

The National CASA Association and the National Council of Juvenile and Family Court Judges are committed to providing judges and advocates the tools they need to be effective in dependency cases. With Adoption and Safe Families Act timelines driving the foster care process, judges, attorneys, child advocates and social workers must be alert to the potential for parental substance abuse as soon as a child enters care. --  
*Editor Judge J. Dean Lewis*

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*“One of the missing pieces in the popular dependency drug treatment courts has been the failure to address the needs of the children of substance abusing parents. We have found that by bringing CASA volunteers into the drug court process, the children have a much stronger voice and that their needs can be identified and addressed more readily. All dependency drug courts should consider CASA as a key member of the drug court team.”*

—Superior Court Judge Len Edwards, San Jose, CA

*“The Family Treatment Court is very pleased to have the assistance of CASA volunteers in helping to address many issues affecting children and families involved in child welfare cases. The collaborative effort aimed at strengthening children and families by giving them the opportunity, support and tools to live happy, healthy and productive lives is one we all embrace as being important to securing our future and the future of these children. It is also an endeavor that helps to renew our belief in the power of mankind to impact the lives of those less fortunate in a positive and productive way.”*

—Judge Anita Josey-Herring, Family Treatment Court, District of Columbia

## The Impact of Parental Substance Abuse in Dependency Cases



*J. Dean Lewis, Judge (retired), Member of the National CASA Association Board and Past President of NCJFCJ*

### Summary

With Adoption and Safe Families Act timelines driving the foster care process, judges, attorneys, child advocates and social workers must be alert to the potential for parental substance abuse as soon as a child enters care. Courts must be able to promptly screen and assess parents and children, identify their needs and provide rehabilitative treatment services appropriate to meet the needs (“reasonable efforts”).

When asked what influences their court dockets most, juvenile and family court judges have long identified substance abuse as a major factor. Few courts have the resources to screen and assess every parent and child entering the dependency system as a routine part of the intake process. Unless the child comes into care as a result of the parents’ alcohol or drug use, such as during the raid of a methamphetamine lab or upon the birth of a “cocaine baby,” the initial intake will probably focus on the act of abuse or neglect itself rather than on the full range of treatment needs of the child and parents. With Adoption and Safe Families Act (ASFA) timelines driving the foster care process, judges, attorneys, child advocates and social workers must be alert to the potential for parental substance abuse as soon as a child enters care. Courts must be able to promptly screen and assess parents and children, identify their needs and provide rehabilitative treatment services appropriate to meet the needs (“reasonable efforts”). The ASFA timelines compel us to look at the initial case intake through a different set of lenses.

We open this issue of *The Judges’ Page* with an informal survey of Model Court judges conducted by the NCJFCJ Permanency Planning for Children Department. The survey asked about the parents’ “drug of choice,” how the stakeholders deal with the substance abuse issue, the impact of substance abuse on the court caseload and how addiction is affecting the children and families involved in court proceedings. The answers are enlightening.

In this issue we have chosen to focus on two drugs of choice. One is a substance that has been around a long time and has consequences for children that frequently go undiagnosed—alcohol. The other is a newer phenomenon creating its own set of problems within the courts and treatment communities—methamphetamine. You will find an article by Kathryn Kelly on Fetal Alcohol Spectrum Disorders (FASD) as well as an article by Diane V. Malbin linked from the NCJFCJ *Juvenile and Family Court Journal* entitled “Fetal Alcohol Spectrum Disorder (FASD) and the Role of Family Court Judges in Improving Outcomes for Children and Families.” “Making Meth: Endangering Kids” by Dr. Gregg Wright will introduce you to the methamphetamine problem facing dependency courts in many areas of the country.

Family Drug Treatment Courts (FDTc) have become an effective way to approach the substance abuse issue. Judge Charles M. McGee (Reno, Nevada), the first judge to take adult drug court concepts and apply them to dependency cases, gives readers an overview of the development FDTc in the article: “Shipping Oars and Going to Sails: The First 10 Years of Dependency Drug Courts.” Judge Douglas F. Johnson (Omaha, Nebraska) addresses ethical implications affecting the role of the judge in the FDTc. An article highlighting the work of the District of Columbia Family Treatment Court and the role of CASA volunteers in the program’s success provides an individual court’s experience. To be effective in dealing with substance abusing parents and their dependent children, the Miami-Dade County FDTc recognized the need to integrate holistic and therapeutic services for families, as you will see in an article linked from the NCJFCJ *Juvenile and Family Court Journal* entitled “Parenting in Dependency Drug Court.”

Judges want to know how to provide “reasonable efforts” and develop timely permanency plans in cases involving substance abusing parents. Dr. Kathleen M. West gives direction in her article: “Substance Abuse and Permanency Planning: Implementation of ASFA when Parental Substance Abuse is a Factor.” For additional information on this important issue, the American Prosecutors Research Institute provides ongoing case law analysis, and I recommend that you subscribe to their publication *Reasonable Efforts*. The following link will take you to an outstanding article which addresses the complex reasonable efforts issue: [www.ndaa.org/publications/newsletters/reasonable\\_efforts\\_volume\\_1\\_number\\_6\\_2004.html](http://www.ndaa.org/publications/newsletters/reasonable_efforts_volume_1_number_6_2004.html)

The NCJFCJ Permanency Planning for Children Department reports on the National Center on Substance Abuse and Child Welfare (NCSACW), created in 2001 to assist agencies working to improve systems and practice for families with substance use disorders who are involved in the child welfare and family judicial systems. To learn more about the Center, link to its website at [ncsacw.samhsa.gov](http://ncsacw.samhsa.gov).

State legislatures have been aware of the impact of drugs on dependency dockets and have responded by enacting legislation. The National Clearinghouse on Child Abuse and Neglect Information published an article entitled “Parental Drug Use as Child Abuse.” The article notes that states have enacted laws within their child protection statutes that address two main areas of concern: first, the harm caused to the fetus by a pregnant woman who abuses substances; and second, the harm to a child of any age caused by substance abuse or illegal drug activity in the home. I recommend that you read the full article and use the state-specific search to determine the approach your legislature has taken. Link to this article at: [nccanch.acf.hhs.gov/general/legal/statutes/drugexposed.cfm](http://nccanch.acf.hhs.gov/general/legal/statutes/drugexposed.cfm)

The National Conference of State Legislatures Children’s Policy Initiative has published an in-depth article, “Substance-Exposed Newborns: New Federal Law Raises Some Old Issues,” by Steve Christian. The article is located at the following link: [www.ncsl.org/print/cyf/newborns.pdf](http://www.ncsl.org/print/cyf/newborns.pdf). Mr. Christian reports that the Keeping Children and Families Safe Act of 2003 added a requirement that states have policies and procedures requiring health care providers to notify CPS of “infants born and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure” in order for the state to qualify for child welfare funding under the Child Abuse Prevention and Treatment Act (CAPTA). A state-specific inventory of statutes implementing this new federal requirement accompanies the article.

As courts, child welfare agencies, communities, attorneys and child advocates struggle to respond to substance abuse issues appropriately, it is our hope that this issue of *The Judges’ Page* will provide you with information which will serve to inform your community’s collaborative process.

On a final note, CASA and the National Council of Juvenile and Family Court Judges lost a dear friend recently—Judge James M. Farris. We dedicate this issue to the memory of a great man who was a true child advocate.

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## Model Court Experiences Regarding “Drugs of Choice”

*Permanency Planning for Children Department  
National Council of Juvenile and Family Court Judges (NCJFCJ)*

### Summary

In an effort to learn more about the “drugs of choice” seen by judges in their caseloads and how drug use impacts the child welfare system, NCJFCJ’s Permanency Planning for Children Department informally surveyed 10 Model Court judges. Read about one judge’s experience with methamphetamine: “Law enforcement go into these homemade labs in garages, trailers, cars, bathrooms, etc., in full hazmat gear, only to find toddlers scooting around in diapers....”

Dependency court judges nationwide deal with parental substance abuse issues and their effects on child abuse and neglect cases on a daily basis. In an effort to learn more about the “drugs of choice” seen by judges in their caseloads and how drug use impacts the child welfare system, the NCJFCJ’s Permanency Planning for Children Department (PPCD) informally surveyed Model Court judges and Model Court representatives from across the country to gain their perspective and share their experiences.

Following are the four questions asked and responses from participants.

### 1. What is the drug of choice that you are seeing most predominately in your caseload?

“Increase in both crack and meth cases.”

*Judge Hector Campoy, Division 17, Arizona Superior Court in Pima County, Tucson, Arizona (Tucson Model Court)*

“Methamphetamine.”

*Judge Constance Cohen, Associate Juvenile Court Judge, Fifth Judicial District, Polk County Courthouse, Des Moines, Iowa (Des Moines Model Court Lead Judge)*

“The drug of choice I see most predominantly on my dependency docket and in our dependency drug court is crack cocaine. Many of these folks also use marijuana and alcohol. Marijuana and alcohol without cocaine are also prevalent. I didn’t see much meth early on, although some say that it is the major drug of choice in Eastern Kentucky, but it is beginning to show up here too. Prescription ‘pain killers’ are also big. For whatever reason, I see very little heroin.”

*Judge Eleanore Garber, Jefferson Family Drug Court, Division Five, Louisville, Kentucky (Louisville Model Court)*

“Alcohol is our number one substance followed by crack cocaine.”

