



Complete Summary

GUIDELINE TITLE

Substance abuse treatment for persons with child abuse and neglect issues.

BIBLIOGRAPHIC SOURCE(S)

Treatment Improvement Protocol Series 36 Consensus Panel. Substance abuse treatment for persons with child abuse and neglect issues. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment; 2000. (Treatment improvement protocol (TIP) series; no. 36). [353 references]

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SCOPE

DISEASE/CONDITION(S)

Substance use disorders

GUIDELINE CATEGORY

Counseling
Risk Assessment
Screening
Treatment

CLINICAL SPECIALTY

Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Managed Care Organizations
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Social Workers
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

To assist alcohol and drug counselors and other treatment providers to work more effectively with adults who have histories of childhood abuse or neglect and adults who abuse or who are at risk for abusing their own children.

TARGET POPULATION

These Guidelines are intended for use in the following types of patients:

- Substance abusing adults who have histories of childhood abuse or neglect
- Substance abusing adults who abuse or who are at risk for abusing their own children

The Guidelines are not intended for use in the following types of substance abusing patients:

- Children who are currently being abused
- Children who are abusing substances
- Pedophiles

INTERVENTIONS AND PRACTICES CONSIDERED

Screening and Assessment

1. Methods to provide a safe, non-threatening environment
2. Methods to prepare for a screening interview
3. Methods to reduce potential barriers to successful screenings and assessments of childhood trauma
4. Screening of childhood abuse or neglect
5. Methods of evaluating whether to conduct assessments for a history of child abuse or neglect
6. Multidisciplinary treatment team screening.
7. Clinical trauma assessment: Obtaining subjective information about traumatic events; Inquiring about childhood symptoms and family characteristics that are consistent with and suggest a history of childhood abuse or neglect
8. Mental health interviews to aid in evaluation of diagnosis, prognosis, and overall severity of mental health disturbance
9. Screening and assessment protocols

Screening instruments

1. Addiction Severity Index (ASI)
2. Childhood Trauma Questionnaire (CTQ)
3. Parent-Child Relationship Inventory (PCRI)
4. Parental Acceptance and Rejection Questionnaire (PARQ)
5. Trauma Symptom Checklist-40 (TSC-40)

Assessment tools

1. Mental health self-reports
 - Beck Depression Inventory (BDI)
 - Brief Symptom Inventory (BSI)
 - Profile of Mood States (POMS)
 - Symptom Checklist-90-Revised (SCL-90-R)
2. Structured mental health interviews
 - Diagnostic Interview Schedule (DIS)
 - Mini International Neuropsychiatric Interview (MINI)
 - Psychiatric Research Interview for Substance and Mental Health Disorders (PRISM)
 - Schedule for Affective Disorders and Schizophrenia (SADS)
 - Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I)
3. Self-reports that evaluate histories of traumatic events
 - Assessing Environments III, Form SD
 - Childhood Maltreatment Questionnaire (CMQ)
 - Trauma Assessment for Adults (TAA)--Self-Report
 - Traumatic Events Scale (TES)
4. Self-reports that evaluate trauma symptoms
 - Dissociative Experiences Scale (DES)
 - Modified PTSD Symptom Scale: Self-Report Version (MPSS-SR)
 - Penn Inventory for Posttraumatic Stress Disorder
 - Posttraumatic Stress Diagnostic Scale (PDS)
 - Trauma Symptom Inventory (TSI)
5. Structured interviews that evaluate histories of child abuse and neglect
 - Childhood Trauma Interview (CTI)
 - Evaluation of Lifetime Stressors (ELS)
 - National Women's Study Event History (NWSEH)
 - Trauma Assessment for Adults (TAA)
6. Structured interview tool that evaluates both traumatic events and symptoms
 - Clinician-Administered Posttraumatic Stress Disorder Scale (CAPS)

Treatment

1. Therapist characteristics that are essential for effective treatment, including sympathetic listening, sincerity, nonjudgmental attitude, empathy
2. Affect management using relaxation techniques
3. Sequential, integrated and concurrent treatment approaches
4. Timing of therapeutic interventions
5. Group therapy, including gender-specific groups for survivors of sexual abuse and self-help groups
6. Involvement of family in treatment

7. Referral when symptoms indicate mental health problems beyond the scope of the counselor's abilities
8. Therapeutic issues for counselors
9. Interventions aimed at breaking the cycle of substance abuse, child neglect and maltreatment

MAJOR OUTCOMES CONSIDERED

- Rates of abstinence and relapse
- Incidence of child abuse and neglect
- Rates of intergenerational transmission
- Psychological and interpersonal functioning

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

All Treatment Improvement Protocols (TIPs) are produced after a major literature search followed by a meta-analysis by skilled professionals on the contractor's staff. Then the research-based evidence is combined with whatever field-based experience is shared at the consensus panel.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

After selecting a topic for a Treatment Improvement Protocol (TIP), the Center for Substance Abuse Treatment invites staff from pertinent Federal agencies and national organizations to a Resource Panel that recommends specific areas of focus as well as resources that should be considered in developing the content of the TIP. Then recommendations are communicated to a Consensus Panel composed of non-Federal experts on the topic who have been nominated by their peers. This Panel participates in a series of discussions; the information and recommendations on which they reach consensus form the foundation of the TIP.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

A large and diverse group of field experts closely reviewed the draft document.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The Consensus Panel's recommendations, summarized below, are based on both research and clinical experience. Those supported by scientific evidence are followed by (1); clinically based recommendations are marked (2).

