being treated in some other way. They include Narcotics Anonymous and Alcoholics Anonymous

Children suffering the effects of in-utero or environmentally-acquired drug or alcohol exposure may have access to greater resources if they are classified as "handicapped"

The court will be in the best position to point out, and urge involvement in, *early intervention* programs for children with developmental disabilities.

In cases where parental alcohol and drug use (or accidental or passive ingestion by the children themselves) may have caused neurobehavioral deficits, the court may wish to order the child protection agency to provide:

1. Medical and mental health evaluations of the current and potential problems
 2. A list of early intervention programs available in the community, and their eligibility requirements
 3. A description of efforts made by the agency to connect the family with these services
-

A. Education for the Handicapped Act

The Education for the Handicapped Act, 20 U.S.C. sec. 1400 et seq. (PL 99-457 amending PL 94-142) specifically intends to serve **children from birth through eight years** who suffer (or are at risk to suffer) from developmental delays.

States will receive federal funds for early intervention when they develop "free and appropriate education" programs that meet the standards set forth in the Act.

Those standards require individualized education for each handicapped child in the state.

All states have qualifying programs for children whose developmental delays have been assessed.

In addition, many states have elected to establish programs for children who are at risk for significant developmental delays.

Programs under the Education for the Handicapped Act provide an array of services to stimulate and support the child. They can be put into place upon birth. Early identification is vital. The court can take the lead.

EARLY INTERVENTION SERVICES FOR DEVELOPMENTALLY-DELAYED INFANTS AND TODDLERS

Education for the Handicapped Act 20 U.S.C. sec. 1472

- (1) The term "handicapped infants and toddlers" means individuals from birth to age 2, inclusive, who need early intervention services because they—
- (A) are experiencing developmental delays as measured by appropriate diagnostic instruments and procedures in one or more of the following areas: cognitive development, physical development, language and speech development, psychosocial development, or self-help skills, or
 - (B) have a diagnosed physical or mental condition which has a high probability of resulting in developmental delay.

Such term may also include, at a State's discretion, individuals from birth to age 2, inclusive, who are at risk of having substantial developmental delays if early intervention services are not provided.

- (2) The term "early intervention services" are developmental services which—
- (A) are provided under public supervision
 - (B) are provided at no cost except where Federal or State law provides for a system of payments by families, including a schedule of sliding fees,
 - (C) are designed to meet a handicapped infant's or toddler's developmental needs in any one or more of the following areas:
 - (i) physical development
 - (ii) cognitive development
 - (iii) language and speech development
 - (iv) psychosocial development, or
 - (v) self-help skills
 - (D) meet the standards of the State, including the requirements of this subchapter,

(E) include—

- (i) family training, counseling and home visits,
- (ii) special instruction,
- (iii) speech pathology and audiology,
- (iv) occupational therapy
- (v) physical therapy
- (vi) psychological services
- (vii) case management services
- (viii) medical services only for diagnostic or evaluation purposes
- (ix) early identification, screening, and assessment services, and
- (x) health services necessary to the infant or toddler to benefit from the other early intervention services

(F) are provided by qualified personnel, including—

- (i) special educators
- (ii) speech and language pathologists and audiologists,
- (iii) occupational therapists
- (iv) physical therapists
- (v) social workers
- (vi) nurses, and
- (vii) nutritionists

B. Americans with Disabilities Act

Enhancing the Education for the Handicapped Act is the new **Americans with Disabilities Act**, 42 U.S.C. 12101 et seq. which requires child care, schools, most private businesses and all state and federal agencies to accomodate children with mental, emotional or physical handicaps.⁹

Effective case management is required in drug-alcohol cases.

The court may wish to designate one of the following to arrange and facilitate the family's multiple tasks:

- 1. Lead professional (e.g. therapist, foster care worker)**
 - 2. Contracted agency (e.g. "LINK")**
 - 3. Multidisciplinary team**
 - 4. Treatment or therapy program**
 - 5. Social worker, child protection agency**
-

Adults whose dominant activity has been obtaining and taking drugs or alcohol usually will be unable to set a priority for tasks, find a telephone and money to make appointments, arrange for child care during appointments, find money and transportation to reach the appointments, and concentrate well enough to complete applications. If family preservation is a goal, drug-alcohol users need a significant amount of concentrated help.

Appendix

Appendix

Array of Services (Federally Funded) E-31

Protocol for Making Reasonable Efforts in
Drug-Related Dependency Cases
(Nat. Council on Juvenile & Family Court Judges). E-37

Order for Multiple Services to a Family E-40

Order for Visitation E-42

Order for Drug-Alcohol Treatment E-43

End Notes. E-44

ARRAY OF SERVICES

(Federally Funded)

Most of this information can be found in the Congressional Research Service *Report to Congress: Federal Programs for Children and their Families*, Jan. 2, 1990. The CSR report is updated approximately every two years.

[Italics refer to drug-alcohol programs; asterisks refer to services for basic needs]

Pregnant Women and Newborns

<i>Abandoned Infants Assistance</i>	Demonstration programs to develop programs for "boarder babies" and Infants with HIV.	Abandoned Infants Assistance Act of 1988 (Health & Human Services)
<i>Education for the Handicapped</i>	Funds states to assist infants and toddlers who have developmental problems, birth through two years	Education for the Handicapped Act (Education)
Maternal & Child Health Services	Grants to states to develop programs to increase prenatal & postpartum women's services, & enhancement of care for infants	Social Security Act, Title V (Health & Human Services)
<i>Pregnant & Postpartum Women & Infants Demonstration Grants</i>	Funds for demonstration programs to educate, prevent, treat & conduct research for substance-using women & their drug exposed infants	Public Health Services Act of 1988. (Health & Human Services)
*Special Supplemental Food Program for Women, Infants & Children (WIC)	Food or vouchers for food for needy pregnant and postpartum women, infants and children to age 4	Child Nutrition Act of 1966 (Agriculture)
Temporary Child Care for Children with Disabilities & Crisis Nurseries	Grants to states for children with special needs, and nurseries for abused & neglected children. In-home or out-of-home. Limit: 30 days per year.	Children's Justice & Assistance Act of 1986, Title II (Health & Human Services)

Childhood Intervention

Adoption

<i>Adoption Assistance</i>	Assistance to families that adopt special needs children who are SSI or AFDC-eligible	Social Security Act, Title IV (Health & Human Services)
----------------------------	---	---

Array of Services, cont.

<i>Adoption Assistance</i>	Facilitation for adoption of hard-to-place special needs children	Child Abuse Prevention & Treatment & Adoption Reform Act of 1978, Title II (Health & Human Services)
<i>Child Care</i>		
*Day Care (Under AFDC Employment Programs)	Day care for children (3 years or older) of parents enrolled in AFDC vocational training (JOBS & WIN)	Social Security Act, Title IV (Health & Human Services)
Dependent Care	Grants to states for day care at schools & community centers. Specifically serves handicapped children as well as others from diverse backgrounds	Omnibus Budget Reconciliation Act of 1981 (Health & Human Services)
<i>Temporary Child Care for Children with Disabilities & Crisis Nurseries</i>	Grants to states for temporary child care for children with special needs. In-home & out-of-home. Limit: 30 days per year.	Children's Justice & Assistance Act of 1986 (Health & Human Services)
<i>Education, Social Development, Health</i>		
Childhood Immunization	Grants to states for child immunization	Public Health Services Act sec. 317(j)(1)
Comprehensive Child Development Centers	Model programs, not yet widely available, to provide comprehensive early childhood development services. 80% federally funded.	Comprehensive Child Development Centers Act of 1988 (Health & Human Services)
<i>Developmental Disabilities Program</i>	Assistance to states for programs that help children with severe, chronic disabilities that will require lifelong services.	Developmental Disabilities & Bill of Rights Act (Health & Human Services)
<i>Drug-Free Schools and Communities</i>	Grants to states for drug prevention demonstrations in schools and community-based organizations	Elementary & Secondary Education Act of 1965, Title V (Education)
*Education for the Handicapped	Assistance to states to meet the educational needs of handicapped children	Education of the Handicapped Act (Education)

Array of Services, cont.

