Substance Abuse and Child Maltreatment Prevention

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Two risk factors have appeared particularly important in terms of strength of association with child physical abuse and neglect: poverty, especially receipt of public assistance (e.g., Brown, Cohen, Johnson, & Salzinger, 1998), and substance abuse (e.g., Chaffin, Kelleher, & Hollenberg, 1996). In 1993, according to the Third National Incidence Study of Child Abuse and Neglect, child maltreatment was 22 times more likely in families with annual incomes below $15,000 than in families with incomes above $30,000 (Sedlak & Broadhurst, 1996). Substance abuse increases the risk of child physical abuse or neglect report threefold (Chaffin et al., 1996; U.S. Department of Health and Human Services, 1993), and most estimates implicate substance abuse in between one-third and two-thirds of substantiated reports to child protective services (U.S. Department of Health and Human Services, 1999). The co-occurrence of these two major risks appears to be particularly associated with physical abuse or neglect. Even though maltreatment is not present in over 90% of families with incomes below $15,000 per year (Sedlak & Broadhurst, 1996), substance abuse appears to be a major discriminator of low-income families in which neglect is and is not present (Ondersma, 2002).

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Although our understanding of the association between substance abuse and child maltreatment is still developing, at least four pathways could connect substance abuse with the occurrence of child physical abuse or neglect. Substance abuse may (a) directly cause physical abuse or neglect, perhaps by disrupting normal nurturing processes and parental willingness and ability to function in the parenting role; (b) indirectly lead to physical abuse or neglect through the host of additional conditions associated with substance abuse (e.g., violence, crime, trauma, physical and mental illness, poverty); (c) be caused by the same factors that increase risk for physical abuse or neglect, for example, poor coping skills, impulsivity, trauma, stress, or mental illness; or (d) simply increase the likelihood that a person will be reported to child protective services (although not all research connecting substance abuse and maltreatment uses child protective services reporting or substantiation as the key outcome). It is likely that all of these pathways play a role in the observed association between substance abuse and child maltreatment.

Substance abuse may thus be an appropriate target for universal or selective interventions designed to prevent physical abuse or neglect. First, focusing on families in which both substance abuse and poverty are present may allow for efficient identification of at-risk children not yet known to child welfare and thus provide more efficient use of limited resources (Ondersma, 2002). Second, mental health, social service, and other agencies are frequently aware of families for whom substance abuse is an issue but who are not currently involved with child welfare. Identifying many such families may thus be quite feasible. Third, substance abuse is a remarkably well-researched problem, therefore giving the maltreatment prevention field a firm empirical base from which to develop interventions.

Assuming for the moment that targeting substance abuse may allow for efficient identification of at risk parents, two questions arise: (1) Is substance abuse amenable to intervention efforts? That is, can we really make a difference in this? (2) If it is possible to affect parental substance abuse, what might a substance abuse-focused physical abuse or neglect prevention approach look like? These questions will be answered in the following two sections.

Is Substance Abuse Treatable?

A great deal of rigorous research comparing treatment and control groups suggests that substance abuse is treatable. In fact, despite assumptions that substance abusing persons never change, these disorders appear to be as treatable as other chronic illnesses, such as asthma or diabetes (Leshner, 1999). Many types of interventions can lead to reductions in substance abuse (National Institute on Drug Abuse, 1999), even very brief, single session interventions (Moyer, Finney, Swearingen, & Vergun, 2002; Wilk, Jensen, & Havighurst, 1997).

Contrary to popular belief, the majority of persons (approximately 75%) who do recover from an alcohol use disorder do so without professional help or 12-step groups (e.g., Sobell, Ellingstad, & Sobell, 2000). The same appears to be true for drug use disorders as well, although less research has focused on this issue. This finding, surprising to many, has held true in studies in the United States, Canada, and Europe. This is not to suggest that such change is easy; it is difficult for nearly all and extremely difficult for many, and most who do achieve long-term sobriety do so only after many repeated recoveries and relapses.

