The use of search warrants

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tools that can assist fact finding. Search warrants can be used to recover evidence and identify victims and offenders. Information gained through the execution of a search warrant may better prepare the investigator to interview the victim and interrogate the offender. Investigators must move quickly when search warrants are used so as to prevent the removal or destruction of evidence. As in all other areas of police work, investigators executing search warrants must be careful and follow proper officer safety procedures. Investigators should consider search warrants an important investigative tool and use them whenever justified.

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CHILD PROTECTIVE SERVICES

Working with CPS families with alcohol or other drug (AOD) problems

—by Ronald Zuskin and Diane DePanfilis

Numerous child welfare professionals have called attention to the fact that children from families with alcohol or other drug (AOD) problems are overwhelming the service delivery capacities of the child protective services (CPS) system (Besharov, 1994; Curtis and McCullough, 1993; McCurdy and Daro, 1993; Tutara, 1990) AOD cases present complex circumstances for CPS workers to sort out; further complicating this growing epidemic is the inadequate understanding of AOD related parenting problems held by the typical CPS worker[1].

It is the responsibility of the CPS worker to (1) recognize alcohol or other drug related symptoms; (2) collect information about AOD use as part of the risk assessment; (3) conduct family assessments that evaluate the specific effect of AOD problems on parenting adequacy; (4) design treatment plans and service agreements that address AOD problems; (5) coordinate meaningful referrals and interventions provided by addiction counseling agencies; and (6) evaluate progress of parents in recovery. The coexistence of AOD problems and child maltreatment is an area in which the development and dissemination of knowledge have not kept pace with the need The purpose of this article is to help meet this need.

Recognizing a problem

The coexistence of AOD problems and child maltreatment is an area in which the development and dissemination of knowledge have not kept pace with the need.

When does use of alcohol or an illegal substance become a problem? Three levels of AOD involvement are commonly identified: use, abuse, and dependence (addiction) R. E. Griffin offers a helpful summary, worth quoting at length:

> Use refers to taking a drug for pleasure in order to achieve a sense of well-being. A drinker who has a martini after work while fulfilling his or her usual responsibilities fits this category. This type of drinker is likely to discontinue use if he or she notices undesirable consequences. For those who abuse drugs, the drug and its effects interfere with the individual's ability to carry out expected responsibilities.
>
> For instance, the abuser may risk eviction by purchasing drugs instead of paying the rent or mortgage. The abuser actively pursues opportunities to use drugs and continues despite untoward results. Often the boundaries between drug abuse, dependence, and addiction are blurred. The drug-dependent individual persists in using drugs, disregarding any negative consequences and exhibiting tolerance to the drug and withdrawal symptoms when he or she cannot have the drug. Preoccupation with acquiring and using the drug results in poor judgment. For example, drug dependent parents may leave an infant unsupervised while they seek the next "fix." In their denial, these individuals often believe that their drugged state is normal and strive to sustain it Such psychological dependence is difficult for the addict to overcome. They are unable to control their drug use and their social functioning is inadequate (Griffin, 1993).

AOD and behavior

Drugs of abuse are used for their mood or mind altering effects. They are grouped by families based on related chemical properties Persons susceptible to tolerance or addiction to one chemical in a family are susceptible to tolerance or addiction to all drugs in that family Table 1 lists all drugs of abuse by family and charts the different effects of various drug families on behavior during intoxication, acute withdrawal, and chronic protracted withdrawal.

Drugs affect behavior, as well as the mood and mind of the user; therefore, the user's parenting will also be affected by AOD problems.

Intoxication

"Intoxication" literally means being poisoned by a toxin. CPS workers are most concerned about the risks for maltreatment generated by intoxication; a review of behaviors associated with intoxication — loss of inhibitions, poor judgment, irritability, depression, paranoia, mood swings, aggression, violence, etc. — support such concerns However, risks to children from a parent's AOD problems are not limited to the parents' intoxicated state.

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[1] While this article is directed toward CPS workers, all professionals in the fields of child maltreatment and substance abuse need to be aware of these concurrent problems and able to respond appropriately

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Table 2. Behavioral and Emotional Consequences during intoxication, acute withdrawal, and chronic protracted withdrawal.