Education of Homeless Children and Youth	Ensures that homeless children have a free and appropriate education	Stewart B. McKinney Homeless Assistance Act (Education)
Emergency Medical Services for Children	Funds for demonstration programs to improve delivery of emergency services for children	Public Health Services Act, sec. 1910
Even Start	Funds to states to enhance school preparation for disadvantaged children (1-7 years) and their parents	Elementary & Secondary Education Act of 1965, Title I (Education)
Follow Through	Funds to states for model programs that enhance education for disadvantaged children (kindergarten - 3rd grade). Also health & social services.	Follow Through Act (Education)
Foster Grandparent Program	Funds supportive services for handicapped or needy children by low-income elderly people	Domestic Volunteer Service Act of 1973 (Health & Human Services)
Fund for Improvement & Reform of Schools and Teaching (FIRST)	Funds to schools for programs that help at-risk children meet academic standards	Hawkins-Stafford Elementary & Secondary School Amendments of 1988 (Education)
Head Start	Education, social, health & nutritional assistance for needy pre-schoolers. 10% of places for handicapped children.	Head Start Act of 1981 (Health & Human Services)
<i>Preventive Health & Health Services</i>	Grants to states for home health, immunization, alcohol & drug prevention	Public Health Services Act Title XIX (Health & Human Services)

Food

Child Care Food Program	Cash assistance to child care centers and homes to prepare free and subsidized meals for needy children between 3 and 5.	Nat. School Lunch Act of 1946 (Agriculture)
National School Lunch Program	Cash and commodity assistance to schools serving free and subsidized lunches to needy children	Nat. School Lunch Act of 1946 (Agriculture)

Array of Services, cont.

School Breakfast Program	Cash to schools serving free and subsidized breakfasts to needy children	Child Nutritional Act of 1966 (Agriculture)
Summer Food Service Program	Cash to states for schools & institutions in poverty areas to serve a meal & snack to children in summer.	Nat. School Lunch Act of 1946 (Agriculture)

Income

*Supplementary Security Income (SSI)	Cash income to disabled, needy adults or children. Federally-guaranteed floor, states may supplement.	Social Security Act, Title XVI (Health & Human Services)
--------------------------------------	---	--

Adolescents

Adolescent Family Life	Funds organizations to prevent, assist & counsel teens, pregnant teens, and teen parents	Appropriation (Health & Human Services)
<i>Community Youth Activity Program</i>	Funds to states to establish drug abuse prevention services for youth in drug-impacted areas	Anti-Drug Abuse Act, Amended 1988 sec. 3521 (Health & Human Services)
<i>Indian Health Service Substance Abuse Services for Youth</i>	Funds to tribes for drug and alcohol prevention and treatment services for Indian youth	Anti-Drug Abuse Act, 1988 Title IV (Health & Human Services)
*Independent Living	Assistance to states to provide independent living skills and jobs training to teens.	Social Security Act, Title IV-E (Health & Human Services)
Runaway and Homeless Youth Program	Temporary residential care, transitional housing for runaway & homeless youth & their families.	Runaway & Homeless Youth Act (Health & Human Services)
<i>Drug Abuse Prevention for Runaway and Homeless Youth</i>	Grants to organizations for outreach and counseling on drugs & alcohol for runaway & homeless youth	Anti-Drug Abuse Act of 1988, sec. 3511-5 (Health & Human Services)
<i>High Risk Youth Demonstration Grant Program</i>	Funds for model programs for prevention & treatment of drug & alcohol abuse among high risk youth	Anti-Drug Abuse Act of 1986, Amend. 1988, sec. 2051 (Health & Human Services)

Array of Services, cont.

Job Corps	Remedial education and skill training for needy youth, 14-21	Job Training Partnership Act, Title IV-B (Labor)
Job Training	Funds to states for remedial education and on-the-job training	Job Training Partnership Act, Title II-A (Labor)
Magnet Schools Assistance	Funds to schools for programs that strengthen academic & vocational skills for minority youth	Elementary & Secondary Education Act Title IV (Education)
School Dropout Demonstration Assistance	Grants to local schools to identify & aid at risk youth in danger of dropping out of school	Elementary & Secondary Education Act Title IV (Education)
Summer Youth Employment & Training Program	Funds to states for employment & job training for needy 14-21 years old	Job Training Partnership Act, Title II-B (Labor)
Vocational Education	Grants to states for vocational education for disadvantaged or handicapped youth.	Carl D. Perkins Vocational Education Act (Education)
Basic Support for Families		
<i>*Alcohol, Drug Abuse & Mental Health Block Grant</i>	Funds for states to provide in- and out-patient alcohol and drug detox. & treatment, adults, families, youth	Public Health Services Act, Title XIX (Health & Human Services)
<i>*Aid to Families with Dependent Children (AFDC)</i>	Cash to needy children and their caretakers. States determine maximum benefit levels. Requires women with children less than 3 to train for work.	Social Security Act. Title IV-A (Health & Human Services)
Community Health Centers	Funds to states for primary health care in medically underserved areas	Public Health Service Act, Section 330
<i>*Emergency Assistance</i>	Cash, in-kind, and medical aid, temporary housing, to needy families. Limit: 30 days per year	Social Security Act, Title IV-A (Health & Human Services)
<i>*Food Stamps</i>	Stamps to redeem staples to prepare food at home. Funds for basic service entirely federal.	Food Stamp Act of 1977 (Agriculture)

Array of Services, cont.

Foster Care	Maintenance payments for children who have been placed in foster care.	Social Security Act, Title IV-E (Health & Human Services)
Indian Child Welfare Assistance	Funds to Indian tribes for foster & institutional care for handicapped and neglected children	Snyder Act of 1921 (Interior)
*Leased Housing Assistance (Sec. 8)	Rental assistance for privately-owned units, for families with children	U.S. Housing Act of 1937 (Housing)
*Medicaid	Fed.-state matching funds for basic health care to AFDC & SSI families, and certain other needy people	Social Security Act Title XIX (Health & Human Services)
*Refugee & Cuban/Haitian Entrant Assistance Program	Medicaid, AFDC & other assistance for refugees the first two years in U.S.	Appropriation (Health & Human Services)
*Vocational Education	Grants to states for vocational training of handicapped & disadvantaged adults	Carl D. Perkins Vocational Education Act (Education)
Supportive Housing for the Homeless	Funds for demonstration programs that provide innovative housing initiatives for homeless people with children.	McKinney Homeless Assistance Act (Housing)

National Council of Juvenile and Family Court Judges
**PROTOCOL FOR MAKING REASONABLE EFFORTS
IN DRUG-RELATED DEPENDENCY CASES**

Questions for social workers

**Services to
prevent removal**

Does the social service agency report include information on resources available to the family?

