Children's Services
PRACTICE NOTES
For North Carolina's Child Welfare Workers
From the NC Division of Social Services and the Family and Children's Resource Program

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Children's Services Practice Notes is a newsletter for North Carolina's child welfare workers produced four times a year by the North Carolina Division of Social Services and the N.C. Family and Children's Resource Program, part of the Jordan Institute for Families and the School of Social Work at the University of North Carolina at Chapel Hill.

In summarizing recent research, we try to give you new ideas for refining your practice. However, this publication is not intended to replace child welfare training, regular supervision, or peer consultation—only to enhance them.

Let us hear from you!
If you would like to comment about something that appears in this or any other issue of *Children's Services Practice Notes*, please do so! Address your comments to:

John McMahon
Jordan Institute for Families
UNC–CH School of Social Work
Chapel Hill, NC 27599-3550
State Courier Number: 17-61-04
E-mail: johnmcmahon@mindspring.com

Newsletter Staff
Joanne Caye, MSW, Advisor
Lane Cooke, MSW, Advisor
John McMahon, MA, Editor
Selena Berrier, Writer
Daniel Brezenoff, Writer
Michelle Wetherby, Writer

SUBSTANCE ABUSE AND CHILD WELFARE

There's no question: if you are a child welfare social worker, you work with people who use drugs. And all the relevant research shows that substance abuse is an added stress for families, another obstacle for social workers and clients, and a risk factor in almost every area, from child abuse, domestic violence, and mental illness to employment, family reunification, and cognitive and emotional development (Ray & Ksir,1993).

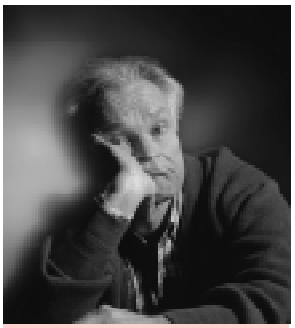
Every child welfare practitioner should know about and understand substance abuse. Receiving professional training, taking a class, attending an in-service workshop, speaking with colleagues and supervisors, and reading books and journals can help you learn about this extremely complex behavior.

As a supplement to such training, this article provides you with some of the fundamentals of drug and alcohol abuse and dependence, their effect on individuals and families, how abuse and dependence may be recognized, and their implications for child welfare practice.

WHO USES DRUGS?

According to the Alcohol and Drug Council of North Carolina, there are nearly 700,000 people addicted to drugs in North Carolina. Another 700,000 have a problem with alcohol (Alcohol/Drug Council of NC, 1998).

Among them are parents and children, athletes and actors, homeless men and women, and lonely adolescents. Some just drink alcohol, others smoke pot and sniff cocaine. People abuse prescription drugs like valium, codeine, and dilaudid, and people sniff gasoline. They inject heroin ("smack, dope") and amphetamines ("crank, speed, meth") and they smoke crack-cocaine ("rock"), speed, and marijuana ("pot, grass, weed").



Substance abuse is an added stress for families and a risk factor in almost every area.

People who abuse drugs can be loving parents, hard workers, next-door-neighbors, bank tellers, janitors, students, lawyers, nurses. Only one thing is certain—no matter what role a person who abuses drugs may play, substance abuse and dependence always add complications and obstacles to successful interventions (Smyth,1995).

USE, ABUSE, & DEPENDENCE

It is important to understand the difference between use, abuse, and dependence (also called "addiction"). **Use** simply means drinking, smoking, inhaling, injecting, or swallowing a chemical substance. If one drinks a beer with dinner, one is using alcohol, but not necessarily abusing it. Some professionals consider any illegal drug use to be "abuse," while others use the stricter definition provided by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), the in-

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strument most professionals use to assess substance abuse.

According to the DSM-IV, **abuse** is "a maladaptive pattern of substance use leading to clinically significant impairment or distress." In other words, if the use of a drug or alcohol causes serious problems—at work, in school, within the family, with the law, or with physical or mental health—then it is probably substance abuse. Abuse can occur over a period of hours, days, months, or years.