Drug Family	Intoxication	Acute Withdrawal	Chronic Protracted Withdrawal
Cocaine (Stimulant)	Extreme alertness Irritability Emotional augmentation Euphoria Depression Talkative Paranoia Aggressive Fornication Craving Compulsion Insomnia Seizures	Sexual dysfunction Psychosis Paranoia Violence Shakes Emotional augmentation Agitation Insomnia Hallucinosis Anorexia Fatigue Weakness Aches Cramps Suicidal ideation Craving	Anhedonia Paranoia Craving Emotional augmentation
Dissociative Anesthetics (PCP)	Power, strength No pain Agitation Confusion Incoherent Flushing Memory Speech impaired Seizures Hallucinosis Violence Suicide Emotional augmentation Delusions Stimulation Depressant Psychosis	Insomnia Craving Sweat Nausea Yawning Emotional augmentation Agitation Psychosis	Blocked speech Sparse speech Memory impaired Cognitive impaired Poor judgement Emotional augmentation Perceptual distortion Auditory hallucinosis Depression Mood swings Paranoia Psychosis
Other Sedative Hypnotics (Tranquilizers, Barbs)	Loss of inhibitions Poor judgement Confusion Emotional augmentation Staggering Lack of coordination Slurred speech Craving	Insomnia sweats Nausea Tremors Anorexia Hallucinosis Emotional augmentation Seizures Depression Isolation Confusion Suicide Preoccupation Craving	Agoraphobia Insomnia Fatigue Depression Psycho-social problems Confusion Emotional augmentation Phobias Health problems Confusion Cognitive/emotional impairment Craving
Stimulants	Decreased appetite Loss of sleep Paranoia Hallucinations Convulsions Emotional augmentation Mood swings Aggressive Antisocial Coma	Crash followed by: Insomnia Anxiety Cravings Emotional augmentation Brain damage Psychosis Violence Suicide	Violence Sexual Dysfunction Emotional Augmentation Suicide
Marijuana/Hashish	Euphoria Lowered pain Dry mouth Nausea, vomiting Diarrhea Hunger Dilated pupils	Anxiety Insomnia Emotional augmentation Craving	Apathy Amotivational syndrome Lowered attention span Brain atrophy Paranoia Lowered immunity Emotional augmentation Craving
Narcotics	Euphoria Loss of appetite Itching Nausea Constipation Amenorrhea	Chills Gooseflesh Tears Runny nose Yawning Elevated heart beat Elevated blood pressure Insomnia Diarrhea Emotional augmentation	Lacks attentiveness Decreased sexual desire Decreased activity
Sedative Hypnotics Alcohol	Loss of inhibitions Poor judgement Confusion Emotional augmentation Staggering Lack of coordination Slurred speech Craving	Insomnia sweats Nausea Tremors Anorexia Hallucinosis Emotional augmentation Seizures D.T.'s Depression Isolation Confusion Suicide Preoccupation Craving	Insomnia Fatigue Depression Psycho-social problems Confusion Emotional augmentation Phobias Health problems Confusion Cognitive/emotional impairment Craving

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Acute withdrawal

The ingestion of a toxic substance initiates pharmacological and biochemical reactions which affect the brain and the central nervous system; intoxication by psychoactive substances alters the user's mood. Everyone, with regular use of a drug, develops some tolerance for it; alcoholics and addicts show a capacity, often from the first use, to tolerate abnormally large quantities of a drug. Continued use of a substance literally trains the body to expect to receive the chemical. Cells in the body adapt to require a certain amount of the drug, and when the amount of the drug in the body drops below the maintenance level, the body goes into withdrawal. This is referred to as "acute withdrawal," and it may occur several times during the course of a day as the substance level drops following ingestion. The addict becomes very active in seeking and ingesting the drug in order to fend off withdrawal. Additionally, the alcoholic/addict may show any or all of the signs of acute withdrawal listed in Table 1. Many alcoholics and addicts—known as "maintenance" alcoholics and addicts—may appear functional and never present the dangers associated with intoxication. CPS workers must understand that acute withdrawal presents as many risks to children as does intoxication. These risks may occur several times a day with alcoholic/addicted parents. Behaviors associated with acute withdrawal—confusion, psychosis, violence, suicidal ideation, agitation, hallucinations, etc.—indicate the risks a parent's behavior presents to children even when the alcoholic/addicted parent is not intoxicated.

A parent fresh out of detoxification is at high risk of relapse, and will remain at high risk for maltreatment for months if not years.

Chronic protracted withdrawal

When alcoholics or addicts are unable to ingest their drug of addiction for a period of time, they enter "chronic protracted withdrawal." Depending upon the particular substances used the duration of their use, this withdrawal may last up to two years. During early, middle, and even late stages of recovery, a person may be dealing with the effects associated with chronic protracted withdrawal: insomnia, fatigue, depression, confusion, paranoia, lack of attentiveness, violence, etc. A parent fresh out of detoxification is at high risk of relapse, and will remain at high risk for maltreatment for months if not years. CPS interventions and case planning need to take this into account.