Regardless, many people report having ceased abusing alcohol or drugs in their own ways and for their own reasons. Some of the most common reasons involve self-image or identity, health, finances, and relationships (Burman, 1997). Quitting is often preceded by a very personal and emotional cognitive appraisal process in which the benefits of a particular substance come to be seen as outweighed by its costs, by the benefits of quitting, or both (e.g., Sobell et al., 2001). Methods commonly used by self-changers include avoiding substance abusing persons or cues, obtaining support from sober family and friends, and finding alternative pleasurable or coping activities (Burman, 1997).

How Can Prevention Efforts Address Substance Abuse?

Integrative Approach

There are a number of ways that professionals concerned with maltreatment prevention can address substance abuse to reduce the risk of child physical abuse and neglect. The most obvious way is for existing prevention programs to devote more energy to the identifi-

cation of substance abuse and for these programs to partner with substance abuse treatment agencies. Many existing prevention programs have endeavored to integrate substance abuse treatment more thoroughly into their existing treatment approaches. Although clear evidence is lacking, such an approach could facilitate better outcomes from a maltreatment prevention standpoint.

However, this approach may have limitations due to its inability to influence more than a fraction of substance abusing parents, for only a fraction of the time in which they may benefit from services. For example, it has been estimated that over six million children have a caretaker who is dependent on alcohol, drugs, or both (Huang, Cerbone, & Gfroerer, 1998). Intensive—and thus expensive—programs cannot be provided to all at-risk parents because of the tremendous amount of funding it would take to do so. Further, research concerning readiness to change suggests that most people with substance use disorders, at any given moment, are not interested in change and thus are unlikely to participate in intensive treatment (DiClemente & Prochaska, 1998). Finally, most maltreatment prevention programs—despite their emphasis on aftercare and follow-up care—can provide services for only one of many important periods in a child's life. Substance use disorders tend to be chronic relapsing conditions, and most who relapse do not return to treatment immediately. Thus, integrative approaches, although potentially helpful with parents who are willing to commit to an active prevention program, may not fit the reality of substance abuse for most at risk parents.

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Motivationally Informed Public Health Approach

Given the above concerns, what else can be done? One possibility is to attempt to apply brief motivational interventions, which have already been validated as a substance abuse intervention, to large numbers of potentially at-risk parents—whether or not they are seeking treatment or are willing to engage in long-term treatment. Such an approach would differ from the integrative approach in several ways: (a) It would be proactive, seeking to provide intervention to a high proportion of at-risk parents, regardless of whether or not they are seeking help or known to any service delivery system; (b) It would be brief and motivational in nature, designed around the reality of limited readiness to change in most substance abusing parents; and (c) It would be repetitive, seeking out parents not just once but on a regular basis to provide intervention throughout the parenting years. Similar approaches to substance abuse, smoking, diet, exercise, food safety, and a number of other behaviors have already been proven successful (e.g., Prochaska, Velicer, Fava, Rossi, & Tsoh, 2001; Thevos, Quick, & Yanduli, 2000).

What might such an approach look like when applied to substance abuse and child maltreatment? Many types of public health-related approaches have received empirical support. One common type of intervention involves community-wide media or law enforcement campaigns. In a study designed to increase public concern regarding children in substance abusing families, a multimedia campaign resulted in dramatic increases in the number of related calls received by a CPS information service (Andrews, McLeese, & Curran, 1995). In another study, a television ad followed up by surveys of representative women was associated with significantly increased self-reported concern regarding alcohol use during pregnancy (Casiro, Stanwick, Pelech, & Taylor, 1994). Community-level law-enforcement campaigns to reduce heavy alcohol use have been found to reduce self-reported episodes of binge drinking by 49% (Holder et al., 2000), and tax increases on beer have been associated with reductions in physical child abuse (Markowitz & Grossman, 2000). Such programs can be altered and repeated continually to access, however briefly, very high proportions of potentially at-risk parents at multiple points in their lives.