The Consensus Panel recommends that, when working with clients with substance abuse problems and histories of childhood abuse and neglect, counselors adopt a broad approach that considers the meaning of the experience to the client, not just legal definitions of child abuse and neglect (1). Counselors must, therefore, understand how clients interpret their experiences. Not all abuse meets the legal or commonly held criteria for abuse, nor do all clients perceive as abusive behavior that which might be legally defined as "abuse."

Screening and Assessment

Without proper screening and assessment, treatment providers may wrongly attribute symptoms of childhood trauma-related disorders to consequences of current substance abuse. Comprehensive screening for root causes of clients' presenting symptoms may greatly increase the effectiveness of treatment. However, counselors face many challenges when screening for and assessing childhood abuse or neglect. Many abuse survivors are ashamed of having been victims of childhood physical, emotional, or sexual abuse and may believe that the abuse was self-induced. Screening and assessment, therefore, should be designed to reduce the threat of humiliation and blame and should be done in a safe, non-threatening environment (2).

While conducting screenings and assessments, counselors should be mindful that adult survivors of childhood trauma commonly suppress memories of certain traumatic events or minimize their symptoms, either intentionally or unintentionally. Moreover, issues of confidentiality, mandated reporting, and trust may influence the responses to interviews and questionnaires by making some clients less inclined to reveal personal histories of abuse or neglect. Given the variable reliability of clients' responses, counselors should neither overemphasize nor overvalue the role of standardized instruments.

Counselor issues

Counselors who will be screening for and assessing histories of child abuse or neglect should receive specific training in these areas. (2) Although there are no rigid rules regarding who should conduct screenings, having certain skills will increase the likelihood that the screening process is conducted appropriately. Staff members should have an understanding of the types of psychiatric disorders and symptoms that are commonly associated with histories of childhood abuse and neglect.

Counselors who conduct screenings will be prompting clients to recall painful and traumatic events. The reemergence of painful memories may cause intense reactions from clients. Treatment staff should be sensitive to this and prepare for the interview in the following ways:

- Inform clients that talking about such issues might create discomfort; clients should be given a choice to disclose such information, being aware of the possible aftermath. (2)
- Have proper supervision and support mechanisms in place for clients in case a crisis occurs following disclosure (e.g., accessibility to mental health practitioners or medical personnel). (2)
- Assess the sources of social and emotional support available to clients when they return home. (2)

There are many potential barriers to successful screenings and assessments of childhood trauma. To reduce some of these barriers, the Consensus Panel recommends the following:

- Be sensitive to cultural concerns. (1)
- Recognize potential language differences. (2)
- Become aware of gender issues. (2)
- Be nonjudgmental and sensitive. (1)

If counselors experience intense discomfort and anxiety when conducting screenings and assessments, the Consensus Panel recommends that they receive guidance and support from a clinical supervisor and consider whether they could benefit from therapeutic assistance to explore the reasons for their discomfort (2). A variety of instruments for screening and assessment are discussed in Chapter 2 of the original guideline document.

Screening

The Consensus Panel suggests screening for child abuse and neglect histories early in the assessment process to identify individuals who exhibit signs and symptoms associated with child abuse and neglect (such as posttraumatic stress disorder, major depression, or mood disorders) and to identify those who may benefit from a comprehensive clinical assessment (2). Screenings should also be conducted at different times throughout the treatment process. Repeated screenings help elicit information about these traumatic experiences--especially after trust has been established in the therapeutic relationship (2). To conduct a screening effectively, treatment staff should

- Learn and understand ways in which childhood abuse and neglect can affect adult feelings and behaviors. (2)
- Identify those individuals who appear to exhibit these symptoms. (2)
- Identify the trauma-related treatment needs of these clients. (2)
- Provide or coordinate appropriate treatment services that will help meet clients' treatment needs. (2)

Screening for childhood abuse or neglect can set in motion a proactive plan with the following benefits:

- Stopping the cycle. Although not all adults who were abused or neglected during childhood abuse their own children, they are at greater risk for doing so. (1)
- Decreasing the probability of relapse. Many substance abusers consume substances to self-medicate posttraumatic stress symptoms related to past physical or sexual abuse or trauma. (1)
- Improving a client's overall psychological and interpersonal functioning. Childhood sexual abuse and neglect may affect the individual's self-concept, sense of self-esteem, and ability to self-actualize. (2)
- Improving program outcome. Screening for a history of child abuse or neglect will help a program to determine the needs of its clients, thus improving treatment outcomes. (2)