An addicted client may be very cooperative, yet unable to stop drinking or taking drugs when his or her body goes into withdrawal. This doesn't necessarily mean that the client is non-compliant; it means he or she is addicted.

One effect associated with all types of drugs during acute or chronic protracted withdrawal is emotional augmentation. "Augmentation" refers to the intensifying and distorting of everyday emotions (Rogers & McMillin, 1992). While the use of substances may blunt or heighten emotional responses, withdrawal from drugs frequently results in emotional augmentation. The brain of a person in acute or chronic protracted withdrawal is agitated, and actually boosts all ordinary feelings related to parenting. This augmentation of everyday emotions serves to generate risks for maltreating behaviors in addition to those symptoms more specifically associated with each drug family.

Models of addiction

Models offer an explanation of the cause of addiction, define treatment related to the view of causality, and generate prognoses related to the application of such treatment approaches to alcoholics and addicts. The Chronic Disease Model (Rogers & McMillin, 1988, 1992) has yielded the most consistent treatment outcomes for the most clients. From the perspective of the Chronic Disease Model, addiction is a disease of the central nervous system having genetic components, thus creating higher risk for offspring of alcoholics and addicts. Numerous studies, cited by Zuskin (1994), report the biochemical and genetic vulnerabilities to alcoholism and addiction which are transmitted intergenerationally.

A summary of a study by Kendler and colleagues in the *Harvard Mental Health Letter* ("In Brief," 1994), reported on twin studies with more than 1,000 pairs of females. Concordance for alcoholism was almost twice as high for identical twins as for fraternal twins. Concordance between parents and children was about the same as fraternal twin concordance. Liability to alcohol problems was shown to have an underlying heritability of about 50%. There was no indication that shared environment or culture played any direct part in the transmission of alcoholism. Apart from heredity, alcoholism in a parent did not raise the risk of alcoholism in a daughter, but, if anything, slightly lowered it. These and other findings give strong credence to the definition of AOD dependency as the result of a genetically transmitted chronic disease process.

When viewed as the result of a disease process, AOD dependency or addiction is seen as chronic, progressive, and potentially fatal. Addiction is an event that occurs in the brain, uninfluenced by reason or insight. An addicted client may be very cooperative, yet unable to stop drinking or taking drugs when his or her body goes into withdrawal. This doesn't necessarily mean that the client is non-compliant; it means he or she is addicted. Remember that clients can be toxic without being intoxicated; clients with abnormal tolerance may function — and even function well — with extremely high levels of drugs in their blood, but will go into withdrawal if they don't continue to ingest drugs.

Treatment in the context of the Chronic Disease Model includes medically-managed detoxifi-

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cation abstinence, supported by attendance at Alcoholics Anonymous or Narcotics Anonymous, education about the disease, promotion of self-diagnosis, and planning around relapse prevention. Prognosis for persons compliant with treatment in this model is good. It is important to note that treatment for alcoholism and addictions is cumulative. Relapse is not uncommon, but long-term successful outcomes are possible when treated in accordance with the principles of the Chronic Disease Model.

Assessment and intervention

Given the risks that AOD dependency pose to children and families, proper and timely assessment of AOD dependency is crucial. The CPS worker will not be directly involved in treating a client's addiction. But eliciting information, screening, assessing, securing a referral to a qualified program, and following up with the client's progress are critical skills in working with alcoholic and addicted clients who maltreat their children. All families experiencing child maltreatment should be screened for addiction, and referred for diagnosis and treatment when necessary. Likewise, as Bays (1990) emphasizes, all addicted families should be screened for maltreatment, as some degree of neglect is almost inevitable.

Young children have great needs for parenting which may be impossible for an active addict to meet.

Assessment

AOD abuse and dependence, like child maltreatment, are wrapped in denial and secrecy. Workers need to be skilled at eliciting information from clients who may be well defended against candidly disclosing abuse-related information. Assessment tools can be extremely helpful in eliciting information for AOD abuse and dependence screening in CPS clients. The CAGE Questionnaire (Bush, et al., in King and Lorenson, 1989), consists of four questions for the initial screening:

1. Have you ever felt you should cut down on your (substance use)?
2. Have people ever annoyed or angered you by criticizing your (substance use)?
3. Have you ever felt bad or guilty about your (substance use)?
4. Do you ever use (substances) after waking up?