*Karen Carroll, Project Director, Erie County Family Court, Buffalo, New York (Buffalo Model Court)*

“The drug of choice in the Portland area is methamphetamine.”

*Martha Strawn Morris, Family Court Coordinator, Multnomah County Family Court, Portland, Oregon (Portland Model Court)*

“Cocaine, marijuana, and alcohol. Methamphetamine use is rising.”

*Annabelle Casas-Mendoza, Drug and Model Court Coordinator, 65<sup>th</sup> Family District Court, El Paso, Texas (El Paso Model Court)*

### 2. How are the court and other stakeholders dealing with the issue?

“FTC monitors their compliance with treatment and tries to get them to establish a sober lifestyle with outside support systems.”

*Karen Carroll, Project Director, Erie County Family Court, Buffalo, New York (Buffalo Model Court)*

“We have a court-based alcohol and drug treatment service that screens parents and helps them enter treatment quickly—and then provides specialized case-management services once they are there. The program is called the Family Involvement Team (FIT) and is available to all parents who volunteer within the first two weeks of their case being filed. For parents who do not avail themselves of FIT services, they can get help from one of three certified alcohol and drug counselors (CADCs) who work exclusively in the child welfare field. The CADCs work closely with three dedicated, non-case-carrying social workers who provide assistance on cases where parents are impacted by addiction. Finally, we have 10 outreach workers who help people at the front end of their cases with transportation, making appointments, etc. The outreach workers are folks who are in recovery themselves, and they ‘talk recovery’ with parents as they drive them around. We are lucky to have a good system of resources to help parents with substance abuse issues. Not all parents choose to use the help that is offered, but for those that do, we have tried to make sure there is someone with expertise they can work with.”

*Martha Strawn Morris, Family Court Coordinator, Multnomah County Family Court, Portland, Oregon (Portland Model Court)*

“We have a dependency drug court which has 35 active participants, thanks to a SAMHSA grant focusing on mothers over 18 who have at least one child under twelve removed. Our program is voluntary, and we target recent removals in order to provide intensive services up front and maximize compliance with ASFA. We have started a six-week-long ‘Caring Persons Program’ focusing on education for families and friends to help them better understand the recovery process, and multiple-family group therapy to learn better communication. It is mandatory for participants’ family or friends. We have recently started a gender-specific father’s family drug court and a children’s program for children of our participants aged 5-12.”

*Judge Eleanore Garber, Jefferson Family Drug Court, Division Five, Louisville, Kentucky (Louisville Model Court)*

“We developed a Family Drug Court (FDC) that is made available to these parents. All parents are eligible for participation, and all parents must attend one session of FDC to observe the process. FDC employs several court staff who encourage parents to join. Specialized treatment is offered to parents through FDC. Additionally, the child protection agency has developed a program called Arizona Families First that deals with early outreach and engagement of families in treatment who are involved in the child welfare system. The court and the agency are working better with behavioral health to provide consistency for these families.”

*Judge Hector Campoy, Division 17, Arizona Superior Court in Pima County, Tucson, Arizona (Tucson Model Court)*

“There have been numerous education opportunities to help us understand the unique nature of this highly addictive drug (methamphetamine) and how it differs from other chemical dependencies. There is a need for a much longer term of court supervision because the relapse rate is so high and the recovery rate is so low.”

*Judge Constance Cohen, Associate Juvenile Court Judge, Fifth Judicial District, Polk County Courthouse, Des Moines, Iowa (Des Moines Model Court Lead Judge)*

“A number of years ago our cabinet established protective services teams trained to deal with families involved in crack cocaine because of the long-term impact on children. We have strengthened linkages with drug and alcohol abuse programs which expedite referrals from court and have liaisons available by pager who can be reached to appear in court as needed. We now have a family drug court. We have also expanded screenings of parents to identify individuals who may have drug and alcohol problems, even though this may not be the presenting issue when the families first come to court.”

*Judge Patricia Walker FitzGerald, Jefferson Family Court, Division Three, Louisville, Kentucky (Louisville Model Court Lead Judge)*

“Promoting the family drug court by educating the community and collaborating with newly developed drug courts such as juvenile drug court. We are also working closely with the governor’s office in developing standardized practices for drug courts in Texas as well as the Texas Association of Drug Court Professionals.”

*Annabelle Casas-Mendoza, Drug and Model Court Coordinator, 65<sup>th</sup> Family District Court, El Paso, Texas*

### **3. What is the impact on your caseload?**

“The caseload at this time has doubled for DFPS caseworkers because of the budget crunch throughout the state. Despite the budget crunch, we collaborated with the agency to designate two DFPS workers to work solely on drug court cases. The number of family drug court participants has increased in the past three months.”

*Annabelle Casas-Mendoza, Drug and Model Court Coordinator, 65<sup>th</sup> Family District Court, El Paso, Texas (El Paso Model Court)*

“It has been estimated that as many as 80% of the families in dependency court have drug and alcohol problems. As drug abuse increases and the use of highly addictive drugs such as crack cocaine increases, the need for intensive services has increased.”

*Judge Patricia Walker FitzGerald, Jefferson Family Court, Division Three, Louisville, Kentucky (Louisville Model Court Lead Judge)*

“We have seen a rather dramatic increase in cases brought to our court in the past five years, though it is difficult to know whether the increase is attributed to increased enforcement/vigilance by law enforcement and the child protection agency or an actual increase in the amount of neglect and abuse being perpetrated in our community.”

*Judge Hector Campoy, Division 17, Arizona Superior Court in Pima County, Tucson, Arizona (Tucson Model Court)*

“There is a huge impact on our caseload. I would surmise that between 80 and 90 percent of our TPRs are meth cases. Meth is also a common precursor of domestic violence. How are we handling it? One case at a time, hoping that the legislature catches up with it at some point before half the adult population is locked up instead of treated.”

*Judge Constance Cohen, Associate Juvenile Court Judge, Fifth Judicial District, Polk County Courthouse, Des Moines, Iowa (Des Moines Model Court Lead Judge)*

“Statistics nationwide indicate that substance abuse is a major contributing fact to neglect and abuse—my anecdotal observations support that. We are working through our CPS on better training for intake workers, who report educational neglect for young elementary students and domestic violence, to investigate whether substance abuse is a major or interlinked factor.”

*Judge Eleanore Garber, Jefferson Family Drug Court, Division Five, Louisville, Kentucky (Louisville Model Court)*

“Handling FTC with a full neglect/abuse caseload is sometimes difficult as FTC cases are very time consuming.”

*Karen Carroll, Project Director, Erie Count Family Court, Buffalo, New York (Buffalo Model Court)*

“Our caseloads have not increased significantly. What does seem clear, and what we hear from service providers in the community, is that the severity and complexity of issues dependency parents face are on the rise. Our mental health system in general has suffered from budget cuts, and the community of alcohol and drug treatment providers is no exception. We are seeing a lot of families with very difficult addiction issues, combined and exacerbated by additional mental impairments, coupled with domestic violence, poverty, lack of education, employment and other problems. Our caseloads have not necessarily increased in number but do seem to have increased in difficulty.”

*Martha Strawn Morris, Family Court Coordinator, Multnomah County Family Court, Portland, Oregon (Portland Model Court)*

#### 4. How is this addiction affecting the children and families before you?

“The addictions affect children and families negatively or they never would have been brought to the court’s attention. Depending on the strength of the addiction, children and their families may struggle their entire lives to get it under control.”

*Karen Carroll, Project Director, Erie County Family Court, Buffalo, New York (Buffalo Model Court)*

“The families are not able to function on their own. Many parents do not have a support system and do not know how to access resources in the community. Parents were also victims of child abuse and neglect when young. Children end up in foster care as a result of substance abuse by their parents. About 75-80% of the cases that enter the child welfare system have drug-related issues.”

*Annabelle Casas-Mendoza, Drug and Model Court Coordinator, 65<sup>th</sup> Family District Court, El Paso, Texas (El Paso Model Court)*

“Many more children, it seems, are being born drug exposed. Many newborns remain in neo-natal intensive care, and many more, it seems, are being born prematurely. These children in turn become special needs children who require more specialized care which marginal parents, even if sober, are challenged to meet. Our parents are struggling to keep pace with the statutory requirements and deadlines imposed by state and federal laws. Comprehensive and effective programs dealing with housing, employment and issues relating to parental history of victimization are lacking. Our strategies dealing with relapses are not well developed. Parents who have long histories of addiction to meth and crack are severely compromised in terms of cognitive impairment.”

*Judge Hector Campoy, Division 17, Arizona Superior Court in Pima County, Tucson, Arizona (Tucson Model Court)*

“Meth has had a devastating impact on Iowa children and families. Children exposed to meth in utero often suffer birth defects and lifelong impairments. Because the first exposure can alter brain chemistry, specialists must evaluate the children and monitor them carefully. They often need special therapies to attempt to resolve the exposure. Many have brain damage, stroke activity, muscular rigidity, respiratory problems, ADHD, etc. Older children often suffer from attachment disorders and physical and sexual abuse as a result of the lack of care and supervision. Children often come to the attention of the court as the result of a drug raid during which children are present. Sometimes children have been burned in explosions or by exposure to caustic chemicals. Law enforcement go into these homemade labs in garages, trailers, cars, bathrooms, etc., in full hazmat gear, only to find toddlers scooting around in diapers. Caregivers will often use for several days, without sleep, and then ‘crash’ for up to three days, leaving children with no supervision. Because of its highly addictive nature, treatment must be long-term, and with scant beds in facilities where moms and children can reside together in a highly structured, safe setting, ASFA deadlines collide with treatment needs. Relapse rates are high. Parents who have been clean for five years, with their cases closing with a presumed successful reunification, have come back into the system with new babies testing positive for meth, drug raids, etc. It is very discouraging overall. Parents who are prosecuted for meth-related crimes, especially in federal court, are often incarcerated for much, if not all, of their children’s minority.”