Regardless of the usefulness of such campaigns, however, they have little to do with the daily work of most child maltreatment prevention specialists, and they may rely upon very different principles. Fortunately, such campaigns are not the only way that low-cost and effective interventions can be brought to large numbers of at-risk parents. Research has provided evidence that brief (even single session) interventions are associated with clinically significant change in substance use (Miller, 2000; Moyer et al., 2002; Wilk et al., 1997). When compared with persons having substance use disorders who get no intervention, those who receive brief, nonconfrontive feedback and intervention are more likely to quit or reduce their substance use.

Brief interventions generally focus on increasing people's motivation to change and facilitating treatment entry. Such sessions are typically used in primary care settings, where they can be provided to very high proportions of at-risk populations (for example, women in the perinatal period, those at HIV screening clinics, and those presenting for treatment in emergency rooms). However, prevention specialists, children's therapists, family support workers, and many others who have access to large numbers of at-risk parents could also conduct brief interventions in a host of other settings. A recent study of the use of these techniques with parents in the CPS system found that parents who received a motivational interview were nearly twice as likely to attend at least one substance abuse treatment session (Carroll, Libby, Sheehan, & Hyland, 2001).

Although the study by Carroll and colleagues is the only current evidence of the efficacy of these techniques in a child welfare setting, brief motivational interventions designed to reduce problem substance use have been validated in a variety of other settings, such as outpatient treatment centers and emergency rooms. In addition, these brief interventions—being client-centered rather than confrontational—utilize methods that are more similar to those typically utilized by mental health professionals than to those often associated with substance abuse treatment.

If integrated into prevention programs, social service agencies, and primary care settings, brief interventions can potentially be provided on multiple occasions throughout the parenting years. This would allow for parents to repeatedly revisit their risks, which may change over time. With proper training, professionals from a wide range of

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disciplines can learn to comfortably provide such interventions. A greatly simplified outline of the key features of a brief intervention is provided in the following section.

Conducting a Brief Intervention for Maltreatment Prevention

Brief motivational interventions are both elegantly simple and technically challenging. With proper training, however, they can be provided with fidelity by a wide range of professionals and paraprofessionals. Although no therapeutic approach can be reduced to a few simple steps, some important points can be highlighted.

- **Think big (and brief)**. If brief interventions are provided only to those parents for whom substance abuse is an obvious problem, very few at-risk parents will be influenced. Further, any intervention increases in overall impact every time it is provided to a new person. Public health researchers define impact as the average effect of an intervention on the individuals it is given to multiplied by the number of people that the intervention has accessed. Using such a definition, many "model" interventions in fact have very little impact because they access such small proportions of the at-risk population. Certainly, we can strive to affect all of the participants in our programs, not just the ones we know have a substance use disorder. But more than this, we can attempt to affect an entire community, whether or not those affected are seeking services.

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- **The less stigma the better.** There is reason to believe that the less that parents feel targeted because of some perceived deficit, the more likely they are to respond. For example, the relative success of the Nurse Home Visitation Program may in part be due to its use of nurses, around whom parents may feel less stigmatized and defensive. Similarly, a recent meta-analysis found that home visitation programs targeting all parents of a given demographic, rather than via the use of a risk screener, were more likely to be successful (Guterman, 1999).

- **Start with a substance abuse screen**. The closer the perceived ties of the screener to CPS, the more likely it is that parents will minimize any substance use. However, many steps can be taken to increase the validity of a substance abuse screen. Confidentiality, to the extent that it exists, should be emphasized; for example, substance abuse is not a mandated report in many states. Second, a "norming" statement (e.g., "Most parents have some areas of strength and some areas where they struggle") can preface the screen to make admitting to some difficulties seem less stigmatizing. Embedding the substance abuse screen in a larger assessment of strengths and challenges can further enhance its acceptability. Third, a validated screening tool should always be used. For alcohol, good options include the TWEAK, CAGE, or MAST (see http://www.niaaa.nih.gov/publications/instabletext.htm for copies of all of these). For drug use, try the Drug Abuse Screening Test (available at http://www.nida.nih.gov/Diagnosis-Treatment/DAST10.html). A very subtle measure shown to identify at-risk drinking (as well as many whose drinking is not problematic) is the Trauma Scale (see www.projectcork.org, also an excellent general resource on substance abuse).