A positive response to any of these questions indicates the need for further assessment. However, since parents who have AOD abuse or dependence problems will often deny a problem, it is sometimes necessary to start with less direct questions. Two indirect approaches to this screening are: (1) developing a genogram adapted to collect information about alcohol and drug problems among at least three generations, and (2) conducting a typical day interview, questioning clients in detail about their day in order to reveal risk factors, indicators of AOD dependency, and/or child maltreatment (Zuskin, 1994).

A genogram is a family tree that records genealogical relationships, major family events, occupations, losses, family migrations and dispersal, identifications and role assignments, and information about alignments and communication patterns over at least three generations of a family (Hartman 1978). The traditional genogram can be enhanced graphically to highlight information about AOD problems in a family's history. The genogram can indicate both genetic susceptibility and the environmental factors which may contribute to the risk of intergenerational transmission of AOD abuse or dependence (Leikin, 1986; Zuskin, 1994).

A typical day interview consists of asking for a detailed account of a typical day in the client's life. Through a typical day interview, indicators of AOD problems such as times of unexplained absences or typical times of parent-child conflicts, can be identified without being specified as AOD-related.

Intervention

Clients who present with indications of either substance abuse or dependency should be referred for further evaluation, including physical examination, blood workup, and treatment. Referrals for evaluation and treatment should not be "recommendations," but need to be supported by available leverage and followed up through each step of the process—screening, intake, assessment, treatment, and aftercare.

The worker must ensure that the treatment program to which referral is made provides viable services. As indicated above, the best available research indicates that treatment approaches based on the Chronic Disease Model will be most effective. Rogers and McMillin (1992) list ten keys to look for in selecting a program which maximizes outcome effectiveness:

1. The program uses a disease model.
2. The program is oriented towards measurable goals.
3. The program emphasizes education
4. The program emphasizes group counseling.
5. The staff is expert in addictions treatment.
6. The program reliably differentiates those receiving in patient vs. outpatient care.
7. The program has good aftercare.
8. Abstinence is the criteria for successful outcome.
9. The program should give good value for the cost.
10. The program should educate the family as well as the addict.

Ensuring the safety of the child

AOD problems significantly heighten the risk of child maltreatment (Kinscherff and Kelley, 1991). Even the parent in treatment and recovery continues to present risks of maltreatment to children in his or

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her care due to the effects of chronic protracted withdrawal. If families are to remain together, both problems—drug abuse and child maltreatment—must be treated simultaneously (e.g., Bavolek and Henderson, 1990). Services must be long-term, issue-specific, family-focused, multi-modal, and interdisciplinary. Throughout the stages of treatment, progress needs to be monitored and necessary leverage, including court involvement, utilized to secure and support treatment.

When considering risks to the child, age is an important consideration. Young children have great needs for parenting which may be impossible for an active addict to meet. The younger the child, the greater the risk for maltreatment. Critical issues for workers to assess, in descending order of urgency, include the child's immediate safety given the using patterns of the parent(s), protection from ongoing maltreatment, available nurturance (with assessment of development and attachment), and permanency. Termination of parental rights may need to be considered based upon the following criteria: abandonment of newborns, refusal to enter drug treatment, age of the child, poor bonding, availability of suitable alternative placements, repeated child maltreatment, recurrent relapses, lack of non-addicted adult in the home, repeated drug-exposed births, and a long history of treatment failure.

Family services

If families are to remain together, several good resources regarding intervention and treatment issues are available for CPS workers involved in case planning, including the Child Welfare League of America's (CWLA) *Children at the Front* (1992), Besharov's *When Drug Addicts Have Children* (1994), and the work of Bays (1990), Tracy (1994), and Zuskin (1994).

Treatment for addictions is cumulative; it is a process in which rapid and dramatic change is unlikely.

Whenever possible, all family members should be included in treatment. In many CPS caseloads, however, this means a single mother and one or more young children, infants, and toddlers. Services delivered at this level need to focus on parenting. In the early stages of recovery, family treatment focusing on the here and now, on specific tasks, and on cognitive-behavioral parenting interventions should coalesce with drug treatment. With very young children, treatment should strengthen the parental attachment to the child and promote the mother's awareness of the child's needs and her acquisition of anger management skills. Drug treatment which includes the care or treatment of young children of single mothers can support the mother's involvement in treatment. Also, drug treatment provided in a child-oriented context, such as a pediatric health center, can support compliance. Many single mothers may need an opportunity to focus on their own needs before they are able to focus fully on meeting those of the child. The Nurturing Program (Bavolek and Henderson, 1990) has been recommended as a means of meeting the needs of all family members.