*Judge Constance Cohen, Associate Juvenile Court Judge, Fifth Judicial District, Polk County Courthouse, Des Moines, Iowa (Des Moines Model Court Lead Judge)*

“Parents with addictions are likely to have their children involved in long-term removals from the home more than other families, and they are less likely to achieve reunification. We use more concurrent planning homes for parents with addictions. Their children often have behavioral and other disabilities due both to environmental issues and use during pregnancy by the mothers, increasing the need for services for the children and for specially trained foster and adoptive parents.”

*Judge Patricia Walker FitzGerald, Jefferson Family Court, Division Three, Louisville, Kentucky (Louisville Model Court Lead Judge)*



“It is a tough illness to overcome, and our children and other family members get discouraged by repeated relapses. Drug court is proving to be a useful tool not only for our successes but our ability to monitor real motivation in a collaborative way. For discharges and drop-outs, CPS workers are moving quickly to change the goal to adoption.”

*Judge Eleanore Garber, Jefferson Family Drug Court, Division Five, Louisville, Kentucky (Louisville Model Court)*

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# The Importance of Early Identification of Fetal Alcohol Spectrum Disorder (FASD)

*Kathryn Kelly*

## Summary

The court, by requiring that inquiries be made early on regarding alcohol exposure in *utero* and ordering diagnostic evaluations when appropriate, can radically alter the population of juvenile court, the adult criminal justice system and corrections as well as influencing treatment programs for sexual deviancy, mental illness and drug abuse.

A thin, wiry, jittery baby comes into your court in the arms of a foster mother. It is the hearing to determine whether or not the allegations against the parents are true, whether or not the court should take jurisdiction of the minor and if so, what the disposition should be. At the initial hearing, it was reported to the court that the mother and baby had been tested and found to have cocaine in their systems at the time of delivery. The foster mother tells you the baby takes a very long time to finish a bottle, is wakeful, startles easily, does not soothe and will arch away from you as though touch is unpleasant if you try cuddling.

Although you might attribute these behaviors to cocaine exposure in *utero*, it is also possible that the behaviors are the result of the baby's exposure in *utero* to alcohol. It is not, in many jurisdictions, routine for infants to actually appear in court, but there should always be a social worker's report to the court providing information on the health and behavior of the dependent child. The court should request of social workers that they ask mothers specifically about alcohol use during pregnancy; how much, what and when they drank. If these aren't routine questions on the social worker's intake form, consider requesting this question be added to the form and directing social workers to provide you this information in every case. Initially the focus should be on the mother's history, not the physical tests of the baby. Because of the transient nature of alcohol in the body, toxicity tests often do not identify alcohol, as they do other drugs, in either mother or baby. Many mothers who use cocaine, heroin, methamphetamines and other substances also use alcohol. Alcohol is a known teratogen, causing birth defects which last a lifetime, while the effects of the other drugs often lessen over the years.

Fetal Alcohol Spectrum Disorder (FASD) is the recently devised consensus term for what we used to refer to as Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE). FASD describes the brain damage (and in 30% of the cases signature physical features such as small head, small eyes, smooth space between the nose and upper lip and thin upper lip) that can occur when a mother drinks alcohol during pregnancy. This damage can take place in the very early stages of the pregnancy, before the mother even knows that she is pregnant, and can result from as little as one evening of 5 or more drinks. It is simply not known how little alcohol exposure can cause this harm since there are many variables, the most significant of which is the mother's metabolism. Every mother has her own rate of metabolizing alcohol; some will pass the alcohol swiftly out of their systems, while in others, the alcohol effects will linger longer. Since the alcohol the mother drinks passes directly to the fetus, via the placenta, within minutes the baby has the same blood alcohol level as the mother. The potential for harm exists every time a pregnant woman drinks. Since 1981, the US Surgeon General has recommended that if a woman is planning a pregnancy or is pregnant she should use no alcohol at all.

Brain damage is the most significant disability that can occur; indeed, alcohol exposure is the major cause of preventable mental retardation. Brain damage from alcohol exposure affects as many as 1 in 100 live births, more than Down's syndrome, Spina Bifida and Childhood Autism. Dr. Ann Streissguth from the University of Washington has been researching this disability since 1973. She has found that appropriate services to address the myriad problems that these babies, children and adults experience can make a very real difference in how effective these individuals are in coping with their environment and its challenges. With diagnosis can come intervention therapies, developmental and parenting classes for caretakers and informational material on effective child-raising. Individuals with this disability can require speech therapy as well as specialized learning techniques and strategies. An understanding of the disability can bring about more realistic expectations from families, adoptive and foster parents, teachers, social workers and others who may deal with these individuals as they grow to adulthood.

With a goal of very early detection of this disability, Dr. Streissguth and her colleagues have, for the past two years, researched the accuracy of ultrasound images obtained through the fontanel to detect this brain damage in newborns resulting from alcohol exposure. The team is very encouraged by their results. Ultrasound is a ubiquitous technology, available in every hospital, non-invasive and inexpensive. Diagnosis in the first three months may well be the future norm, changing radically the prospects for this disability.

If you, as a dependency court judge, ask the relevant questions of the caretakers and follow up where warranted by asking the social worker, CASA volunteer or attorney in the matter to investigate further, you can then order a diagnostic evaluation of the baby or child. The appropriate experts are a dysmorphologist, a specialist in diagnosing birth defects, or a pediatrician with training in identifying FASD (our website has a state-by-state listing of these diagnosticians). You can then put in place interventions while the baby's brain is still growing. A referral can be made to your Regional Child Development Center for services shortly after birth in some locations, somewhat later in infancy in others.

If an older child comes before you because of an inability to concentrate, focus on learning or attend calmly in the classroom—and he or she has been diagnosed with Attention Deficit Disorder (ADD) or Attention Deficit Hyperactive Disorder (ADHD)—ask the social worker, CASA volunteer or attorney what is known of the child's exposure to alcohol in *utero*. It is clearly important to understand the etiology of the child's behaviors since these children learn differently and as a consequence need educational strategies tailored to the disability. Even medication can be problematic since children with FASD often react adversely to commonly prescribed drugs for the treatment of ADD and ADHD. What is effective for the child without brain damage can be wholly ineffective for the child affected by FASD.

And what about the many parents who appear in court and seem to have their own cognitive problems? The court needs to be on the lookout for mothers (and fathers) with suspected FASD, whose lives could be stabilized by a diagnostic evaluation and appropriate services. A foster family, well versed in this disability, could be an appropriate setting for a parent and child or children together, offering much-needed structure for all.

What is the result if these questions remain unasked, the etiology unquestioned, the diagnosis unattained? These individuals experience significant problems which often go unaddressed. Dr. Streissguth's research reveals that 60% of adolescents and adults with FASD have been in trouble with the law. Approximately 50% of those disabled by FASD have been confined in jail, prison, a drug treatment program or a mental hospital. More than 60% have had school disruption. Of this population, around 70% have been sexually or physically abused, approximately 50% have engaged in inappropriate sexual behavior and some 50% or more have had problems with drug and alcohol abuse.

Who with FASD fares better? Those with at least a four-year period in a stable, nurturing home; those who have been diagnosed before the age of 6; and those who have never experienced violence directed against them. But even if the diagnosis is at a later age, it can still be helpful to a person with FASD in understanding their own behavior and to families and professionals who are involved in their lives. Clearly, this is a disability which if not accommodated with interventions, therapies, supports and remediations can lead to escalating problems for the individual, the families and society. Dependency court judges are in essence first responders. Decisions made here can have a lifetime impact on both the child and the family. The pivotal position the court occupies is of huge significance, making possible an entirely different outcome for a large population. The court, by requiring that inquiries be made early on regarding alcohol exposure in *utero* and ordering diagnostic evaluations when appropriate, can radically alter the population of juvenile court, the adult criminal justice system and corrections as well as influencing treatment programs for sexual deviancy, mental illness and drug abuse. Court orders for useful interventions and accommodations for this disability are well justified by the potential for improved outcomes.

The court's charge is to protect these infants and children from the effects of their lifelong disability—particularly because these young ones were not protected by society nor could they protect themselves from the initial harm. As the Florida Supreme Court observed in its 1994 decision in *Dillbeck v. State*, “We can envision few things more certainly beyond one’s control than the drinking habits of a parent prior to one’s birth.”