Has there been a full assessment of other members of the household, parents residing out of the home, extended family members and significant others, who may be vital resources in restructuring the capacity of the family to provide adequate protection for the children involved?

Does the agency report reflect an offer of services, and appropriate contact made with these resources, such as intensive, home-based services, that are designed to improve the skills and capacity of the family to better protect children and monitor closely the circumstances that previously put children at risk?

Has the father and his extended family been identified and contacted, and is he a placement option and/or resource for the child? Has the social service agency identified and actively pursued extended family placement options

Has the availability/eligibility of the following service programs been examined:

- family-centered drug treatment services
- other family-centered services
- intensive, family preservation services
- counseling
- emergency housing
- in-home caretaker
- out-of-home respite care
- teaching and demonstrating homemakers
- parent skills training
- transportation
- emergency cash assistance
- government aid programs:
- Women, Infants, Children food supplement program (WIC)
- Food Stamps
- Aid to Families with Dependent Children (AFDC)

Reasonable Efforts Protocol, cont.

- Medicaid
- SSI
- Disability payments
- Head Start or age-appropriate infant/child care program

Has there been adequate interagency or intra-agency coordination to ensure that *concrete* services have been made available in a timely manner so that the child is not removed as a result of delays in processing approval or beginning delivery of such services?

Treatment How has the social service agency helped the substance abusing parent obtain treatment?

Has there been a professional assessment by substance abuse professionals, of the mother's substance abuse problems, with recommendations for appropriate treatment?

Has the agency identified appropriate programs that are experienced and qualified in treating women with the mother's particular addiction and problems with small children?

Are the programs accessible to the mother financially as well as in other ways?

Did the agency provide or help the mother obtain transportation and day care so that she could attend treatment?

Visitation Have appropriate and frequent visitation opportunities been facilitated for all family members to promote reunification of those children who have been placed?

Have appropriate and frequent visitation opportunities been facilitated for all family members to promote reunification of children who have been placed?

Case Plan Has the agency been consistently active in the implementation of the case plans and assisting families in utilizing the resources needed to stabilize the family?

Reasonable Efforts Protocol, cont.

Has there been an in-depth, holistic assessment of the family in context, including in-home evaluation of the family's environment, home, extended family and peers, including potential capacity as well as potential risks?

Is there a process for individual tailoring of services and service packages for families?

Reunification Have appropriate, family-focused services been provided to promote reunification?

Are active family strengthening services being continued after reunification has occurred?

Have appropriate family-centered services have been provided to families where a child has been placed to promote reunification?

Are active family-centered services being continued after reunification has occurred?

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR MULTIPLE SERVICES TO A FAMILY

In order to strengthen the family, the following services shall be provided:

A. ____ **Family Preservation** (intensive in-home) services. Services are to be provided:

____ by (name of program): _____

____ as arranged by social service agency

B. ____ **Homemaker**. Services are to be provided:

by (name of program) _____

____ as arranged by social service agency

C. ____ **Enrollment for Public Benefits**. Benefits to be investigated include:

____ emergency assistance

____ AFDC

____ WIC

____ Food Stamps

____ SSI

____ child care

____ public housing

____ Section 8

____ vocational rehabilitation

D. ____ **Drug-Alcohol Treatment**. Services to be arranged by (agency) _____.

Services to be investigated include:

____ detoxification

____ in-patient, short-term

____ in-patient, residential

____ therapeutic community

____ out-patient counseling

____ as arranged by social service agency

Order for Services (I), p.2

E. _____ Individual Therapy

_____ services to be provided by (agency)

_____ as arranged by social service agency

F. _____ Family Therapy

_____ services to be provided by (agency)

_____ as arranged by social service agency

G. _____ Visitation

_____ shall occur (how often) _____

_____ shall be arranged by (agency) _____

_____ shall take place at (site) _____

_____ shall be supervised by (agency or person) _____

_____ be limited to the following people

_____ take place as arranged by the social service agency

H. Other Services _____

JUDGE

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR VISITATION

In order to strengthen the family, visitation with the child shall occur as follows:

A. Visits shall be arranged by (agency) _____

B. Visits shall occur according to the following schedule:

_____ daily
_____ twice a week
_____ weekly
_____ other (describe) _____

C. Visits shall take place at (place) _____

D. Visits shall be supervised by (agency or person) _____

E. Persons entitled to visit with the child include the following:

JUDGE

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR DRUG/ALCOHOL TREATMENT

A. (Person) _____ shall enter drug/alcohol treatment as soon as appropriate treatment is available.

B. Services shall be facilitated by (social service agency)

C. Services to be investigated shall include:

_____ detoxification (name(s) of facility, if known)

_____ in-patient, short-term (name(s), if known)

_____ in-patient, residential (name(s), if known)

_____ out-patient, counseling (name(s), if known)

D. A report to the court shall be submitted by (agency) _____ no later than (date) _____ describing progress in obtaining drug-alcohol services.

E. Case will be heard again on (date) _____

JUDGE

END NOTES

1. Bays, *Substance Abuse and Child Abuse: Impact of Addiction on the Child*, 1990 Pediatric Clinics of North America, Vol.37, No.4, 881-904.
2. Chasnoff, et al., *Cocaine/Polydrug Use in Pregnancy: Two-Year Follow-Up*, 1992 Pediatrics, Vol.89, No.2, pp.284-289.
3. Comm. on Ways and Means, U.S. House of Representatives, *1991 Green Book: Overview of Entitlement Programs*, U.S. Gov't Printing Office, May 7, 1991.
4. Congressional Research Service, *CRS Report for Congress: Federal Programs for Children and their Families*, Jan.2, 1990.
5. Goldstein, et al., *Beyond the Best Interests of the Child*, 1973 MacMillan (The Free Press).
6. Meisels, *Meeting the Mandate of Public Law 99-457: Early Childhood Intervention in the Nineties*, 1989 Am.J. of Orthopsychiatry, Vol.59, No.3, pp.451-460.
7. Office of National Drug Control Policy, *Understanding Drug Treatment*, White Paper, June 1990.
8. Office for Substance Abuse Prevention, *Citizen's Alcohol and Other Drug Prevention Directory: Resources for Getting Involved*, DHHS Pub.No. (ADM)90-1657, 1990.
9. Surr, *The Americans with Disabilities Act (ADA) Affects the Whole Child Care Profession. What Should You Do?*, [to be published, June, 1992, in Young Children]
10. Wald & Woolverton, *Risk Assessment: The Emperor's New Clothes?* 1990 Child Welfare, Vol.69, No.6, pp.483-511.
11. Zuckerman & Frank: *"Crack Kids" Not Broken*, 1992 Pediatrics, Vol.89, No.2 337-339.