A full range of child welfare services may be helpful to families, including intensive family services, long-term in-home services, residential parent-child treatment, kinship care, and long-term, stable foster care. A key premise for case planning is that treatment for addictions is cumulative; it is a process in which rapid and dramatic change is unlikely.

Research and policy

Addictions and child maltreatment are at epidemic proportions in the United States. The CWLA's North American Commission on Chemical Dependency and Child Welfare (1992) and Bays (1990) join many other authors listed here in recommending that further research be done into the relationship between these twin epidemics. Such research could begin with the gathering of data from addictions treatment sources and from child welfare sources. Research into the risk and protective factors for addictions and maltreatment could be used to plan prevention and treatment. Research on the effectiveness of various approaches to treat this population would obviously follow.

The CWLA's Commission and the National Association of Public Child Welfare Administrators (1991) have made policy recommendations regarding the social work response to these problems. Recommendations include providing accessible services which are non-punitive; securing interdisciplinary participation, financing, and training; providing outreach services to clients at risk; developing a comprehensive national policy on addictions and child welfare; and improving coordination among relevant funding and service agencies at all levels of government.

Social workers must recognize that the presence of one of these problems is a signal to assess for the other. Social workers must acquire the skills and knowledge base to make the appropriate assessments and referrals. And it is critical that the professional community begins to collaborate in serving these families, who cannot be successfully treated without multi-agency and interdisciplinary involvement. Interdisciplinary training which promotes self-awareness, cultural competence, and awareness of the co-occurrence of drug addiction and child maltreatment is a critical first step. Relevant professional communities must organize so that coordination of available and accessible resources becomes a priority. Workers need case management skills to be able to secure appropriate services and coordinate their delivery among a service team. Programs need to be developed which provide strategic addictions and parenting services by skilled, empathic professionals working together in multi-modal, collaborative, interdisciplinary treatment

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programs. These are some of the steps by which we can assist families in which addiction and child maltreatment occur together—perhaps the most daunting challenge facing CPS workers today.

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LAW

Thoughts on How Prosecutors Can Inform Judges on Child Abuse and Neglect Issues

—by Paul Stern

They are stories of frustration for professionals.

A child sees a therapist for behavioral problems. After a thorough evaluation, the therapist is convinced the child has suffered long term abuse by a parent. The child will likely continue to be abused and needs to be removed from the home, the professional concludes. But the judge refuses the request, not wanting to disrupt the family.

A 12-year-old is testifying about the many times her father entered her room late at night and molested her. When the judge hears that she had a lock on her bedroom door, but never used it, that she waited three years to make her disclosures, and that the disclosures were not made until her mother began divorce proceedings, the judge rules that the child can't be credible, and dismisses the case.

A jury has convicted a defendant for sexually molesting three of his grandchildren. His own children come forward and report that he abused them when they were younger. The defendant denies all the abuse allegations. The judge, whose father is the same age as the defendant, can't bear to send him to prison. Even though the defendant is still in denial, the judge orders him to sexual deviancy treatment.

Many of the most important decisions affecting the lives and safety of abused children are made by judges. These decisions are informed by what the particular judge believes to be true about child abuse. And those beliefs are significantly shaped by the amount and quality of the knowledge the judge has acquired about the subject. Most child abuse professionals acknowledge that, by and large, judges do an outstanding job dealing with these complex issues. Unfortunately, even the best-educated and most well-intentioned judges may have little accurate knowledge of child sexual abuse.

Until recently, little formal training about sexual abuse was available for judges. The National Judicial College did not offer a specific program dealing exclusively with child abuse issues until May, 1993. Specific judicial training in this area remains limited.

Many child abuse professionals might question the difficult decisions made by judges, examples of which opened this article. Professionals have an obligation to do more than question judicial decisions and walk away, however: they have an obligation to help judges reach decisions that are as well informed and accurate as possible. Prosecutors are in a particularly good position to bring relevant information to judges' attention.

Below are seven principles for prosecutors who wish to credibly, ethically, and effectively inform the bench.

Try self-examination before criticism.

A prosecutor who thinks a judge has made a terrible decision should not react in anger, but as a professional. Examine critically whether the judge really was wrong. Just because the decision went against you doesn't mean it was wrong.

If you are convinced the judge is in error, review why your arguments were not accepted.

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