Abuse is not dependence. **Dependence**, or **addiction**, according to the DSM-IV, has two main characteristics: tolerance and withdrawal. **Tolerance** means that larger and larger amounts of the substance are needed to achieve the same level of intoxication, or "high." Tolerance can be very dangerous because as more and more of a drug is taken, the risk of **overdose**—that is, illness or death from toxic levels of the drug—increases. An experienced user may not feel "high" but may still be close to overdose.

Withdrawal is the syndrome caused when a dependent person stops taking the drug to which he or she is addicted. Certain drugs—especially alcohol, amphetamines, cocaine, and opiates (e.g., heroin, morphine)—create a physical dependence so severe as to cause a risk of severe pain, illness, mental disturbance, and even death if the dependent person quits using or is unable to obtain enough of the drug to get intoxicated. Alcoholics who go for even a few hours without drinking may experience delirium, black-outs, tremors, nausea, seizures, and hallucinations. Heroin users who stop taking heroin often experience intense muscular pains, uncontrollable shaking, diarrhea, and high fever. For people struggling with substance dependence, quitting without treatment can be as risky as continuing to use.

Nicotine and caffeine may be the two drugs that cause the most dependence. However, because they do not cause severe intoxication and are not linked with violent or anti-social behavior in the way that alcohol and other drugs are, we will not focus on them here.

ADDICTION IS AN ILLNESS

An important point to understand is that regardless of the substance involved, addiction is a mental illness just like depression, schizophrenia, or an anxiety disorder. These conditions are diseases, not so different from cancer or diabetes.

People who abuse substances are suffering from a debilitating illness, not

RECOGNIZING ABUSE

The effects and dangers of different drugs vary so much that it would be impossible to describe here all the signs and symptoms of even the most common drugs.

Many drugs, such as marijuana and LSD, cause the user's pupils to dilate. Heroin, on the other hand, may cause the pupils to contract. Alcohol intoxication can be very obvious when the drinker is stumbling and slurring her speech, but less obvious when she simply seems tired. Longtime alcoholics may become very skilled at hiding their drinking, and even the keenest observer may miss it.

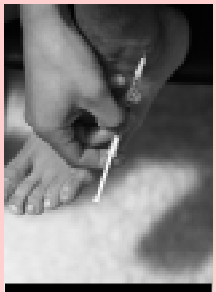
People who abuse prescription drugs may act more strangely when they are unable to obtain their drugs of choice than when they are intoxicated, and taking the drug may return them to an apparent state of "normalcy." They may swallow pills quite openly, saying they have a prescription and need the medicine to sleep, stay calm, or stop smoking. And all this may be true without changing the fact that they are substance-dependent.

Finally, because everyone knows that certain drugs are illegal, users of narcotics and other "street drugs" are likely to go to great lengths to keep their addiction secret (Weil & Rosen, 1993).

What all this means is that substance abuse is easy to miss. It is also easily confused with other phenomena, including brain injury and stroke, the effects of crying or insomnia or too much sleep, mental illnesses, or simply having an unusual personality (DSM-IV, 1996).

Sometimes substance abuse may seem quite obvious. Yet delirium, total irrationality, extremely red eyes that can barely stay open, constant dozing off, unpredictable outbursts and extreme agitation, confused speech, and other strange behaviors can all be signs of many things, not just substance abuse. But when one or more of these behaviors shows up in someone who has previously not exhibited them, drugs are likely involved.

However, it is impossible to know that drugs are being used unless you observe them being ingested, smoked, injected and so forth, which is unlikely, or a person admits to using, or you receive reliable reports—as opposed to gossip and rumors—that a person uses.



It is hard to know for sure that someone is using unless you see them abusing drugs or alcohol yourself, they admit their use to you, or you receive a report from a reliable source.

But in the end, for a child protective worker, it is okay to be uncertain. While it is helpful to have as much information as possible, the fact that a caretaker uses drugs is not, in itself, of fundamental significance. What matters is the caretaker's ability to care for his children (Mason, 1996).