MODEL ORDERS

ORDERS

Orders

Case Management	F-3
Drug Screen	F-5
Infant Neurobehavioral/Developmental Assessment	F-7
Infant Needs Assessment	F-8
Child's Physical Examination	F-9
Mental Health Screening	F-10
Full Mental Health Assessment	F-11
Multiple Services	F-13
Visitation	F-16
Drug-Alcohol Treatment	F-17
Priority Drug Treatment, Pregnant Woman	F-18

Court:
Division:
County and State:

Case Name:
Case Number:
Date:

ORDER FOR CASE MANAGEMENT

In order that this case proceed as efficiently as possible and that _____
(name of child) and the family receive services that will help to keep the family together, the
court makes the following order as to case management:

A. _____ (agency) shall have lead responsibility to facilitate
services to the family. The person assigned from the above designated agency shall:

- _____ schedule appointments for services
- _____ arrange transportation to appointments
- _____ receive reports from service providers
- _____ compile and forward reports to the court
- _____ develop a case plan for the family

B. The lead agency shall coordinate the work of at least the following service providers:

1. _____
2. _____
3. _____
4. _____
5. _____

C. The lead agency shall assure that the following tasks are accomplished, either by the lead
agency itself or by another designated service provider:

- _____ appointments for services scheduled
- _____ transportation to appointments arranged
- _____ case plan for family developed
- _____ reports from service providers received and forwarded to
court

D. The following services shall be provided:

- _____ services to be determined by the lead agency
- _____ drug tests—assessments
- _____ drug tests—on-going
- _____ medical assessments
- _____ medical care—on-going
- _____ mental health screening
- _____ mental health assessments
- _____ individual therapy
- _____ family therapy
- _____ parenting classes
- _____ child care
- _____ detoxification
- _____ drug-alcohol treatment
- _____ visitation
- _____ emergency assistance
- _____ public benefits
- _____ food
- _____ housing
- _____ child care
- _____ vocational training
- _____ educational or developmental assessment
- _____ early child intervention services
- _____ develop family case plan
- _____ other: _____

JUDGE

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR DRUG SCREEN

A. Drugs to be tested shall include at least the following drugs:¹

<input type="checkbox"/> amphetamines	<input type="checkbox"/> lysergic acid diethylamide
<input type="checkbox"/> barbiturates	<input type="checkbox"/> methadone
<input type="checkbox"/> benzodiazepines	<input type="checkbox"/> opiates
<input type="checkbox"/> cannabinoids	<input type="checkbox"/> phencyclidine
<input type="checkbox"/> cocaine metabolites	<input type="checkbox"/> propoxyphene
<input type="checkbox"/> ethyl alcohol	
<input type="checkbox"/> others (describe) _____	

<input type="checkbox"/> choice of common street drugs to be determined lab	

¹ (Note: most labs test for three or four popular street drugs.
Additional drugs of concern to the court must be specified)

B. ☐ Positive tests to be confirmed by a different method²

C. Tests shall occur according to the following schedule:

☐ scheduled

☐ twice a week

☐ at two or three day intervals

☐ other (describe) _____

☐ random

☐ on one to twenty-four hour telephone notice

☐ on one to two days' notice

☐ other (describe) _____

☐ today only

² (Note: Drugs dissipate quickly. Twice weekly, or random short notice is required to catch most drug use)

D. The drug screen shall be performed:

_____ by the following agency (name) _____

_____ by a facility arranged by (agency) _____

E. (Name of person to be tested) _____ is ordered to appear for the first
test:

_____ on (date) _____

_____ as scheduled by the laboratory

_____ as arranged by (name of person or agency):

JUDGE

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR INFANT NEUROBEHAVIORAL/DEVELOPMENTAL ASSESSMENT

A. A neurobehavioral/developmental assessment shall be administered to:
_____ (infant's name) for the purpose of assessing infant impairments and deciding on therapeutic and early intervention strategies.

B. The test(s) shall be performed at:

_____ hospital (name) _____
_____ other facility _____
_____ facility to be chosen by test giver _____
_____ facility to be chosen by social service agency _____
_____ other arrangement (describe) _____

C. Test(s) shall be performed by:

_____ physician (name) _____
_____ other professional (name and profession) _____
_____ as decided by testing facility _____
_____ as decided by social worker _____
_____ as decided by (name, profession) _____

D. Test(s) shall include:

_____ Brazelton Neonatal Behavioral Assessment Scale
_____ Bayley Scales of Infant Development
_____ Other: _____
_____ As decided by test-giver _____

E. Results of test(s) shall be sent to: _____

Court shall receive results by (date): _____

JUDGE

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR INFANT NEEDS ASSESSMENT

A. A needs assessment report shall be prepared for (infant's name):

The report shall be prepared by (agency) _____

B. The court is particularly concerned about effects arising from:

_____ cocaine exposure
_____ alcohol exposure
_____ narcotic (opioid) exposure
_____ inhalant exposure
_____ polydrug exposure
_____ other exposure (describe) _____

C. The needs assessment shall address:

_____ apnea monitor
_____ vulnerability to SIDS
_____ potential for seizures
_____ cerebral palsy
_____ heart irregularities
_____ congenital deformities
_____ HIV/AIDS
_____ other (describe) _____

D. The report shall assess:

_____ physical therapy requirements for the next year
_____ recommended early intervention programs
_____ projected long-term needs
_____ other (describe) _____

E. The report shall describe how the agency plans to meet the child's needs.

JUDGE

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR CHILD'S PHYSICAL EXAMINATION

Child (name) _____ shall be examined at:

- _____ public-funded hospital or clinic
- _____ facility chosen by social service agency
- _____ facility chosen by examining physician
- _____ other (describe): _____

Particular attention shall be given to:

- _____ physical trauma
- _____ congenital defects
- _____ drug-alcohol reactions
- _____ any deformities or impairments for which early inter-
vention is recommended
- _____ other (describe) _____

Reports of the examination shall be submitted to _____

The court shall receive the results by (date) _____

JUDGE

Orders
Mental Health Screening

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR MENTAL HEALTH SCREENING

_____ (person) is to participate in a mental health screening.

The screening is to be performed by (agency): _____

The screening psychologist or psychiatrist is to:

rule out or assess for any current drug-alcohol problems (psychoactive substance induced mental disorders) or any long term drug-alcohol problems (psychoactive substance use disorders) as well as any pre-disposing factors or complications associated with these disorders [consult DSM III-R classifications]

The screening:

_____ is scheduled on (date) _____

_____ will be scheduled for the earliest available date by (person or agency) _____

Social information is to be provided to the screening psychologist or psychiatrist by (agency or social worker) _____ prior to the screening appointment.

A written report of the screening results is to be provided to the court by (date, time):

The mental health screening is to be paid for by (person or agency):

JUDGE

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR FULL MENTAL HEALTH ASSESSMENT

_____ (name of person) shall participate in a full mental health assessment.

The full mental health assessment shall include:

- _____ psychological assessment
- _____ psychiatric assessment
- _____ other (describe) _____

The following questions shall be addressed by the mental health professionals:

- _____ **To what extent are drugs or alcohol interfering with the parenting abilities and tasks of this person?**
- _____ **Is this child receiving the care and nurture required for a healthy and stable childhood?**
- _____ **Is it possible that the child's safety will be threatened if the child is left in the exclusive care of this adult?**
- _____ **What course of mental health treatment, and drug-alcohol treatment, would be required to restore health and stability to this person?**
- _____ **What degree of closeness to the parent is it in the best interests to maintain during attempts to treat and stabilize this family?**
- _____ **Other (describe):** _____

- _____ **Other (describe):** _____

Orders
Mental Health Assessment

Order for Mental Health Assessment, p.2

The mental health assessments shall be performed by: _____

_____ mental health professionals, or agency
(describe) _____

_____ mental health professionals as arranged by (name of
agency) _____

A report by each examining mental health professional shall be provided to the court by
(date): _____