### Central Nervous System Structural and Functional Effects of In *Utero* Alcohol Exposure by Age

Age	Effects
Newborn:	Microencephaly (small head), jitteriness, opisthotonus (hyperextension of body with arched back), seizures, tremors, weak suck, unpredictable and disrupted sleep/wake cycles, hypotonia (low muscle tone), hypertonia (tense muscle tone), decreased vigorous bodily activity, hyperacusis (low hearing threshold), failure to thrive (given adequate opportunity), poor habituation (difficulty tuning out redundant stimuli), EEG abnormalities
Infancy:	Delayed development in one or more area, head banging and/or body rocking, poor fine motor or gross motor control, neurological dysfunction (including cerebral palsy)
Preschool:	Hyperactivity, poor eye-hand coordination, poor balance, central auditory dysfunction, delayed or perseverative (repetitive) language, mental retardation
Early school age:	Attentional impairments, learning disabilities, arithmetic disabilities, specific cognitive disabilities, deficits in higher order receptive and expressive language, poor impulse control
Later school age and adolescence:	Memory impairments, difficulties with judgment, difficulties with abstract reasoning, poor adaptive functioning, inability to read to grade level, playing with much younger children, impulsivity, poor judgment as to friends and activities, repeating the same mistakes over and over, not learning from experience

Adapted from Streissguth, A. *Fetal Alcohol Syndrome: A Guide for Families and Communities*. 1997 Paul H. Brookes, Baltimore, MD.

*Please see the “Online Resources” section for additional information on the subject of FASD recommended by Kathryn Kelly.*  
*Editor’s Note: Kathryn Kelly is the project director of the FAS/FAE Legal Issues Resource Center ([depts.washington.edu/fadu/legalissues/](https://depts.washington.edu/fadu/legalissues/)), a joint project of the University of Washington School of Medicine and School of Law. The Resource Center consults with judges, attorneys, probation officers, corrections and law enforcement as well as maintaining a website which includes summaries of nearly 150 state and federal cases in which FASD was a factor.*

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## **Juvenile and Family Court Journal Highlights Substance Abuse Issues**

### **Summary**

NCJFCJ's *Journal* provides articles to assist judges in understanding the unique challenges of dealing with substance abusing parents in dependency cases.

The National Council of Juvenile and Family Court Judges (NCJFCJ) publishes the quarterly *Juvenile and Family Court Journal*. Authors from a variety of disciplines share research results, innovative program descriptions and court improvement information on current juvenile justice and family law topics to inform and assist practitioners across the nation. The first volume was published in September 1949 on the 50th anniversary of the creation of the first juvenile court in the United States.

Two articles published in the Summer 2004 issue of *Juvenile and Family Court Journal* have been chosen for this issue of *The Judges' Page*:

- "Fetal Alcohol Spectrum Disorder (FASD) and the Role of Family Court Judges in Improving Outcomes for Children and Families" [www.ncjfcj.org/publications/Spr\\_04\\_5%20Malbin.pdf](http://www.ncjfcj.org/publications/Spr_04_5%20Malbin.pdf)

Fetal Alcohol Spectrum Disorder is an invisible physical disability that is under-diagnosed and over-represented in juvenile justice. Most people with FASD accumulate mental health diagnoses, e.g. Attention Deficit Disorder and Oppositional Defiant Disorder. Interventions based on these diagnoses typically fail since they do not recognize brain damage, which then leads to chronic treatment failures and prolonged involvement with the courts.

The purpose of this article is to increase recognition of the disorder and efficacy of services for people with FASD in the legal system. Sections include: 1) Overview of FASD diagnostic criteria and current terminology; 2) Exploration of FASD as a physical disability with behavioral symptoms; 3) Case example illustrating common patterns of behaviors in children and adults with FASD without appropriate treatment; and 4) Recommendations for family court judges.

- "Parenting in Dependency Drug Court" [www.ncjfcj.org/publications/Sum\\_04\\_1\\_Dice\\_et\\_al.pdf](http://www.ncjfcj.org/publications/Sum_04_1_Dice_et_al.pdf)

The nation's first modern drug court opened in Miami-Dade County, Florida, in 1989 and became a pioneer in the national drug court movement. Miami's Dependency Drug Court (DDC) focuses on treating the entire family affected by substance abuse. It offers integrated services with community agencies ensuring that children are provided proper care and safe, nurturing homes while parents receive adequate treatment services, including parenting programs.

This article discusses how the DDC developed its parenting program through collaboration with community partners and by offering a structured therapeutic approach to improve caregivers' parenting skills. Sections highlight the background of the DDC; the role of the dependency drug court judge; finding the right community partners; developing a parenting curriculum; and evaluating the parenting program's effectiveness.

*As you examine the challenges facing your jurisdiction, NCJFCJ can provide resources such as speakers and faculty, publications, curricula and other technical assistance through our various departments. For further assistance, please contact Joey Binard, NCJFCJ manager of technical assistance, at (775) 784-1665; Ruby White, manager of technical assistance, Family Violence Department Resource Center at (800) 527-3223; or Kim Taitano, manager, Training and Technical Assistance Resource Division of the Permanency Planning for Children Department, at (775) 327-5303.*

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## **Making Meth: Endangering Kids**

*Gregg Wright, MD, Med*

### **Summary**

Methamphetamine has been called the “walk-away” drug because it can induce a person to walk away from children, marriage, family, job, friends, food, sleep and everything else that is normally important. Methamphetamine is a diabolic drug that endangers children by affecting parents, degrading children’s environments and directly harming children. Keeping children safe from the effects of methamphetamine requires a coordinated response from police, prosecutors, judges, physicians, social workers, CASA volunteers, foster parents, emergency medical personnel, pharmacists, retailers and substance abuse treatment professionals.

### **A Diabolic Drug**

Methamphetamine is a diabolic drug—cunning and cruel. It is cunning because it is easily absorbed into the body by many routes and slowly metabolized to give very long-lasting effects. It directly triggers deep centers in the brain that reinforce us for things that are important to the survival of our species, and it tempts the user to illegal manufacture. It is cruel because it induces accommodation in the brain that rapidly leads to tolerance and then addiction, quickly becoming more important to the addict than everything necessary for survival and the enjoyment of life including children, caring relationships, food, water, sleep and work. Its illegal manufacture involves chemicals that are particularly dangerous to everyone in the immediate vicinity and to the community.

### **Effects on Parents**

Methamphetamine may be smoked, injected, snorted or eaten. It quickly enters the bloodstream and the brain, where it directly releases dopamine in a deep brain structure related to both pleasure and reinforcement. Rats given the opportunity to electrically stimulate this brain center with a lever will ignore both food and water, starving to death before they will stop pressing the lever. Methamphetamine has been called the “walk-away” drug because it can induce a person to walk away from children, marriage, family, job, friends, food, sleep and everything else that is normally important.

Parents who are addicted to methamphetamine get a message from the drug, through their deep brain center, which says, “This is important to your very survival.” Under this influence, the needs of the child are forgotten. The drug induces paranoia and obsessive-compulsive behavior, and ultimately brain damage, all dangerous to the child.

### **Environmental Effects**

The clandestine manufacture of methamphetamine has rapidly increased in urban and rural areas across the country. All methods start with purchased or stolen over-the-counter medication containing ephedrine or pseudoephedrine. All methods involve highly flammable organic solvents as well as caustic acids and bases. Approximately 20% of labs are discovered because they blow up—the ultimate child endangerment. Lye stored in a pop bottle or ether stored in a Mason jar in the refrigerator pose huge dangers to children. One method uses anhydrous ammonia, which is highly caustic and difficult to handle and store. The other common method uses iodine and phosphorus and can generate nearly odorless toxic gasses. Many pounds of toxic waste are dumped on the community from the manufacture of one pound of methamphetamine.

### **Effects on Children**

Methamphetamine may be given to children intentionally or it may be accidentally ingested in doses that can cause hypertensive crisis, hyperthermia or even death. When ingestion is even remotely suspected, a urine test should be done at the earliest possible time to document exposure to the drug. However, methamphetamine, sold by prescription as Desoxyn®, is approved by the FDA as a Schedule II drug for the treatment of hyperactivity in children in 5 mg. doses. Although rarely prescribed or recommended for this purpose, the drug’s existence influences the interpretation of the trace environmental exposures that children are certain to experience when living in environments where methamphetamine is used or made. Children are endangered by parenting they receive and by the manufacture discussed above, even if not a molecule of methamphetamine is discovered on or in their body.

### **Keeping Children Safe**

Responding to these risks requires awareness and coordination. Before a raid of a lab, police and social service workers should compare notes. At the scene, information about risks should be documented from the point of view of a small child. A child specialist should take custody of the child. Obvious contamination of a child's body or clothes must be dealt with by decontamination at the scene. Absent obvious contamination, the child should still be considered contaminated, and *containment* should be the priority with barrier techniques used to transport the child to a shower. A physician should examine the child within four hours, not just for chemical exposure but also for signs of abuse and neglect. Foster parents need information about mental health and physical health considerations. The child needs a source of continuous medical care, and both parent and child need addiction treatment resources. Finally, retailers and police must work together to limit the availability of lab chemicals.

### **Conclusion**

The coordination needed to respond to methamphetamine endangerment of children cannot happen in isolation. A wide range of involved professionals must plan together in every community and at the state and national level in order to meet this enormous challenge.