This is not to say that there is no appropriate response to finding out that there is substance abuse going on in a family. You will want to ascertain whether children are being put at risk, whether they are being exposed to dangerous activities, and whether they themselves are using. Finding the answers to these questions is what matters (Mason, 1996).

from a flaw in their character or a moral shortcoming. This does not mean they are not responsible for their actions. But it does mean that they are entitled to the same respect, the same services, and the same treatment as anyone else.

SUBSTANCE ABUSE AND CHILD MALTREATMENT

The evidence linking alcohol and drug abuse to child maltreatment makes it clear that there is an increased risk of neglect and abuse in families where substance abuse occurs.

Several studies have indicated that a quarter of all child welfare cases involve families where substance abuse is occurring (Kropenske & Howard, 1994); one study placed the number closer to 40 percent (National Committee to Prevent Child Abuse, 1997). Several studies conducted in Boston found that, of the most severe instances of child maltreatment, as many as nine out of ten caretakers abused drugs or alcohol (Murphy, et al., 1991; Kowal, 1990).

Drugs, Alcohol & TPR. One of these studies showed that of the parents referred to CPS who abused "hard" drugs, such as cocaine and heroin, 90 percent eventually had parental rights terminated. Those who abused alcohol had parental rights terminated only 60 percent of the time (Murphy, et al.). These findings demonstrate the key role substance abuse can play in child welfare.

However, they may also demonstrate a bias among social workers against illegal drugs as opposed to alcohol, which, despite being legal, is still extremely dangerous. One study found that children of mothers characterized as "problem drinkers" had more than double the risk of serious injury (Bijur, et al., 1992).

PRACTICE IMPLICATIONS

- **Know the symptoms of drug and alcohol use.** When one or more of these behaviors shows up in someone who has previously not exhibited them, it's likely drugs are involved.
- **Don't jump to the gun**. Make sure reports of substance abuse are reliable or rely on your own observation. Substance use is hard to identify with certainty; its symptoms may be identical to those caused by other factors.
- **Stay focused**. In CPS investigations, the well-being of the child is the primary concern, not the presence of drug abuse.
- **Guard against personal bias**. Although substance abuse is a factor in many child welfare cases, the majority of people who use or abuse substances do not abuse or neglect children.
- **Understand confidentiality as it relates to substance abuse**. (see p. 4).

Effects on Children. Children living in homes where a caregiver abuses substances suffer from a variety of physical, mental, and emotional health problems at a greater rate than the general population (Prevent Child Abuse, 1996). For example, as a group, children of alcoholics tend to experience feelings of low self-esteem and failure and struggle with depression and anxiety (Children of Alcoholics, 1992).

Later on, many of these children succumb to the same patterns exhibited by their parents; they are more likely to abuse substances, and, if they were abused, they are more likely to abuse their kids (Prevent Child Abuse, 1996).

Treatment is Critical. When families are struggling with substance abuse *and* child maltreatment, both problems must be addressed to ensure the safety of children. Ending the drug dependency will not automatically end child maltreatment, but parenting skills will improve little until this step is taken (Prevent Child Abuse, 1996). For more about treatment, see page 4.

A Final Caution. It is important to keep in mind that even though a great number of maltreatment cases involve substance abuse, most people who use or abuse drugs do not abuse children. One study found that less than two percent of drugs abusers have abused or neglected their children (Egami, et al., 1996). Other studies have produced similar results.

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SUBSTANCE ABUSE TREATMENT & PREVENTION: WHAT YOU SHOULD KNOW

On the face of it, child welfare workers have little to do with the prevention and treatment of substance abuse. Beyond making a referral and monitoring the situation, there is little else you can do, right? After all, if attending treatment is part of what parents must do to hold on to their kids or get them back, what happens is really up to *them*.

Yet as a child welfare worker, you know what a big issue this is. You may not know the statistics, the ones that say 40 to 80 percent of all parents investigated for child abuse or neglect use drugs or alcohol (BHRP, 1998), or that children of substance-abusing mothers are more likely to experience multiple placements and to stay in foster care longer than other kids (Curtis & McCullough, 1993). But you know from your own experience that drug and alcohol abuse has a devastating effect on families and kids. And you want to do something about it.