These assessments shall be paid for by _____

JUDGE

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR MULTIPLE SERVICES TO A FAMILY

In order to strengthen the family, the following services shall be provided:

A. _____ **Family Preservation** (intensive in-home) services.
Services are to be provided:

_____ by (name of program): _____
_____ as arranged by social service agency

B. _____ **Homemaker**. Services are to be provided:

_____ by (name of program) _____
_____ as arranged by social service agency

C. _____ **Enrollment for Public Benefits**. Benefits to be investigated include:

_____ emergency assistance
_____ AFDC
_____ WIC
_____ food stamps
_____ SSI
_____ child care
_____ public housing
_____ Section 8
_____ vocational rehabilitation

D. _____ **Drug-Alcohol Treatment**. Services to be arranged by (agency) _____
Services to be investigated include:

_____ detoxification
_____ in-patient, short-term
_____ in-patient, residential
_____ therapeutic community
_____ out-patient counseling
_____ as arranged by social service agency

E. _____ Individual Therapy

_____ services to be provided by (agency) _____

_____ as arranged by social service agency

F. _____ Family Therapy

_____ services to be provided by (agency) _____

_____ as arranged by social service agency

G. _____ Visitation

_____ shall occur (how often): _____

_____ shall be arranged by (agency): _____

_____ shall take place at (site): _____

_____ shall be supervised by (agency or person): _____

_____ be limited to the following people:

_____ take place as arranged by the social service agency

Order for Services I, p.4

H. Other Services.

JUDGE

Orders
Visitation

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR VISITATION

In order to strengthen the family, visitation with the child shall occur as follows:

A. Visits shall be arranged by (agency) _____

B. Visits shall occur according to the following schedule:

_____ daily
_____ twice a week
_____ weekly
_____ other (describe) _____

C. Visits shall take place at (place) _____

D. Visits shall be supervised by (agency or person) _____

E. Persons entitled to visit with the child include the following:

JUDGE

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR DRUG/ALCOHOL TREATMENT

To promote the recovery of this adult, drug/alcohol treatment services shall be obtained as follows:

A. Services shall be facilitated by (social service agency) _____

B. Services to be investigated shall include:

_____detoxification (name(s) of facility, if known):

_____in-patient, short term (name(s), if known):

_____in-patient, residential (name(s), if known):

_____therapeutic community (name(s), if known):

_____out-patient, counseling (name(s), if known):

C. A report to the court shall be submitted by (agency) _____ no later
than (date) _____describing progress in obtaining drug-alcohol services.

D. Case will be heard again on (date) _____

JUDGE

Court:
Division:
County & State:

Case Name:
Case Number:
Date:

ORDER FOR PRIORITY DRUG TREATMENT FOR PREGNANT WOMAN

A. (Agency) _____ shall make every effort to facilitate entrance of
(person) _____ into a program with the following attributes:

_____ for a pregnant woman

_____ *in-patient*

_____ long-term (6 mo.-1yr)

_____ mid-length (3-6 mo.)

_____ 28 day

_____ *out-patient*

_____ full-day (5 to 7 days a week)

_____ drug-alcohol counseling

_____ *self-support groups*

_____ N.A. or A.A.

_____ other (describe) _____

**The highest priority is to be given this case, as the health of
both the fetus and the mother are at issue.**

B. Report shall be made to this court by (date) _____ of the success of efforts
to enroll this woman in the above-described treatment program. If sufficient progress has not
been made, based upon the court's assessment of the report, the parties will appear before this
court on (date) _____ to explain why.

JUDGE

BIBLIOGRAPHY

Bibliography

Amaro, et al., *Drug Use Among Adolescent Mothers: Profile at Risk*, 1989 Pediatrics, Vol. 84, pp 144-151

Amaro, et al., 1990 *Violence During Pregnancy and Substance Use*, Am. J. Public Health, vol.;80, pp.575-579.

American Academy of Pediatrics, Comm.on Substance Abuse, *Drug Exposed Infants*: Pediatrics, Oct. 1990, Vol. 86, No.4, p.639-642.

American Academy of Pediatrics, *Neonatal Drug Withdrawal*, 1983 Pediatrics, 895-907

American Psychiatric Association (ed.), *Diagnostic and Statistical Manual*, Third Edition, Revised, 1987.

American Medical Association, Law and Medicine, Board of Trustees Report, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, Journal of the American Medical Association (JAMA) Nov. 28, 1990, Vol. 264, No.20, p. 2663-2670.

Anastasi, *Psychological Testing*, 7th Edition, MacMillan, N.Y., 1980.

Bandstra & Burkett, *Maternal-Fetal and Neonatal Effects of In Utero Cocaine Exposure*, 1991 Seminars in Perinatology, Vol.15, No.4, pp. 288-301.

Bays, *Substance Abuse and Child Abuse*, 1990 Pediatrics Clinics of North America, Vol. 37, No.4, p.881-904.

Bass, et al., *Death-scene Investigation in Sudden Infant Death*, 1986 New Eng. J. of Med., Vol. 315, No.2, p.100-105.

Bateman & Heagarty, *Passive Freebase Cocaine ("Crack") Inhalation by Infants and Toddlers*, Jan.1989 American Journal of Diseases in Children, Vol. 143, p.25-27.

Bavolek & Henderson, *Child Maltreatment and Alcohol Abuse: Comparisons and Perspectives for Treatment*, Special Issue: Aggression, Family Violence and Chemical Dependency, 1989 Journal of Chemical Dependency Treatment 3(1), pp.165-184.

Bayley, *Bayley Scales of Infant Development*, Manual, The Psychological Corp. (1969).

Bays, *Substance Abuse and Child Abuse: Impact of Addiction on the Child*, 1990 Pediatric Clinics of North America, Vol.37, No.4, pp.881-904.

Brazelton, *Neonatal Behavioral Assessment Scale*, Blackwell Scientific Publications, 2nd Ed. (1984).

Bibliography

- Brounstein, et al., *Patterns of Substance Use and Delinquency Among Inner City Adolescents*, 1989 Report of the Urban Institute for the U.S. Dept. of Justice Office of Juv. Justice and Delinquency Prevention.
- Bureau of Justice Assistance, *American Probation and Parole Association's Drug Testing Guidelines and Practices for Adult Probation and Parole Agencies* (Monograph No. NCJ 129199), July 1991.
- Chasnoff, *Cocaine Intoxication in a Breast Fed Infant*, 1987 Pediatrics, Vol. 80, No. 6, p.836-838.
- Chasnoff, et al.: *Cocaine/Polydrug Use in Pregnancy: Two-Year Follow-Up*, 1992 Pediatrics, Vol. 89, No.2, pp.284-289.
- Chasnoff, *Drug Use and Women: Establishing a Standard of Care*, 1989 Annals of N.Y. Academy of Science, Vol. 562, pp.208-210.
- Chasnoff, *Newborn Infants with Drug Withdrawal Symptoms*, 1988 Pediatrics in Review, Vol. 9, No. 9, pp.273-277.
- Chasnoff, *Perinatal Effects of Cocaine*, May 1987 Contemporary OB/GYN, pp.163-179.
- Chasnoff, *Prenatal Drug Exposure: Effects on Neonatal and Infant Growth and Development*, 1986 Neurobehavioral Toxicology and Teratology, Vol.8, p.357.
- Chasnoff, et al., *Temporal Pattern of Cocaine Use in Pregnancy*, 1989 JAMA, Vol. 261, No. 12, pp.1741-1744.
- Chavez, et al.: *Maternal Cocaine Use During Early Pregnancy as a Risk Factor for Congenital Urogenital Anomalies*, 1989 JAMA, Vol. 262, No.6, p.795
- Chavkin, *Drug Addiction and Pregnancy: Policy Crossroads*, 1990 Am.J. Public Health, Vol 80, No 4, pp 483-487.
- Chavkin, *Mandatory Treatment for Drug Use During Pregnancy*, 1991 JAMA, Vol.266, No.11, pp.1556-1561.
- Chouteau, et al.: *The Effect of Cocaine Abuse on Birth Weight and Gestational Age*, 1988 Obstetrics and Gynecology, Vol. 72, No.3, Part 1, pp.351-354.
- Cole, *Testimony on Behalf of Los Angeles Unified School District, before U.S. House of Representatives Select Committee on Children, Youth and Families*, April 27, 1989.
- Coleman, *Child Physical and Sexual Abuse among Chemically Dependent Individuals*, Special Issue: 1987 Chemical Dependency and Intimacy Dysfunction, Journal of Chemical Dependency Treatment, Vol. 1, pp.27-38.
- Comm. on Ways and Means, U.S. House of Representatives, *1991 Green Book: Overview of Entitlement Programs*, U.S. Gov't Printing Office, May 7, 1991.