- **Respond empathically**. Responding to drug use in a low-key and empathic manner is the best way to facilitate further communication and motivation. Immediately rushing to point out negative aspects and consequences of substance use is likely to elicit defensiveness. Endeavoring to respectfully discover what parents like and dislike about drinking or drugs is more likely to lead to a meaningful and effective conversation about change.

- **Provide treatment options**. A client presented with options is more likely to engage in change than one given a single choice for change. Provide parents with handouts that list as many local treatment options as possible (even if the only options available are a 12-step group and two local counselors) and that describe some of the benefits that can be expected from decreasing one's substance use (e.g., a better relationship with children, a decreased likelihood that one's children will use drugs or abuse alcohol, more money, better health, less trouble).

- **Read, read, read**. A great deal of information is available about the use of motivational techniques. Probably the single best source is the motivational interviewing text by William R. Miller and Stephen Rollnick, the revised version of which came out in April 2002 (*Motivational Interviewing: Preparing People for Change*, Guilford). In addition, excellent web resources are available. Try www.motivationalinterview.org, which also has a nationwide list of trainers, and the guide, "Enhancing Motivation for Change in Substance Abuse Treatment" (CSAT TIP #35), provided by the U.S. Department of Health and Human Services' Center for Substance Abuse Treatment (http://www.samhsa.gov/publications/publications.html).

It must be emphasized that the foregoing is just a rough indication of what such an approach might look like. It is also important to remember that such interventions, although validated for the treatment of substance abuse with general and child protective services populations (Carroll et al., 2001), may not substantially impact maltreatment risk if substance abuse is only a correlate and not a cause of maltreatment.

Regardless of the success or failure of the brief model proposed here, our field must give serious thought to the extent to which we have devoted resources and attention to interventions that intend to be quite intensive, that consequently are too expensive to be provided to all who are at risk, and that may not be attractive to parents who are not ready to change. To have a community-wide effect and to have at least some contact with the "silent majority" of at-risk parents who never cross our path, we may need to adopt more of the methods of our colleagues in public health. Doing so may involve a broad shift away from intensive, individually based efforts and toward widespread, brief, practical, and motivational solutions.

References

Andrews, A. B., McLeese, D. G., & Curran, S. (1995). The impact of a media campaign on public action to help maltreated children in addictive families. *Child Abuse & Neglect, 19*(8), 921-932.

Brown, J., Cohen, P., Johnson, J. G., & Salzinger, S. (1998). A longitudinal analysis of risk factors for child maltreatment: Findings of a 17-year prospective study of officially recorded and self-reported child abuse and neglect. *Child Abuse & Neglect, 22*(11), 1065-1078.

Burman, S. (1997). The challenge of sobriety: Natural recovery without treatment and self-help groups. *Journal of Substance Abuse, 9*, 41-61.

Carroll, K. M., Libby, B., Sheehan, J., & Hyland, N. (2001). Motivational interviewing to enhance treatment initiation in substance abusers: An effectiveness study. *American Journal of Addiction, 10*(4), 335-339.

Casiro, O. G., Stanwick, R. S., Pelech, A., & Taylor, V. (1994). Public awareness of the risks of drinking alcohol during pregnancy: The effects of a television campaign. Child Health Committee, Manitoba Medical Association. *Canadian Journal of Public Health, 85*(1), 23-27.

Chaffin, M., Kelleher, K., & Hollenberg, J. (1996). Onset of physical abuse and neglect: Psychiatric, substance abuse, and social risk factors from prospective community data. *Child Abuse & Neglect, 20*(3), 191-203.