You know substance abuse hurts families. Learn how you can help.

IDENTIFICATION

A first step is recognizing substance abuse as a problem in individual families. Sometimes the symptoms can be difficult to recognize, and many child welfare workers do not ask about substance use explicitly. As a result these problems go unacknowledged and untreated.

One way to inquire about alcohol abuse in a nonjudgmental and open way is the CAGE method, which involves asking:

C Have you ever felt the need to **C**ut down on your drinking?

A Have people **A**nnoyed you by criticizing or complaining about your drinking or drug use?

G Have you ever felt bad or **G**uilty about your drinking?

E Have you ever had a drink first thing in the morning to steady your nerves and get rid of a hangover (**E**ye-opener)?

Getting a "yes" answer on two or more of these questions suggests that a more thorough assessment should follow.

CONFIDENTIALITY

If it is an open fact that a family member has substance abuse issues, you can help by offering to refer this person to someone who has experience working with substance using clients. To do this, you need permission from the individual abusing drugs or alcohol. You cannot simply call the police or the detoxification center and report the parents of your clients. To do so would be a gross violation of social work ethics, no matter what your opinion of substance abuse.

In fact, substance abuse issues are given special status in matters of confidentiality. Even if a client signs a standard "release of information" form, revealing the presence of substance abuse is not permitted. Only when an individual gives written consent specifically regarding substance abuse may a practitioner reveal the problem to other professionals (Burke & Clapp, 1997). Many agencies have forms solely for the release of substance abuse information.On the other hand, if substance abuse by a caretaker is putting a child at risk, a report can (and must) be made to CPS (Mason, 1996).

REFERRAL

There are many places to turn to refer someone for treatment. Some DSS's in North Carolina now have a Qualified Substance Abuse Professional (QSAP) in the agency. This person is available to provide additional screening and make appropriate substance treatment referrals.

In addition, all mental health centers have substance abuse clinicians—just call the clinic and ask for a substance abuse counselor. If you can, get to know the substance abuse clinicians in your community on a personal level—this will help bridge the barriers that often exist between agencies.

If you are making the referral directly to the treatment agency, as much as possible, look for programs that focus on client strengths and encourage the client to participate in his or her treatment goal planning. For more on this topic, see *Women Who Abuse Substances*, pages 6 and 7.

TREATMENT STRATEGIES

Although as a child welfare worker your role in substance abuse treatment will be limited, it is important to know about the different types of treatment out there. Unfortunately, many communities do not have a broad continuum of treatment options. As a result, clients sometimes end up in whatever treatment program is available, rather than in one that meets their individual needs. This can hurt a person's chance of quitting successfully.

Treatment options include detoxification, inpatient and residential settings, and outpatient treatment. An individual's treatment generally depends on the severity of the problem.

Detoxification is a 5 to 30+ day treatment intended to wean the user from his or her substance. This can be done in a hospital-like setting or in a community-based program. **Inpatient** and residential settings (halfway houses, recovery homes) usually treat clients for 14 to 28 days.

Outpatient. Frequently addiction is treated in an outpatient setting. Some people receive care in *day treatment* programs, where they attend treatment for part of the day but spend the night at home. *Self-help groups* are another form of outpatient treatment. *Twelve-step programs* are available nationwide and are run by group members. The best

known of these are Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).

Group treatment has been identified by substance-abuse clinicians as the treatment of choice. This method tends to be effective because it uses peer feedback, modeling, confrontation, and support. Group treatment can also be used to teach coping and interpersonal skills.

Biological treatment, a form of outpatient treatment, involves using drugs (e.g., antabuse, methadone) to reduce a person's physical need for substances.

Family treatment (e.g., couples counseling, multifamily therapy, single-family therapy) focuses on stabilizing the family and helping them set boundaries with the substance user.

Outpatient counseling/therapy can be used in inpatient treatment programs or in the community. The goal is to help clients gain insight into their substance-using behaviors, to address problem behaviors, teach social skills, and provide support.