- Congressional Research Service, *CRS Report for Congress: Federal Programs for Children and their Families*, Jan.2, 1990.
- Connolly & Marshall, *Drug Addiction, Pregnancy and Childbirth: Legal Issues for the Medical and Social Services Communities*, Drug-Exposed Infants and their Families: Coordinating Responses of the Legal, Medical and Child Protection Systems, ABA Monograph 1990.
- Cook, et al.: *Alcohol, Tobacco and other Drugs May Harm the Unborn*, 1990 OSAP, DHHS Pub. (ADM) 90-1711.
- Dale, *Constitutional Analysis of Proposals to Establish a Mandatory Public Employee Drug-Testing Program*, Congressional Research Service Report to Congress, April 12, 1988.
- Dalgleish & Drew, *The Relationship of Child Abuse Indicators to the Assessment of Perceived Risk and to the Court's Decision to Separate*, 1989 Child Abuse & Neglect, 1986 Child Care Quarterly 15(2), pp.138-140.
- DiClemente et al., *Determinants of Condom Use Among Junior High School Students in a Minority, Inner-City School District*, 1992 Pediatrics, Vol. 89, No.2, pp.197-202.
- Dixon: *Effects of Transplacental Exposure to Cocaine and Methamphetamine on the Neonate*, West J. Med. 1989, Vol. 150, pp.436-442.
- Doberczak, et al., *One-Year Follow-Up of Infants with Abstinence-Associated Seizures*, 1988 Arch Neurol, Vol.45, pp.649-653.
- Drug Testing for Federal Employees before the Subcommittee on Gov't Operations of the House Committee on the Post Office and Civil Service*, 100th Cong., 1st Sess.(1987).
- Dubowski, *Drug-use Testing*, 11 Nova L.Rev.415 (1987).
- Durkin, *The Use of Therapeutic Day Care to Resolve the Legal Dilemma of Protecting the Rights of Both Children and Parents in Equivocal Cases of Child Abuse and Neglect*, 1986 Child Care Quarterly 15(2), pp.138-140.
- Edelin, et al., *Methadone Maintenance in Pregnancy: Consequences to Care and Outcome*, 1988 Obstetrics and Gynecology, Vol.71, No.3,pp. 399-404.
- Education Development Center, Inc., *Effective Treatment for Drug-Involved Offenders: A Review and Synthesis for Judges and Court Personnel*, prepared for State Justice Institute, 1991 (Draft).
- English & Henry, *Legal Issues Affecting Drug-Exposed Infants*, Youth Law News, Vol. XI, No.1, p.1 (1990).
- Ernst & Sanders, *Unexpected Cocaine Intoxication Presenting as Seizures in Children*, 1989 Annals of Emergency Medicine, Vol 18, No.7, pp.774-776.
- Falloon, et al., *Human Immunodeficiency Virus Infection in Children*, 1989 J. of Pediatrics, Vol 114, No.1, pp.1-30.

Bibliography

- Fannellaro, et al, *Advisability of Substance Abuse Testing in Parents who Severely Maltreat their Children: the Issue of Drug Testing before the Juvenile/Family Courts*, 1988 Bulletin of the American Academy of Psychiatry and the Law, Vol.16, pp.217-223.
- Farrow & Deisher, *A Practical Guide to the Office Assessment of Adolescent Substance Abuse*, 1986 Pediatric Annals, Vol.15, No.10, pp.310-316.
- Finklehor, *A Sourcebook on Child Sexual Abuse*, Beverly Hills, Sage Publications, 1986.
- Finnegan & Wapner, *Narcotics Addiction in Pregnancy*, in *Drug Use in Pregnancy*, ed. Lea and Febiger, 1987, pp. 203-222.
- Freier, et al, *In Utero Drug Exposure: Developmental Follow-up and Maternal-Infant Interaction*, 1991 Seminars in Perinatology, Vol.15, No.4, pp.310-316.
- Fullilove, et al., *Risk of Sexually Transmitted Disease among Black Adolescent Crack Users in Oakland and San Francisco, Calif.*, 1990 JAMA, Vol. 263, No.6, pp.851-855.
- Gabel & Shendledecker, *Parental Substance Abuse and Suspected Child Abuse/Maltreatment Predict Outcome in Children's In-patient Treatment*, 1990 J. of Am. Academy of Child and Adolescent Psychiatry, 29(6), pp.919-924.
- Gallagher, *Prenatal Invasions and Interventions*, 10 Harv. Women's L.J. 9 (1987)
- Gawain & Ellinwood, *Cocaine and other Stimulants: Actions, Abuse and Treatment*, N.Eng.J.of Med., 1988, Vol.318, No.18, pp.1173-1182.
- Gawain & Kleber, *Abstinence: Symptomatology and Psychiatric Diagnosis in Cocaine Abusers*, Arch Gen Psychiatry, Feb.1986, Vol.43, pp.107-112.
- Goldsmith, *Sex Tied to Drugs = STD Spread*, 1988 JAMA, Vol.260, No.14, p.2009.
- Green, *Psychiatric Treatment of Abused Children*, 1978 J.of Am. Academy of Child Psychiatry, Vol.17, pp.356-371.
- Greenblatt, *Urine Drug Testing*, 23 New England L.Rev.651, No.3 (1988-89).
- Goldstein, et al, *Beyond the Best Interests of the Child*, 1973 MacMillan (The Free Press).
- Halmesmaki, *Alcohol Counselling of 85 Pregnant Problem Drinkers: Effect on Drinking and Fetal Outcome*, Brit J of Obstetrics and Gynecology, Mar.1988, Vol.95, pp.243-247.
- Hatziandreu, *The Effectiveness of Drug Abuse Treatment: Implications for Controlling AIDS/HIV Infection*, Background Paper No.6 on AIDS-Related Issues, Office of Technology Assessment, U.S. Congress, September 1990.
- Hawkins, et al, *Delinquents and Drugs: What the Evidence Suggests About Prevention and Treatment Programs*, paper presented to NIDA Technical review on Special Youth Populations, July 16-17, 1986, Rockville, Md.