DiClemente, C. C., & Prochaska, J. O. (1998). Toward a comprehensive, transtheoretical model of change: Stages of change and addictive behaviors. In N. Heather (Ed.), *Treating addictive behaviors* (2nd ed., pp. 3-24). New York: Plenum.

Guterman, N. B. (1999). Enrollment strategies in early home visitation to prevent physical child abuse and neglect and the 'universal versus targeted' debate: A meta-analysis of population-based and screening-based programs. *Child Abuse & Neglect, 23*(9), 863-890.

Holder, H. D., Gruenewald, P. J., Ponicki, W. R., Treno, A. J., Grube, J. W., Saltz, R. F., Voas, R. B., Reynolds, R., Davis, J., Sanchez, L., Gaumont, G., & Roeper, P. (2000). Effect of community-based interventions on high-risk drinking and alcohol-related injuries. *Journal of the American Medical Association, 284*(18), 2341-2347.

Huang, L., Cerbone, F., & Gfroerer, J. (1998). Children at risk because of parental substance abuse. In Analytic Series A-7, *Analyses of substance abuse and treatment need issues* (Online). Retrieved, 2001, from: http://www.samhsa.gov/oas/nhsda/treatan/httoc.htm

Leshner, A. I. (1999). Science-based views of drug addiction and its treatment. *Journal of the American Medical Association, 282*(14), 1314-1316.

Markowitz, S., & Grossman, M. (2000). The effects of beer taxes on physical child abuse. *Journal of Health Economics, 19*(2), 271-282.

Miller, W. R. (2000). Rediscovering fire: Small interventions, large effects. *Psychology of Addictive Behavior, 14*(1), 6-18.

Moyer, A., Finney, J. W., Swearingen, C. E., & Vergun, P. (2002). Brief interventions for alcohol problems: A meta-analytic review of controlled investigations in treatment-seeking and non-treatment-seeking populations. *Addiction, 97*(3), 279-292.

National Institute on Drug Abuse. (1999). *Principles of drug addiction treatment: A research-based guide (NIH publication 99-4180)*. Bethesda, MD: U.S. Department of Health and Human Services.

Ondersma, S. J. (2002). Predictors of neglect within low-SES families: The importance of substance abuse. *American Journal of Orthopsychiatry, 72*(3), 383-391.

Prochaska, J. O., Velicer, W. F., Fava, J. L., Rossi, J. S., & Tsoh, J. Y. (2001). Evaluating a population-based recruitment approach and a stage-based expert system intervention for smoking cessation. *Addictive Behavior, 26*(4), 583-602.

Sedlak, A. J., & Broadhurst, D. D. (1996). *Third national incidence study of child abuse and neglect (NIS-3)*. Washington, DC: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect.

Sobell, L. C., Ellingstad, T. P., & Sobell, M. B. (2000). Natural recovery from alcohol and drug problems: Methodological review of the research with suggestions for future directions. *Addiction, 95*(5), 749-764.

Sobell, L. C., Klingemann, H. K., Toneatto, T., Sobell, M. B., Agrawal, S., & Leo, G. I. (2001). Alcohol and drug abusers' perceived reasons for self-change in Canada and Switzerland: Computer-assisted content analysis. *Substance Use & Misuse, 36*(11), 1467-1500.

Thevos, A. K., Quick, R. E., & Yanduli, V. (2000). Motivational interviewing enhances the adoption of water disinfection practices in Zambia. *Health Promotion International, 15*(3), 207-214.

U.S. Department of Health and Human Services. (1999). *Blending perspectives and building common ground: A report to Congress on substance abuse and child protection.* Washington, DC: Government Printing Office.

U.S. Department of Health and Human Services. (1993). *A report to Congress: Study of child maltreatment in alcohol abusing families.* Washington, DC: HHS National Center on Child Abuse and Neglect.

Wilk, A. I., Jensen, N. M., & Havighurst, T. C. (1997). Meta-analysis of randomized control trials addressing brief interventions in heavy alcohol drinkers. *Journal of General Internal Medicine, 12*(5), 274-283.