#### *Editor's Note:*

*Gregg F. Wright, MD, MEd, is a pediatrician with specialty training in school health and child development. His training took him to Case Western University in Cleveland (MD), the University of Rochester, New York (Pediatrics) and the University of Texas Medical Branch in Galveston (Fellowship). Wright served as the director of the Nebraska State Health Department for eight years and is currently a research associate professor at the Center on Children, Families, and the Law at the University of Nebraska, Lincoln, where he is involved with the training of Nebraska's protection and safety workers. He is the chair of Nebraska's Drug Endangered Children Subcommittee and a member of the working group that has developed the CHEM-L protocol for dealing with Nebraska children exposed to methamphetamine labs.*

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## Shipping Oars and Going to Sails: The First Ten Years of Dependency Drug Courts

*Charles M. McGee, Judge and Caroline S. Cooper*

### Summary

The development of family drug treatment courts has been in large part generated by the considerable pressure for reform in the handling of dependency cases as a result of the enactment and enforcement of the Adoption and Safe Families Act of 1997.

In the mid-nineties, communities across the country were facing a crisis caused by the growing number of children placed in foster care as a result of their parents' drug and/or alcohol addiction. While courts and treatment professionals struggled to get parents clean and sober, the difficulties of delivering and coordinating the panoply of treatment and other necessary rehabilitative services, coupled with the lengthy period a parent generally needs to conquer an addiction, resulted in children often languishing for years in multiple foster placements and in institutions.

During this period, sparked by the success of an inaugural program in Dade County, Florida, adult drug courts began to cross the country like wildfire. Acting independently, two courts, one in Reno, Nevada and one in Pensacola, Florida, conducted an experiment to see whether traditional adult drug court concepts could be effectively adapted to dependency courts—those which supervised the placement of children whose parents had been charged with abuse and neglect.

Both of these programs, and many since, have heavily relied upon Court Appointed Special Advocate (CASA) volunteers to perform daily or weekly monitoring of children and their families. Many CASA volunteers go above and beyond the call of duty by linking recovering parents with community resources that provide transportation, housing, jobs and health care for the children. While the development of family drug treatment courts has not kept pace with the truly phenomenal growth of adult drug courts, a lot has happened in the field since the mid-nineties. The purpose of the full version of this article and other links below is to bring interested readers up-to-date with what has transpired in the first 10 years of this specialty court.

### Additional resources:

- For an in-depth review of the development of family drug treatment courts (FDTCs) nationally over the past 10 years, link to the full article by Judge McGee and Caroline Cooper at [www.ncjfcj.org/publications/JMdrugcourtarticle.pdf](http://www.ncjfcj.org/publications/JMdrugcourtarticle.pdf).
- A study of the Pima County Family Drug Treatment Court is featured in the following article. Tentative findings: "that the family drug court group had higher engagement and completion rates of residential and outpatient treatment than was true of the other comparison groups." [www.ncjfcj.org/publications/Fall04\\_3Ashford.pdf](http://www.ncjfcj.org/publications/Fall04_3Ashford.pdf)
- For another helpful article on the progress of family drug treatment courts, link to "Courts That Heal" by Norah Lovato and Kelly Mack at the Child Welfare League of America website: [www.cwla.org/articles/cv0303courts.htm](http://www.cwla.org/articles/cv0303courts.htm)

*Editor's note: Caroline S. Cooper is director of the BJA Drug Court Clearinghouse as well as being research professor and associate director of the Justice Programs Office, School of Public Affairs, American University. She can be reached at 4400 Massachusetts Ave., N.W., Brandywine Suite 100; Washington, D.C. 20016-8159; Tel. 202/885-2875. Judge Charles M. McGee of the Second Judicial District Court can be reached at P.O. Box 30083, Reno, Nevada, 89520; Tel.: 775/328-3179.*

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## Judicial Ethics in Family Drug Treatment Courts

*Douglas F. Johnson, Judge, Separate Juvenile Court of Douglas County, Omaha, Nebraska*

### Summary

Judges are encouraged to participate in family drug treatment courts because of their effectiveness but receive limited direction on potential ethical implications. Judge Johnson raises questions and solutions for judges to consider.

As of this writing, my research yielded no judicial ethics advisory opinions or disciplinary cases regarding the judicial role in family drug treatment courts (FDTCs). Provided below are citations to literature that review in depth drug courts (primarily criminal) and other specialty problem-solving courts in relation to Judicial Canons prohibiting impropriety, bias, prejudice and ex parte communications. (See American Bar Association [ABA] Model Judicial Code of Conduct [Amended 2003]). While the articles are helpful in raising awareness about judicial ethical issues, they do not specifically cover FDTC. Since I am in the planning stages of starting an FDTC in my own court, I considered the articles and talked to a number of our mutual colleagues who either have established or are operating FDTCs or plan to in the near future. Viewpoints about ethics and the role of the judge in FDTCs were passionate and varied, as you might expect. We will look at a couple of the key issues and how some judges are resolving them.

It is common knowledge that a well founded and well run FDTC has positive outcomes for children and their substance-abusing parents. It is the best chance for a parent to get better sooner and for children to be reunified or freed for adoption promptly when parents do not comply with the rehabilitative services offered. In spite of the Conference of Chief Justices' Resolutions (Resolution 22—August 2000 and Resolution 21—January 2001) supporting problem-solving courts, such as drug court, there appears to be no ethical guidance for judges and the judicial role in FDTC other than the various Judicial Codes of Conduct as they exist across the country. Consequentially, judges should review their own version of Canon 3 and its mandate that a judge shall perform judicial duties without bias or prejudice and not engage in *ex parte* communications in relation to the FDTC.

The first issue for consideration: Does a judge who actively participates in the FDTC team have an ethical conflict of interest based on bias or prejudice when a sanction matter, say a dirty urine analysis (UA) result, is brought forward for her to hear and rule upon? Will the parent feel prejudged because the judge already knows the parent well and knows about the dirty UA from attending an earlier team meeting reviewing the parent's progress? Does the judge sense an ethical issue? Does the parent's defense attorney?

Some judges find no ethical issue because of the parent's voluntary agreement to enter FDTC and abide by its rules. The judge hears the sanction matter; therapeutic jurisprudence is applied. Other judges think there is an ethical issue due to either the appearance of or reality of bias and prejudice. The resolution in this scenario is to have another judge hear the sanction matter. This allows continued judicial team participation. At the same time, due process is served because the parent has evidence in the sanction proceeding heard by an objective and independent fact-finder.

Second example: A long-standing best practice of the National Council of Juvenile and Family Court Judges is "one judge—one family." Among other things, having one judge hear the case from start to finish provides for timely hearings, reduced continuances and better continuity of judicial decision-making to achieve the best interests of children and due process for parents. Should this principle apply if a termination of parental rights (TPR) action is filed against a parent who fails to succeed in FDTC? That is, is it ethical for a judge who participates on the FDTC team to hear the TPR? In doing so, would the judge have the appearance (actual or not) of impropriety, bias or prejudice having known the parent through countless team meetings and reviews of progress with the parent? How would the parent see it?

Some judges see no ethical issue for the same reasons as in the previous example. Other judges think there is an ethical issue and resolve it by not hearing the TPR. The same arguments of the prior example apply.

Finally, is it a violation of the Judicial Code of Conduct to talk on an *ex parte* basis to an FDTC coordinator outside a team meeting about a parent's progress?

Some judges think there is no ethical issue because the information will be discussed openly at the team meeting with the parent present anyway. Additionally, the parent volunteered to participate in FDTC and agreed to its rules. Most importantly, the role of the judge in FDTC is not the traditional detached finder of fact but an active problem-solving participant. In contrast, other judges only discuss the case at the team meeting to prevent any appearance or reality of inappropriate *ex parte* communication.

I also visited with a couple of judges who are seasoned FDTC team members. They recently have reconsidered their role in light of their experience with the above judicial ethics issues of bias, prejudice and *ex parte* communication. In order to avoid any ethical exposure, maximize limited judicial resources and hear all matters in a case without "handing off" to a colleague, they have opted not to continue to serve on the team. Now the team meets and then presents the case status to the judge to make findings and orders. The judges still consider themselves problem-solvers and actively encourage or sanction parents but do so from behind the bench.

The Omaha Model Court continues to work on implementing its pilot FDTC. I am not yet sure of my role and whether I will be a team member or not given the present Judicial Code of Conduct. I may ask for an ethics advisory opinion. If you have questions about your role in FDTC, you may want to ask for an opinion if your state provides them. We know FDTC works and that the role of the judge is critical to its success. The question remains: How do we do what works and comply with our ethical mandates?

#### **References:**

30 Fordham Urb. L.J. 955 (2003) *Special Series: Problem Solving Courts and Therapeutic Jurisprudence—Due Process and Problem Solving Courts*, E. Lane.

10 Wash. U. J.L. & Pol' 63 (2002) *Access to Justice: The Social Responsibility of Lawyers—Courting Disorder: Some Thoughts On Community Courts*, A.C. Thompson.

*Ethical Considerations for Judges and Attorneys in Drug Court*, K. Freeman-Wilson, R. Tuttle, S. Weinstein, (National Drug Court Institute 2001).

Greg Berman, "What Is A Traditional Judge Anyway?" 84 *Judicature* 78 (2000).

76 Wash. U. L.Q. 1205 (1998) *Rehab. Punishment & the Drug Treatment Court Movement*, R.C. Boldt.

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## District of Columbia Family Treatment Court Partners With CASA Program

*Anita Josey-Herring, Judge, Family Treatment Court, District of Columbia and Jo-Ella Brooks, Coordinator, Family Treatment Court, District of Columbia*

### **Summary**

Recognizing that transition from the structure and security of inpatient substance abuse treatment is a turning point in the lives of program participants and their children, the District of Columbia Family Treatment Court appoints CASA volunteers to support the children and their mothers as they move from residential treatment into aftercare.