- Hein, *Adolescent Acquired Immunodeficiency Syndrome*, 1990 Am.J. of Diseases in Children, Vol 144, pp.46-48.
- Howard, et al.: *The Development of Young Children of Substance-Abusing Parents: Insights from Seven Years of Intervention and Research*, June, 1989 Zero to Three, p. 8-12
- Hubbard, et al, *Drug Abuse Treatment: A National Study of Effectiveness* (Chapel Hill, 1989).
- Joint Commission on Accreditation of Hospitals Organization, *Accreditation Manual for Hospitals*, 1992, Alcoholism and Other Drug Dependence Services, p.3.
- Jones & Lopez: *Component Report on Drug Abuse*, Public Health Service Report on the Content of Prenatal Care, 1990 Vol. II, Chapter 16, p.273.
- Kaltenbach & Finnegan, *Perinatal and Developmental Outcome of Infants Exposed to Methadone In-Utero*, 1987 Neurotoxicology and Teratology, Vol.9, No.9, pp.311-313.
- Kandall & Gaines, *Maternal Substance Use and Subsequent Sudden Infant Death Syndrome (SIDS) in Offspring*, 1991 Neurotoxicology and Teratology, Vol.13, pp.235-240.
- Kaplan & Sadock, *Pocket Book of Clinical Psychiatry*, Williams & Wilkins, Baltimore, Md., 1990.
- Kemper: *Self-Administered Questionnaire for Structured Psychosocial Screening in Pediatrics*, 1992 Pediatrics, Vol. 89, No.3, 433-436.
- Khoury, et al., *Does Maternal Cigarette Smoking During Pregnancy Cause Cleft Lip and Palate in Offspring?* 1989 American Journal of Diseases in Children, Vol 143, pp.333-337.
- Kochman, *Black and White Styles in Conflict*, University of Chicago Press, Chicago, IL, 1981.
- Kolata, *Experts Finding New Hope on Treating Crack Addicts*, N.Y.Times, Thurs., Aug.24, 1989, p.A1.
- Kumpfer, *Prevention of Alcohol and Drug Abuse: A Critical Review of Risk Factors and Prevention Strategies*, in Prevention of Mental Disorders, OSAP Monograph Series 1989.
- Larsen, *Creating Common Goals for the Medical, Legal and Child Protection Communities*, in Drug-Exposed Infants and their Families: Coordinating Responses of the Legal, Medical and Child Protection Systems, ABA Monograph, 1990.
- Larsen, et al., *Medical Evidence in Cases of Intrauterine Drug and Alcohol Exposure*, 18 Pepperdine L.Rev. 279 (1991)
- Larsen & Horowitz, *Judicial Primer on Drug and Alcohol Issues in Family Cases*, 1991 American Bar Association.
- Leonard & Jacob, *Alcohol, Alcoholism and Family Violence*, at pp.386-406 in Van Hasselt, et al., *Handbook of Family Violence*, N.Y., Plenum Press, 1988.

Bibliography

- MacGregor, et al.: *Cocaine Use During Pregnancy: Adverse Perinatal Outcome*, 1987 American Journal of Obstetrics and Gynecology, Vol. 157, No 3, pp.686-690.
- Marsh & Miller, *Female Clients in Substance Abuse Treatment*, The Int'l J. of the Addictions, 1985, Vol.20, Nos.6 & 7, p.995.
- Martin & Bracken: *Association of Low Birthweight with Passive Smoke Exposure in Pregnancy*, 1986 Am.J. of Epidemiology, Vol. 124, No.4, pp.633-642.
- Meisels, *Meeting the Mandate of Public Law 99-457: Early Childhood Intervention in the Nineties*, 1989 Am.J. of Orthopsychiatry, Vol.59, No.3, pp.451-460.
- Miller, et al., *Delinquency, Childhood Violence, and the Development of Alcoholism in Women*, Special Issue: Women and Crime, in Crime and Delinquency 35(1), pp.94-108, (1989)
- Millman & Sbriglio, *Patterns of Use and Psychopathology in Chronic Marijuana Users*, Psychiatric Clinics of North America, 1986 Vol.9, No.3, pp.533-544.
- Mondanaro, *Women: Pregnancy, Children and Addiction*, 1977 J. of Psychedelic Drugs, Vol.9, No.1, pp.59-68.
- Moss, *Legal Issues: Drug Testing of Post-Partum Women and Newborns as the Basis for Civil and Criminal Proceedings*, Clearinghouse Review, Feb.1989.
- Moss, *Substance Abuse During Pregnancy*, 13 Harv.Women's L.J. 278 (1990)
- Office for Treatment Improvement, *Treatment Improvement Protocol Statements (TIPS): Pregnant, Substance-Using Women*, 1991 (Draft)
- Office of National Drug Control Policy, *Understanding Drug Treatment*, White Paper, June 1990.
- Office of Substance Abuse Prevention, *Citizen's Alcohol and Other Drug Prevention Directory: Resources for Getting Involved*, DHHS Publication No.(ADM) 90-1657, 1990.
- Oro & Dixon, *Perinatal Cocaine and Methamphetamine Exposure: Maternal and Neonatal Correlates*, 1987 Journal of Pediatrics, Vol.111, No. 4, pp.571-578
- Orr, et al., *Factors Associated with Condom Use Among Sexually Active Female Adolescents*, 1992 J. of Pediatrics, Vol. 120, No.2, Part 1, pp.311-317.
- Ostrea, et al., *Drug Screening of Newborns by Meconium Analysis: A Large-Scale, Prospective Epidemiologic Study*, 1992 Pediatrics, Vol. 89, No.1, pp.107-113.
- Ostrea, et al., *A New Method for the Rapid Isolation and Detection of Drugs in the Stools (Meconium) of Drug-Dependent Infants*, Annals of N.Y. Academy of Science, 1989, Vol.562, p.372.
- Proficiency Standards for Drug Testing Laboratories, Hearings before a Subcommittee on Government Operations, U.S. House of Representatives. 100th Cong., 1st Sess., June 10 and 11, 1989.*