WITHDRAWAL, RELAPSE, & RISK

An effective treatment program will help most people deal with the physical and psychological challenges of quitting and staying off drugs. However, as a child welfare worker, it is important for you to remember "that the withdrawal experienced by parents who cease using alcohol or other drugs presents specific risks. The effects of withdrawal often cause a parent to experience intense emotions, which may increase the likelihood of child maltreatment (Zuskin & DePanfilis, 1987). During this time, lasting as long as two years, it is especially important that resources be available to the family" (Prevent Child Abuse, 1996).

Relapse. From your work with families, you probably know that people attempting to quit drugs or alcohol often backslide. Relapse should be viewed as a normal and natural part of the recovery process for many clients. Recovery from drugs and alcohol is the process of learning how to live a meaningful and comfortable life without the need for alcohol or drugs. Abstaining from drugs or alcohol alone does not mean a full recovery has occurred.

PREVENTION

Your role as a child welfare worker may give you an opportunity to help prevent substance abuse from occurring at all. To do this it will be helpful to know two things: the factors that reduce the likelihood of substance abuse ("protective factors") and the resources in your community that help people develop these protective traits.

Protective Factors. Research tells us that there are a number of factors that can protect individuals against substance abuse. On an environmental level they include adequate housing and income, stable employment, low neighborhood crime and drug use, good health care, access to adequate social services, and good schools. On the family level they include marital harmony, close relationships with siblings, family rituals and traditions, and the presence of an extended family.

Protective personal factors include positive self-esteem, flexibility, creativity, the ability to make friends, independence, a sense of humor, and good problem-solving skills (OSAP, 1990; McCullough et al., 1993).

At first glance, these protective factors may read like a laundry list of the things that many clients of social services lack. But rather than despairing for the families you work with, look to their strengths. Indeed, since identifying family strengths is already part of what you do to help families address the issues that brought them to the attention of DSS, spend some time talking with them about how their strengths can be enhanced to ensure family members don't run into trouble with drugs or alcohol.

It will help if you can refer families to the programs in your community aimed at helping individuals improve on their protective qualities. Because so many resources fall into this category, from job training to family therapy, it is not feasible to list **cont. page 8**

MORE INFORMATION

Adult Children of Alcoholics
Central Service Board, P.O. Box 3216
Torrance, CA 90510, 310/534-1815

Alcoholics Anonymous (AA)
P.O. Box 459, Grand Central Station
New York, NY 10163, 212/870-3400

Al-Anon Family Group Headquarters
P.O. Box 862, Midtown Station
New York, NY 10018-0862,
212/302-7240

For Family and Friends Involved with an Alcoholic
Institute on Black Chemical Abuse
2616 Nicollet Avenue South
Minneapolis, MN 55408
612/871-7878

Narcotics Anonymous World Service Office
P.O. Box 9999, Van Nuys, CA 91409
818/780-3951

Nar-Anon Family Group Headquarters
World Service Office, P.O. Box 2562
Palos Verdes Peninsula, CA 90274
310/547-5800

National Association for Native American Children of Alcoholics
1402 Third Avenue, Suite 1110
Seattle, WA 98101, 206/467-7686

National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20847-2345
301/468-2600 or 800/729-6686

National Coalition of Hispanic Health and Human Service Organizations (COSSMHO)
1501 16th Street, NW
Washington, DC 20036, 202/387-5000

National Institute on Drug Abuse (NIDA) Hotline, 800/662-HELP

Parents Without Partners
8807 Colesville Road,
Silver Springs, MD 20910
800/637-7974 or 800/352-0386

Women for Sobriety, Inc.
P.O. Box 618
Quakertown, PA 18951-0618
215/536-8026

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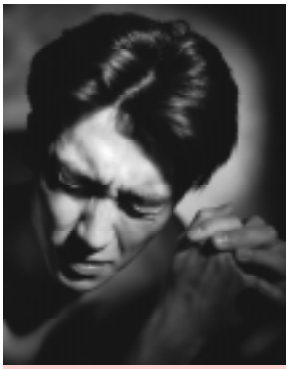
WOMEN WHO ABUSE SUBSTANCES MAY BENEFIT FROM A DIFFERENT APPROACH TO TREATMENT

Pretend for a moment that you are working with a family headed by a 22-year-old single mother who abuses alcohol. Through your work with her, you find out she herself was sexually abused as a child, and started using alcohol at the age of 15. Her current level of use prevents her from keeping a job and being able to afford transportation and child care, so if she continues to use alcohol you will have to place her children out of the home.