The District of Columbia Family Treatment Court celebrated its one-year anniversary in May 2004. The mission of the Family Treatment Court is to promote safe and permanent homes for neglected and abused children by working collaboratively with stakeholders to develop readily accessible services. These services are based on a continuum of care that is culturally competent, family-focused and strength-based.

The Family Treatment Court exclusively serves mothers with substance abuse problems that result in neglect or abuse of their children. The program transitioned from the pilot phase and became fully operational as a permanent court calendar in May 2004. There are many District child-serving agencies that provide supportive services to the Family Treatment Court. The collaboration that exists between the court and its partners is essential to the program's ability to accomplish its mission. In addition to the governmental stakeholders, CASA for Children of the District of Columbia has partnered with the Family Treatment Court to support participants and their children in accomplishing reunification.

During the initial phase of the Family Treatment Court, mothers involved in the program participate in six months of residential treatment. This is followed by six months of aftercare in a community setting. Residential treatment is offered by a single provider in a setting where mothers are allowed to have up to four children, 10 years of age and younger, with them during treatment. Services provided to families include mental and physical health examinations, counseling and therapy, assistance with securing social services, educational opportunities, drug education, parenting classes, observational parenting feedback and housing upon completion of the residential treatment phase. The program is designed to front-load services to enhance the families' ability to make a seamless transition into the community during aftercare.

Recognizing that transition from the structure and security of inpatient treatment is a turning point in the lives of program participants and their children, the Family Treatment Court appoints CASA volunteers to support the children and their mothers as they move from residential treatment into aftercare. Both the CASA program and the court felt that CASA volunteers would be most needed at this critical point as mothers assume primary responsibility for their children and face the challenge of remaining drug-free while in the community. All the while, CASA volunteers are looking out for the safety and best interest of the children.

Because of their unique role, CASA volunteers provide the Family Treatment Court judge with an unbiased perspective of the families' level of functioning and their continuing service needs. They do so with the key principle of the children's best interest in mind. CASA volunteers visit their assigned families weekly and make critical observations of the children and the parent(s), while providing feedback on the level of their interaction. They also assess the families' strengths and work with social service providers, guardians ad litem and others to resolve barriers to reunification. CASA volunteers provide a wide array of support to children and their families, including outreach concerning school issues, school visits and the tracking of court-ordered services. Their involvement in these aspects of the families' lives helps to reduce the participants' level of anxiety at a very critical point in the mother's recovery. CASA advocates also submit regular court reports and attend Family Treatment Court hearings.

*Judge Anita Josey-Herring is the presiding judge of that court and led the initiative to develop the program with District stakeholders. "The Family Treatment Court is very pleased to have the assistance of CASA volunteers in helping to address many issues affecting children and families involved in child welfare cases. The collaborative effort aimed at strengthening children and families by giving them the opportunity, support and tools to live happy, healthy and productive lives is one we all embrace as being important to securing our future and the future of these children. It is also an endeavor that helps to renew our belief in the power of mankind to impact the lives of those less fortunate in a positive and productive way."*

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## Substance Abuse and Permanency Planning: Implementing ASFA When Parental Substance Abuse Is a Factor

Kathleen M. West, DrPH

### Summary

Judges and the child welfare system must act quickly to recognize and treat the disease of drug and alcohol dependence when it presents. To do this, courts must know what they're looking for and how to respond appropriately.

One- to two-thirds of child abuse/neglect cases coming before juvenile courts involve parental substance abuse according to local, state and national surveys undertaken to gauge the incidence of this problem. The perception of many child welfare case workers and judges, however, is that alcohol and illicit drug abuse are major factors in roughly 80-90% of their cases. Whatever the exact range, it's enough of a problem to warrant our concern and action. Studies over the last few decades have shown that children whose parents abuse alcohol and other drugs have roughly a 270% greater chance of abuse and a 420% greater chance of neglect.

Such numbers essentially tell us that we may expect more problems in families where drug/alcohol abuse is occurring—a fact of little help in the task of making concrete placement decisions. Due to the multiple demands placed on the courts—safeguarding children's well-being and “best interest,” ensuring “reasonable efforts” to strengthen or reunify families and implementing the timelines of the Adoption and Safe Families Act (ASFA)—judges and the child welfare system must act *quickly to recognize and treat the disease of drug and alcohol dependence* when it presents. To do this, courts must know what they're looking for and how to respond appropriately.

The National Institute of Drug Abuse (NIDA) defines *addiction* as “a disease consisting of a number of brain chemistry disorders.” Major strides in the neuroscience of psychoactive substance use and dependence have enabled medical and treatment practitioners to differentiate clients along the continuum of drug use, abuse and dependence (addiction). Advances in psychopharmacologic understanding of both the course of disease and recovery among different drug *classes* (types) have improved the ability of treatment providers to deliver targeted and more effective substance abuse treatment. For example, it is clear today that methamphetamine addicts have a different recovery trajectory than heroin addicts or those dependent on marijuana. Researchers are finding that the extent of brain damage and the degree and rates of recovery vary considerably based on the *class of drug being abused*. The *duration* (how long?, how many years/months?), *frequency* (how often?) and *quantity* (how much?) of use, as well as the *quality* (purity or strength) of the drugs being used are factors that influence a person's course of recovery.

In the context of the juvenile court, such knowledge permits the development of an improved and more realistic permanency plan, moving it closer to compliance with ASFA. But how can the courts acquire knowledge of parents' needs and then move to meet them as required through reasonable efforts?

The first step is to ensure that all parents with allegations of alcohol/drug use receive a thorough standardized assessment (preferably onsite at the court ASAP). The American Society of Addiction Medicine (ASAM) has clear guidelines regarding best screening and assessment practices. As the case moves forward, recognize that reassessments may be needed to help distinguish parental “non-compliance” from inability to comply. As stated above, recovery progresses at different rates based on a variety of factors, with basic brain recovery, for example, taking up to 15 months post-abstinence in the case of some stimulants (e.g., methamphetamine).

Second, based on assessment findings, an appropriate and specific referral should be made to a reputable treatment program. To maximize the likelihood of client compliance, research shows that a treatment intake appointment should be scheduled within 24 to 36 hours of assessment. Since the availability of high-quality, comprehensive and gender-specific treatment programs is sorely lacking in many communities, this step may require judges to lay some groundwork by employing their power to convene community stakeholders to improve access and quality of services for court families.

In *Principles of Effective Treatment*, a succinct NIDA booklet, judges will find clear, research-based guidance for better understanding of what constitutes effective treatment programming.

The third step is to ensure that the parent's treatment and case plan incorporates "child-parent relationship" issues throughout. To date, many good substance abuse treatment plans for parents fail to include meaningful measures of their ability to parent, which sobriety and even substantial recovery alone do not necessarily confer. Relapse prevention and recovery are lifelong jobs for those suffering from drug dependency, with children and other family members intimately affected by the success of parents in managing this challenge.

Last, and regardless of the final placement decision, judges can work to ensure that adequate support services are in place for all concerned parties, thus helping to prevent intergenerational cases from appearing in the court. Post-adoption families are often recognized as in need of service, but post-termination parents, siblings and other family members are also highly likely to require some counseling support after their case has ceased to be of concern to the court.

*Editor's Note: Dr. Kathleen West is a public health professional with expertise in the areas of substance abuse in the context of its affects on children, the family, intergenerational substance abuse and related drug and alcohol treatment and prevention issues. Her research focus has been on issues related to infants prenatally and environmentally exposed to alcohol and other drugs—specifically cocaine and methamphetamine and the medical, developmental and social placement experiences and outcomes in the first few years of life with a sub-focus on children in dependency court settings. Since 2002, Dr. West has served as a consultant at the World Health Organization in Geneva and internationally, focusing more broadly on high-risk maternal and child health problems, including substance abuse issues as they affect families and children globally.*

*Please see "Online Resources" in this issue for additional information recommended by Dr. West, including numerous free publications which would be suitable for training and distribution.*

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**National Center on Substance Abuse and Child Welfare**  
*Permanency Planning for Children Department*  
*National Council of Juvenile and Family Court Judges (NCJFCJ)*

**Summary**

The mission of the National Center on Substance Abuse and Child Welfare (NCSACW) is “to improve systems and practice for families with substance use disorders who are involved in the child welfare and family judicial systems by assisting local, State and tribal agencies.”

Increased national attention to substance use disorders among families involved in the child welfare system led to the creation of a National Center on Substance Abuse and Child Welfare (NCSACW) in the fall of 2001. The center is an initiative of the Department of Health and Human Services, jointly funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) and the Administration on Children, Youth and Families (ACYF), Children's Bureau's Office on Child Abuse and Neglect (OCAN). The mission of NCSACW is to “improve systems and practice for families with substance use disorders who are involved in the child welfare and family judicial systems by assisting local, State and tribal agencies.”