- Reed, *Developing Women-Sensitive Drug Dependence Treatment Services: Why so Difficult?* Journal of Psychoactive Drugs, 1987 Vol.19, No.2, pp.151-161.
- Regan, et al., *Infants of Drug Addicts: At Risk for Child Abuse, Neglect, and Placement in Foster Care*, 1987 Neurotoxicology and Teratology, Vol.9, pp.315-319.
- Rivkin & Gilmore, *Generalized Seizures in an Infant due to Environmentally Acquired Cocaine*, 1989 Pediatrics, Vol. 84, No. 6, p.1100-1102.
- Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality and the Right of Privacy*, 104 Harv.L.Rev.1419 (1991).
- Rogeness, et al, *Psychopathology in Abused or Neglected Children*, 1986 J.of Am.Academy of Child Psychiatry, Vol.25,pp.659-665.
- Schneider, et al: *Infants Exposed to Cocaine in Utero: Implications for Developmental Assessment and Intervention*, Inf Young Children, July 1989.
- Schneider & Chasnoff, *Cocaine Abuse During Pregnancy: its Effects on Infant Motor Development -- a Clinical Perspective*, 1987 Topics in Acute Care and Trauma Rehabilitation, Vol. 2, No. 1 pp.59-69.
- Shannon, et al., *Cocaine Exposure in Pediatrics*, April 1988 American Journal of Diseases in Children Vol. 142, p.385 [abstract]
- Shedler & Block, *Adolescent Drug Use and Psychological Health*, 1990 American Psychologist, Vol. 45, No.5, pp.659-665.
- Silver, et al., *Addiction in Pregnancy: High Risk Intrapartum Management and Outcome*, 1987 J. of Perinatology, Vol VII, No.3, pp.178-184.
- Soyka & Joffe, 1980 *Male Mediated Drug Effects on Offspring*, Drug and Chemical Risks to the Fetus and Newborn, A. Liss, Inc. p. 49-66.
- Smith, *Cocaine-Alcohol Abuse: Epidemiological, Diagnostic and Treatment Considerations*, Journal of Psychoactive Drugs, 1986 Vol.18, No.2,pp.117-129.
- Smith, *Heavy Cocaine Use by Adolescents*, Pediatrics, 1989 Vol.83, No.4, pp.539-542.
- Stewart & Bennett, *American Cultural Patterns: A Cross-Cultural Perspective*, Intercultural Press, Inc., Chicago, Il, 1991.
- Streissguth, et al., *A Manual on Adolescents and Adults with Fetal Alcohol Syndrome with Special Reference to American Indians*, University of Washington, 2nd Ed., 1988.
- Streissguth, et al., *Fetal Alcohol Syndrome in Adolescents and Adults*, 1991 JAMA, Vol. 265, No. 15, p.1961-1967
- Streissguth, et al., *A Natural History of the Fetal Alcohol Syndrome*, Fall 1985 Alcohol Health and Research World, Vol. 10, No.1, pp.6-12.

Bibliography

Streissguth, et al., *Neurobehavioral Dose-Response Effects of Prenatal Alcohol Exposure in Humans from Infancy to Adulthood*, 1989 Annals of N.Y. Academy of Science, Vol. 562, pp.145-157.

Streissguth & LaDue: *Psychological and Behavioral Effects in Children Prenatally Exposed to Alcohol*, Fall 1985 Alcohol Health and Research World, Vol. 10, No. 1, pp.6-12.

Surr, *The Americans with Disabilities Act (ADA) Affects the Whole Child Care Profession. What Should You Do?*, in Young Children, June 1992, pp. 8-21.

Syva, Co., *Frequently Asked Questions About Syva and Drug Abuse Testing*, (pamphlet available upon request from Syva Co., (800) 227-8994.

Thomas, *Triple Jeopardy: Child Abuse, Drug Abuse, and the Minority Client*, 1989 Journal of International Violence, Vol.4, pp.351-355.

Thompson, (1990) *Working with Alcoholic Families in a Child Welfare Agency: the Problem of Underdiagnosis*, 1990 Child Welfare, Vol.69, pp.464-470.

Wald & Woolverton, *Risk Assessment: The Emperor's New Clothes?* 1990 Child Welfare, Vol.69, No.6, pp.483-511.

Wallace, *Cocaine Dependence Treatment on an Inpatient Detoxification Unit*, Journal of Substance Abuse Treatment, Vol.4, 1987, pp.86-92.

Wallace, *Psychological and Environmental Determinants of Relapse in Crack Cocaine Smokers*, Journal of Substance Abuse Treatment (1989) Vol.6, pp.95-106.

Weiss & Mirin, *Subtypes of Cocaine Abusers*, Psychiatric Clinics of North America, 1986, Vol.9, No.3, pp.491-501.

Yazigi, et al. *Demonstration of Specific Binding of Cocaine to Human Spermatozoa*, 1991 JAMA, Vol 266, No.14, p.1956-1959.

Zeese, *Drug Testing: Legal Manual*, Clark Boardman, 1991.

Zuckerman & Bresnahan, *Developmental and Behavioral Consequences of Prenatal Drug and Alcohol Exposure*, 1991 Pediatric Clinics of North America, vol.38, pp.1387-1406.

Zuckerman & Frank, *"Crack-Kids" Not Broken*, 1992 Pediatrics, Vol.89, No.2, 337-339.

Zuckerman, et al: *Effects of Maternal Marijuana and Cocaine Use on Fetal Growth*, N.Eng.J.Med. 1989 Vol. 320, No.12, p.762-768.

CASES

Blum v. Yaretsky, 457 U.S.991 (1982) [4th Amendment]

Cox v. Ct. of Common Pleas, 537 N.E. 2d 721 (Ohio App.1988) [no jurisdiction over fetus possible]

Dept. of Soc.Serv.on behalf of Mark S. v. Felicia B., 543 NYS 2d 637 (Fam.Ct.1989) [duty towards child exists at fetal stage but ripens to cause of action at birth]

Dept. of Soc.Serv. v. Nash, 419 N.W.2d 1 (Mich.App.1987) [Infant's drug-exposed characteristics plus mother's prior neglect record sufficient for jurisdiction]

In the Matter of Baby X, 293 N.W. 2d 736 (Mich.Ap.1980) [prenatal conduct of mother may be considered along with drug withdrawal symptoms to establish jurisdiction]

In the Matter of "Male" R, 422 NYS 2d 819 (Kings Cty.Fam.Ct., 1979) [based on mother's past drug record, newborn child was in imminent danger of abuse from mother]

In the Matter of Stefanel Tyesha C., 556 NYS 2d 280 (A.D.1 Dept.1990) [newborn's positive toxicology combined with mother's confession of prenatal drug use and failure to enrol in treatment program is sufficient to show neglect]

In re Fletcher, 141 Misc.2d.333, 5333 N.Y.S.2d 241 (Fam.Ct.1988) [Nexus between test and neglect]

In re Ruiz, 500 N.E.2d 935 (Ohio Com.Pl.1986) [In her perinatal drug abuse, mother abused "child" by creating a substantial risk to the newborn's health]

In re Troy D., 263 Cal Rptr 869 (Cal.App.4 Dist.1989) [mother's prenatal behavior can be considered after birth of drug-exposed child]

In re Vanessa F., 351 NYS 2d 337 (1974) [Newborn with drug withdrawal symptoms is, prima facie, a neglected child]

Jones v. U.S., No.86-31 (D.C.Ct.Ap[p.1988 [confirmation of drug test]

Lahey v. Kelly, N.Y.2d 135 (N.Y.Ct.App.1987) (confirmation of drug test]

Matter of Damien H., N.Y.L.JJ. 1/6//92 at 26, Col.3 (Fam.Ct., King County)

Matter of Fletcher, 141 Misc.2d 333, 533 NYS 2d 241 (Fam.Ct.1988) [prenatal drug use can only be a factor in neglect if there is a direct connection to child's health and safety]

Matter of Smith, 128 Mich.2d 976, 492 N.W.2d 331 (Fam.Ct.1985) [mother who misused alcohol during pregnancy created imminent danger to child]

Nat. Treasury Employees Union v. Von Raab, 489 U.S.602 (1989) [4th Amend., drug test]

Rendell-Baker v. Kohn, 457 U.S. 803 (1982) [4th Amend., drug test]

Schmerber v. Cal., 384 U.S. 757 (1966) [4th Amend., drug test]

Skinner v. Railway Labor Executives Ass., 489 U.S. 602 (1989) [4th Amend., drug test]

State v. Gray, 62 Ohio St.3d 514 (1992) [drug exposure prior to birth does not amount to "child endangerment" under Ohio law]