She genuinely wants to overcome her addiction, but has not had success doing it on her own. Given the situation and the fact that she cannot afford private treatment, what referral might you make to her?



She genuinely wants to overcome her addiction, but has not had success doing it on her own. What referral might you make to her?

Many social workers would probably connect her to the local chapter of Alcoholics Anonymous (AA). The group is free and has a long history of success with individuals working to overcome their addiction to alcohol.

But AA may not be the best solution for everyone, especially women. Research suggests that because women are socialized differently then men, a different approach to treatment is more effective. Programs that work successfully with substance-abusing women recognize that women are more likely to define themselves through relationships with others than men. For that reason, successful treatment focuses on developing healthy connections with others (Byington, 1997).

RELATIONAL THEORY

This type of approach, known as **relational theory**, is based on the assumption that women value relationships differently than men. Because women thrive when they are well-connected to others (moreso than men) they are more vulnerable to substance abuse problems when they are without significant relationships or in unhealthy relationships (Byington,1997). Byington argues that in such situations, women develop "relationships" with a substance or substances: "Addiction develops when a relationship with a drug, including alcohol, food, gambling, or another person . . . is considered to be at least as important as relationships with other people" (p. 36).

Relational theory holds that because substance abuse in women may be closely linked to relationship problems, treatment of women needs to have a great deal of focus on building healthy relationships if it is to succeed. Healthy women have positive relationships with themselves that include self-care and self-empathy, relationships with other people, spirituality, and some sort of job identification (Byington, 1997).

Addicted women may also tend to have unhealthy relationships with themselves, which include shame-filled and negative self-images. "Relationships with drugs are initially seductive and less stressful than interpersonal relationships, which may be troubled. Unfortunately, as the drug relationship becomes addictive, the initial pleasant connections become more difficult to attain and more effort goes into regaining them" (p. 37).

RELATIONSHIPS KEY TO RECOVERY

Although a woman's need for relationships can be at the basis of her addiction, it is also a tremendous strength she can use in her recovery. In particular, focusing on important relationships (such as children) can be a strong motivation for recovery. Also, women-only support groups can provide a way for women to form healthy relationships with others. Byington states that, "since many women have been sexually or physically abused by men, women-only groups can provide a safe haven to explore their experiences away from potential abusers" (p. 42).

In their work *Gender-Specific Substance Abuse Treatment* (1997), Finkelstein, Kennedy, Thomas, and Kerns also suggest that to help women recover from abuse substance programs should:

- Provide a setting in which women can role-play and/or practice healthy relationship skills;
- Help them to visualize life without the drug;
- Encourage women to examine their relationships with themselves; provide them with information about feminism as a basis of identifying women's strengths;
- Help women to cultivate their spirituality;
- Avoid a confrontational approach;
- Offer a safe, nurturing and supportive environment;
- Address women's relationship issues, especially love relationships with partners, mothers, and children; and
- Arrange treatment hours that can accommodate working women and mothers of school age children, hours that coincide with local transportation service (p. 21).

To help end a woman's relationship with a drug, Byington suggests encouraging women to give the drug a name and talk to it so that they can separate themselves from the

substance; writing a eulogy to say goodbye to the drug may even prove helpful, since recovering from addiction is very similar to the grieving process (p. 41).

PRACTICE IMPLICATIONS

As child welfare workers, you will not be conducting the direct treatment of substance-abusing women, but you will be referring them for treatment. Relational theory suggests that the first and best place to refer women are women-only support groups and those treatment facilities that focus on helping people develop healthy connections with others.