The center is implemented by staff from Children and Family Futures (CFF) under contract with CSAT. A consortium of organizations has been developed to support implementation. The consortium members bring expertise and resources to the substantive work of NCSACW and facilitate access to a very large constituency base for information gathering and dissemination. Consortium members include:

- American Public Human Services Association (APHSA)
- Child Welfare League of America (CWLA)
- National Association of State Alcohol and Drug Abuse Directors (NASADAD)
- Permanency Planning for Children Department (PPCD) of the National Council of Juvenile and Family Court Judges (NCJFCJ)
- National Indian Child Welfare Association (NICWA)

**Technical Assistance**

The center is available to provide technical assistance (TA) on substance abuse issues in the child welfare population. TA is available to national, state and local agencies as well as family court systems, tribal agencies and others interested in information regarding these fields. A key feature of NCSACW's efforts is assistance in developing the cross-system partnerships and practice changes that are needed to address the issues of substance use disorders among families in the child welfare system.

**In-Depth Technical Assistance**

NCSACW is concluding an 18-month program of in-depth technical assistance with Colorado, Florida, Michigan and Virginia, working to increase collaboration among alcohol/drug/child welfare systems and courts and tribes. The agency is also involved in the development of strategic plans for improving services to families in the child welfare system affected by substance use disorders. NCSACW helped facilitate the development of strategic plans tailored to each state's needs, identifying and bringing in additional technical assistance as needed by the sites, and assisted the sites in implementing their plans.

NCSACW will study the progress made and lessons learned in each site with the aim of broadly disseminating the information gained to help further collaborative efforts and linkages among alcohol and drug services, child welfare, family courts and tribes in other jurisdictions. Additional sites for in-depth TA were recently announced.

**On-Line Tutorials and Training**

NCSACW is in the process of developing four online self-tutorials, which will establish a baseline for knowledge on substance use disorders and child welfare. This series of online self-tutorials is available free of charge, and those who successfully complete each tutorial can earn continuing education units.

The first in this series of tutorials, *Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals*, is currently available on the NCSACW website. The second is *Understanding Substance Abuse Treatment and Recovery: A Guide for Child Welfare Workers*. The third, *Understanding Substance Abuse and Child Welfare Issues: A Guide for Judicial Officers*, is anticipated to be released in Summer 2005.

### **National Conferences**

“Putting the Pieces Together: 1<sup>st</sup> National Conference on Substance Abuse, Child Welfare and the Dependency Court” took place in Baltimore on July 14-15, 2004. This conference was a two-day event designed to benefit frontline practitioners and administrators of child welfare, alcohol and drug services, the dependency court, policymakers and researchers. Close to 400 participants and speakers attended the conference.

The NCJFCJ Permanency Planning for Children Department continues to serve as a national consortium member for NCSACW. Joey Orduna, JD, NCSACW program manager for PPCD, represented the NCJFCJ at the conference, offering publications (400 were disseminated during the conference), onsite technical assistance and information about the NCJFCJ. Through its role as a consortium member, the PPCD also facilitated and moderated many workshop sessions related to the courts and child welfare cases.

The conference was organized to provide representatives of alcohol/drug/child welfare services and dependency courts nationwide with multiple opportunities to share innovative policy and programmatic efforts, to learn about relevant research and best practices in providing services to families and to support further collaboration across agencies. Many individuals stated that the information they received over the two days, as well as the opportunity to network with others doing similar work, infused them with energy to go back to their jurisdictions to further collaborative efforts aimed at serving families involved in the child welfare system who are affected by substance use disorders. The 2<sup>nd</sup> national conference is currently being planned for Fall 2006.

*The NCJFCJ Permanency Planning for Children Department continues to serve as a national consortium member for NCSACW. Contact Joey Orduna, JD, NCSACW program manager for PPCD at P.O. Box 8970, Reno, Nevada 89507, telephone 775-784-6012 or contact the National Center on Substance Abuse and Child Welfare 4940 Irvine Blvd, Suite 202, Irvine, CA 92620, telephone 714-505-3525, [www.ncsacw.samhsa.gov/](http://www.ncsacw.samhsa.gov/)*

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## CASA and NCJFCJ Lose a Good Friend

*M. James Toner, Dean and Director of Continuing Judicial Education, NCJFCJ*



### Summary

Judge James M. Farris, longtime friend of CASA and the National Council of Juvenile and Family Court Judges, died November 5 at Baptist Memorial Hospital in Beaumont, Texas. He was 72 years of age.

As president of the NCJFCJ in the term 1993-94, Judge Farris also served on the board of National CASA. In 1998 he was elected president of Texas CASA. On the local level, he was instrumental in starting CASA of Southeast Texas, where he was an honorary member of the board at the time of his death.

He called himself the “short, fat judge from Beaumont, Texas,” but there is no question he stood tall as an advocate for children and families across the nation.

Judge John Specia, NCJFCJ board member and district court judge in San Antonio, Texas, remembers hearing Jim Farris when Judge Specia was a young attorney: “I’m not a member of the Democratic Party. I’m not a member of the Republican Party. I’m a member of the *Children’s Party!*” That statement “epitomizes Jim Farris,” says Judge Specia.

While he was very visible on the national front, he quietly and modestly performed good deeds, serving as a mentor to many, rejoicing in their success. Carole Hurley, JD, director of the Texas Department of Protection and Regulatory Services in Austin, reminisces: “Jim Farris always called me when I needed it most and was least likely to pick up the phone myself. Without fail, every three weeks or so, the telephone would ring, and on the other end I would hear that East Texas voice saying ‘This is Jim.’ I called him maybe eight or ten times in the seven years I knew him. I think he called me at least a hundred. Whether it was to find out when our next task force meeting was, to talk about some happening we were both ticked off about or just to remind me I was appreciated, those calls made a difference in my life. The knowledge that Jim Farris respected the way I did both of my jobs means the world to me and fills a place in my heart that will stay with me forever. Although all of us miss him dearly, I can’t say that Jim Farris’s death leaves a void. The void would have been to never know him. The children who sleep in a safe, warm place, who are alive today, when they might have been abused or murdered at the hands of a parent or caregiver, will never know the awful void that might have been their fate if not for Jim Farris.”

Judge Farris was known especially for his sense of humor, often self-deprecating—he claimed to have “graduated in the half of the class that made the top half possible.” When he signed his letters, many handwritten, he included a smiling face in the loop of the “J.” He confessed that committee deliberations were not his forte. He recognized his gift of public speaking, however, a gift that could move full auditoriums to laughter, then to tears, while imparting a message of inspiration and motivation. As a result, he was constantly in demand across the country. Standing ovations were routine. One family friend reflected that although he has sat through many a commencement speech in his lifetime, the only one he recalls to this day is the address Judge Farris gave years ago to his fraternity.

After graduation from Baylor University, Jim served 17 months in the US Army in Korea, returning to Baylor Law School, which honored him in 1997 as the “Baylor Lawyer of the Year.” In 1999, he was elected president of the Baylor Law Alumni Association. Elected to the bench first in 1969, he was re-elected seven times without opposition.

Numerous awards were given Jim Farris. In 1991, the US Department of Health and Human Services selected him as the Texas recipient for the Commissioner’s Award for the Prevention of Child Abuse and Neglect. In 1992, the Texas Court Appointed Special Advocates (CASA) named him Judge of the Year. In 1995, the Naches River Festival honored him as Citizen of the Year.

Throughout his life, Jim Farris never lost the common touch. He called people “pardner.” A favorite expression was “dad-gummed.” Participants would seek him out at conferences just to talk. He never met a stranger.

He was most proud of his wife Ellarene, two sons and a daughter. He enjoyed being a doting grandfather and had looked forward to coming to the NCJFCJ Juvenile Justice Conference in Orlando in March 2005 in that capacity. He was close to his older brother, Joe, and maintained regular contact with him.

Many did not know how much of a perfectionist Judge Farris was. He labored over preparing his speeches, good as he was. He even asked his minister to tell a story before other speechmaking at his funeral. The story involved Daniel and the lions’ den. When asked how he managed to survive, Daniel said “I whispered in the ear of each lion: after dinner there’ll be speeches.”

Rabbi Peter Hyman, in a touching speech read by his wife Susan at the funeral, recalled how they had invited Judge Farris to attend the ceremony honoring two Hyman sons who had achieved the rank of Eagle Scout in the Boy Scouts. Jim Farris had just missed attaining Eagle Scout status; he lacked his life-saving badge. “Pardners, I’m proud of you—you done what I wanted to do and you done good,” he told the Hyman boys. When Judge Farris died, Daniel Hyman cut the lifesaving badge from his uniform, and Ari Hyman gave his Eagle pin. They pinned both to the judge’s robe in the casket. “Not for what you didn’t do as a Scout, but for what you did as a man.”

There was laughter at the funeral. There were happy memories shared. If he had it his way, Jim Farris would have spoken at his own funeral.

As Carole Hurley also observed, “Jim used to give a talk about heroes. I wonder, did he know he was mine?”

We are going to miss you, “Pardner.”

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## Online Resources for Substance Abuse and Dependency Issues



*Joey Binard, Manager of Technical Assistance at the National Council of Juvenile and Family Court Judges and Editor of Brevity, a weekly e-newsletter*

### **Family Treatment Drug Courts**

#### **Child Welfare League of America**

“Courts That Heal” is an article providing an overview of family drug courts nationally, with information about successful innovations and challenges. From CWLA’s *Children’s Voice*, March/April 2003.

[www.cwla.org/articles/cv0303courts.htm](http://www.cwla.org/articles/cv0303courts.htm)

#### **Children’s Bureau**

The article “Implementing an Evidence-Based Parenting Program in Dependency Drug Court” profiles Miami’s Dependency Drug Court. This court’s approach includes an interdisciplinary plan to help the whole family as well as a parenting program, intensive case management and monitoring, communication across systems and a high level of involvement on the part of the judge.

[cbexpress.acf.hhs.gov/articles.cfm?issue\\_id=2004-12&article\\_id=900](http://cbexpress.acf.hhs.gov/articles.cfm?issue_id=2004-12&article_id=900)

#### **Connect for Kids**

“A Court That Heals Families” is an article on California’s dependency drug courts. Includes a description of the San Diego Substance Abuse Recovery Management System (SARMS) program.

[www.connectforkids.org/resources3139/resources\\_show.htm?attrib\\_id=312&doc\\_id=204121&parent=82343](http://www.connectforkids.org/resources3139/resources_show.htm?attrib_id=312&doc_id=204121&parent=82343)

#### **Family Drug Court Planning Initiative**

Resources from the Bureau of Justice Assistance. [dcpj.ncjrs.org/dcpj\\_family.html](http://dcpj.ncjrs.org/dcpj_family.html)

#### **National Drug Court Institute**

Provides a comprehensive drug court training series for practitioners; supports investigative projects aimed at the development of more effective drug court policies and procedures; and disseminates important drug court specific research, evaluations and relevant commentary. [www.ndci.org/](http://www.ndci.org/)

### **Fetal Alcohol Spectrum Disorder (FASD)**

#### **Canadian Centre on Substance Abuse**

Provides recent, accurate information on the important and complex issue of substance use and pregnancy. [www.ccsa.ca/index.asp?ID=150](http://www.ccsa.ca/index.asp?ID=150)

#### **FAS Community Resource Center**

Particularly helpful in providing ways to deal with behavioral issues in children affected by FASD.

[www.come-over.to/FASCRC/](http://www.come-over.to/FASCRC/)

#### **FAS/FAE Legal Issues Resource Center**

Includes links to topics related to the criminal justice system, court cases and Social Security disability benefits. [depts.washington.edu/fadu/legalissues/](http://depts.washington.edu/fadu/legalissues/)

#### **FASlink**

The Canadian Fetal Alcohol Spectrum Disorders’ internet support, information, advocacy and discussion forum. [www.acbr.com/fas/](http://www.acbr.com/fas/)

**Fetal Alcohol and Drug Unit, Department of Psychiatry and Behavioral Sciences, University of Washington School of Medicine**

Another route to the FAS/FAE Legal Issues Resource Center described above, with additional links to research, publications and other resources. [depts.washington.edu/fadu/content.html](http://depts.washington.edu/fadu/content.html)

***Iceberg***

A quarterly international educational newsletter on FASD from FASIS, a parent/professional partnership. [www.FASiceberg.org/](http://www.FASiceberg.org/)

**National Organization on Fetal Alcohol Syndrome (NOFAS)**

Resources for advocates, health professionals, parents and educators. [www.nofas.org](http://www.nofas.org)

**Substance Abuse and Mental Health Services Administration (SAMHSA) Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence:**

A federal initiative devoted to preventing and treating FASD. [fascenter.samhsa.gov/index.cfm](http://fascenter.samhsa.gov/index.cfm)

**Methamphetamines**

**“Addiction Drains Life Out of Body and Soul“**

The *Utah Deseret News* ran a six-part series in November 2004 on the downward spiral of methamphetamine abuse and its effects on primarily young women addicts. Meth use in Utah is overwhelming law enforcement, child welfare and drug-abuse treatment centers.

[deseretnews.com/dn/view/0,1249,595106651,00.html](http://deseretnews.com/dn/view/0,1249,595106651,00.html)

**“Meth User: A Child’s Face“**

This December 2004 article from *The Oregonian* shows that the number of treatment admissions for boys 17 and under has grown steadily in the past five years. It has jumped 57% among girls. Last year more than 1,700 children were treated for methamphetamine abuse in Oregon. More than 1,000 are girls. Oregon treats more people for meth addiction per capita than any other state in the country.

[oregonlive.com/search/index.ssf?/base/news/1102165581269170.xml?oregonian?lcp](http://oregonlive.com/search/index.ssf?/base/news/1102165581269170.xml?oregonian?lcp)

**Parenting**

**Center for the Improvement of Child Caring**

A parenting and parenting education organization with books, parenting programs, resources for professionals and the new *Discovery Tool*, a simple way to let parents know whether their child may have special unmet needs. The Tool asks questions about a child’s skills and behavior through a series of questions, starting with newborns and up to age 4. [www.ciccparenting.org/](http://www.ciccparenting.org/)

**Substance Abuse and Child Maltreatment**

**Alcohol Dependence or Abuse Among Parents with Children Living in the Home**

*National Survey on Drug Use and Health Report, February 2004.*

[oas.samhsa.gov/2k4/ACOA/ACOA.cfm](http://oas.samhsa.gov/2k4/ACOA/ACOA.cfm)

**Child Welfare League of America**

Article on “Substance Abuse and Child Abuse” from CWLA’s *Children’s Voice*, 2001.

[www.cwla.org/articles/cv0109sacm.htm](http://www.cwla.org/articles/cv0109sacm.htm)

**Connect for Kids**

“The Impact of Substance Abuse on Foster Care”: Article provides Information on substance abuse among parents, pregnant women and youth in foster care. Theories of substance abuse, prevention and treatment. [www.connectforkids.org/content1552/content\\_show.htm?doc\\_id=8160&attrib\\_id=312](http://www.connectforkids.org/content1552/content_show.htm?doc_id=8160&attrib_id=312)

**National Center on Addiction and Substance Abuse at Columbia University**

“No Safe Haven” report finds that drug and alcohol abuse causes or exacerbates seven out of ten cases of child abuse or neglect. [www.casacolumbia.org/pdshopprov/files/No\\_Safe\\_Haven\\_1\\_11\\_99.pdf](http://www.casacolumbia.org/pdshopprov/files/No_Safe_Haven_1_11_99.pdf)

### **National Center on Substance Abuse and Child Welfare**

The NCJFCJ Permanency Planning for Children Department is a partner in this national organization. See the resources and online tutorials and training sections. [www.ncsacw.samhsa.gov/resources.asp](http://www.ncsacw.samhsa.gov/resources.asp)

The first of a series of online tutorials has been published and is available online—*Child Welfare and Dependency Court: A Guide for Substance Abuse Treatment Professionals*.  
[ncsacw.samhsa.gov/tutorials/index.asp](http://ncsacw.samhsa.gov/tutorials/index.asp)

### **National Clearinghouse for Alcohol and Drug Information**

Link to publications from NCADI, a program of the Substance Abuse and Mental Health Services Administration (SAMHSA) and US Department of Health and Human Services. The following link will take readers to the top 50 publications that have been ordered in the current week.  
[store.health.org/catalog/top.aspx](http://store.health.org/catalog/top.aspx)

### **National Clearinghouse on Child Abuse and Neglect (NCCAN) Information Resources**

#### **“Acts of Omission: An Overview of Neglect”**

This 10-page report does a very thorough job of reviewing knowledge about neglect, research on neglect, characteristics of neglected children and their families and consequences of neglect.  
[nccanch.acf.hhs.gov/pubs/focus/acts/acts.pdf](http://nccanch.acf.hhs.gov/pubs/focus/acts/acts.pdf)

#### **Parental Drug Use as Child Abuse**

Link to individual state statutes relating to this topic and many others.  
[nccanch.acf.hhs.gov/general/legal/statutes/drugexposed.cfm](http://nccanch.acf.hhs.gov/general/legal/statutes/drugexposed.cfm)

#### **Substance Abuse and Child Maltreatment**

Fact sheet on the links between substance abuse and child abuse.  
[nccanch.acf.hhs.gov/pubs/factsheets/subabuse\\_childmal.cfm](http://nccanch.acf.hhs.gov/pubs/factsheets/subabuse_childmal.cfm)

#### **Substance Abuse Information Resources**

A number of helpful reports from the US Department of Health and Human Services.  
[nccanch.acf.hhs.gov/topics/issues/substance.cfm](http://nccanch.acf.hhs.gov/topics/issues/substance.cfm)

#### ***Principles of Drug Addiction Treatment: A Research-Based Guide***

Provides information about addiction, drug treatment and recovery to new patients in drug treatment and to their friends and family. The book is also published in Spanish. Order through the following link: [165.112.78.61/PODAT/PODATindex.html](http://165.112.78.61/PODAT/PODATindex.html)

*For more information, you may want to take a look at the **Child Abuse and Neglect** [training.ncjfcj.org/child\\_abuse\\_neglect.htm](http://training.ncjfcj.org/child_abuse_neglect.htm) and **Alcohol and Other Drugs** [training.ncjfcj.org/Alcohol%20Drugs.htm](http://training.ncjfcj.org/Alcohol%20Drugs.htm) pages from the subject library of Brevity [www.ncjfcj.org/dept/training/brevity/](http://www.ncjfcj.org/dept/training/brevity/), a weekly internet newsletter I publish for NCJFCJ. Brevity is available to anyone with an interest in juvenile justice and child dependency matters at no charge and with no obligation. To become a Brevity subscriber, go to [www.ncjfcj.org/dept/training/brevity/](http://www.ncjfcj.org/dept/training/brevity/) and see the bottom of the page for instructions*

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