To enhance your practice in this area and improve outcomes for families, you should learn all you can about making referrals (see page 5) and educate yourself about the substance abuse treatment programs in your community and across the state. In North Carolina there are several programs that specifically target women:

- Alcoholics Anonymous has women-only chapters,
- Women for Sobriety is a national women-only group (215/536-8026),
- The Mary Frances Center (Tarboro) serves women inmates (252/-641-1111),
- At least eight North Carolina communities also have programs that serve pregnant and postpartum women and their families: Step-By-Step (Raleigh); Horizons (Chapel Hill); CASCADE (Charlotte); Day by Day (Johnston Co.); Eastern Region Women and Infant's Project (Greenville); Family Wellness and Recovery Services (Chapel Hill); Mary Benson House (Asheville); and Kelly House (Wilmington).

In addition, consider contacting private nonprofit women's support agencies, such as the Women's Center in Orange County, which often offer support groups and other resources for women. For a list of privately-operated substance abuse treatment facilities, see the Substance Abuse Treatment Referral Site (maintained by N.C. State University) at <http://sasw.chass.ncsu.edu/s&a/Substanc.htm>.

Substance abuse is a complex issue for women. Even though each case will need special attention, we can accomplish more by understanding the "big picture" issues women face. Knowing the best services for women with substance abuse problems is a good foundation for best practice.

GENDER AND ALCOHOL ADDICTION

Some differences between males and females with alcohol addictions include:

1. *Family/Genetic Factors.* Women with alcohol problems are more likely to have an alcoholic role model in their nuclear families and to have alcoholic spouses than are alcoholic men.
2. *Onset.* Women usually have drinking problems at later ages.
3. *Consumption Patterns.* Women typically consume less alcohol than men and are less likely to drink daily, to drink continuously, or to engage in binges.
4. *Course of Illness.* Women progress rapidly from onset of drinking through later stages of alcoholism (known as "telescoping").
5. *Attribution of Etiology.* Women often attribute their drinking to a traumatic event or stress.
6. *Co-existing Mental Disorders.* Women with alcohol problems tend to have affective disorders (mood disorders such as depression, mania, and bipolar disorder), whereas alcoholic men are more likely to have antisocial personality disorder.
7. *Societal Response.* Women experience more social disapproval for alcohol use, and women with alcoholism are more stigmatized.
8. *Social Consequences.* Disruptions for women are more likely to occur in family life and more likely to result in separation or divorce. Disruptions for men tend to occur in the job arena.
9. *Medical Consequences.* Women have more liver cirrhosis than men.
10. *Personal Response to Illness.* Women with alcoholism generally feel more guilty, anxious, or depressed than do men with alcoholism.

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WANT TO KNOW MORE?

Then you should attend "Substance Abuse in Child Welfare Services." Offered by the N.C. Division of Social Services, Children's Services Section, this three-day training session teaches you to analyze the impact of alcohol and drug problems and chemical dependency on families, provides you with knowledge about service needs and intervention strategies, and gives you skills you need help children and families affected by this serious problem. To register, see your agency's copy of the Division's training calendar.

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them here. If you are lucky enough to have a choice between different programs specifically designed to reduce an individual's risk of substance abuse, choose one that uses an approach called "competency enhancement." The most effective substance abuse prevention approach, competency enhancement focuses on developing personal and social skills that help guard against substance using behaviors, as well as on addressing other personal and developmental issues (Botvin & Botvin, 1992).

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TREATMENT AND PREVENTION: WHAT YOU CAN DO

- Learn to recognize the symptoms of substance abuse and use.
- Incorporate the CAGE or another screening tool into your initial meetings with families.
- Understand ethics and confidentiality as they relate to substance abuse.
- Develop your knowledge of substance abuse treatment strategies and keep up to date on the treatment resources in your community.
- Build a relationship with the QSAP in your agency and/or a substance abuse clinician at the nearest mental health center.
- Learn about the protective factors that help children and adults avoid becoming involved with drugs and alcohol.
- Increase your knowledge of the resources and programs in your community that help people develop their resiliency.

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Family & Children's Resource Program
Jordan Institute for Families
UNC–School of Social Work
Campus Box 3550
Chapel Hill, NC 27599-3550
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