Assessments

The primary purpose of an assessment is to confirm or discount a positive screening for childhood abuse or neglect, as well as to identify clients' needs so that treatment can be tailored to meet them. The more clinical information a program has about clients' particular treatment needs, the better the program can accommodate them. All clients who screen positive for a history of childhood abuse or neglect should be offered a comprehensive mental health assessment (2). There is no standard trauma-oriented assessment tool, and no single tool can

be considered truly comprehensive. Rather, wisely selected, each of these tools can be a valuable component of a comprehensive assessment process.

When deciding whether to conduct assessments for a history of child abuse or neglect, the treatment team should evaluate clients'

- Current substance use or quality and length of abstinence
- Commitment to the treatment and recovery process
- Risk of relapse

The Consensus Panel believes that treatment decisions and activities are best conducted within the context of a multidisciplinary treatment team, with members having special knowledge in such areas as mental health, child abuse and neglect, and family counseling (2). Each member of the treatment team should help decide if and when to conduct assessments for childhood trauma, and clients should be asked to evaluate their own readiness to confront child abuse or neglect issues.

Trauma-related assessments are important because they can help the treatment staff understand the types of childhood traumatic events experienced by clients, their subjective response and perceptions of these events, and common current symptoms that may result from childhood trauma. Decisions regarding the types of instruments to use should be influenced by the purpose of the assessment, the setting of the assessment, the population being treated, and the individual client and the severity of his problems. (2)

Assessing histories of childhood trauma can provoke or exacerbate a psychological emergency that must be addressed; therefore the Consensus Panel recommends that the treatment team include a licensed mental health professional to handle medical issues that may arise and to conduct more formal assessments that may be required.

Subjective experience of the events

How clients remember traumatic events can shape their psychological response more than the actual circumstances can; counselors, therefore, need to obtain subjective information about these events. Such information is necessary in order to plan appropriate treatment. Information that should be obtained includes:

- What the client thought about during the abuse
- What the client felt during the abuse
- How the client understood, as a child, what was happening to her and what she thinks about it now
- How the client thinks and feels about how the abuse has affected his adulthood and substance abuse, and how he deals with the aftereffects of the abuse now
- The feelings most closely associated with the abuse experience
- The client's memories of the abuse
- The unique aspects of the client's perceptions about the abuse
- The client's coping strategies, and their effectiveness for the client

Childhood symptoms and family characteristics

The assessment should inquire about childhood symptoms and family characteristics that are consistent with and suggest a history of childhood abuse or neglect (2). Symptoms to look for include:

- Depression (including thoughts of death, passive suicidal ideation, and feelings of hopelessness)
- Dissociative responses during childhood
- Aggressive behavior or other "acting out," including:
 1. Early sexual activity or sexualized behavior
 2. Physically abusing or harming pets or other animals
 3. Other destructive behaviors
- Poor relationships with one or both parents
- Attachment disorder, difficulty trusting others
- Excessive passivity
- Passive/aggressive behavior
- Inappropriate age/sexuality formation
- Blacked-out timeframes during childhood
- Excessive nightmares, extreme fear of the dark, or requested locks on doors

Family-of-origin characteristics to consider include

- Parental substance abuse
- Battering within the family
- Involvement with CPS agencies or foster care
- Placement with foster parents or relatives
- Severe discipline during childhood
- Traumatic separations and losses

Treatment Planning

A very important factor in predicting treatment success is the number of services clients receive (e.g., case management, parenting education, counseling for posttraumatic stress disorder and childhood abuse) (1). Clients receiving more specialized services, often concurrently with substance abuse treatment, are more likely to stay in recovery (1). Treatment planning for clients with childhood abuse histories should be a dynamic process that can change as new information is uncovered, taking into account where a client is in the treatment process (e.g., confronting abuse issues too early in treatment can lead to relapse) (2).

However, it is also important for counselors to remember that until some degree of sobriety is achieved, a client's sense of reality is likely to be distorted and her judgment poor. When disclosures of past abuse take place before a client has achieved sobriety, information on childhood abuse and neglect should be heeded, but full exploration of the issue should be postponed until later (2). Listed below are general recommendations and guidelines counselors should be aware of when planning a client's treatment.

- Counselors should exhibit unconditional positive regard, a nonjudgmental attitude, and sincerity--therapist characteristics that are essential for effective treatment, regardless of therapeutic modality. (1)
- Providers must be sensitive to their clients' cultural issues and how they interact with clients' child abuse or neglect history. The Consensus Panel

- strongly urges alcohol and drug counselors to be aware of how clients' backgrounds may affect treatment. (2)
- Sympathetic listening can be an important first step in helping a formerly abused client begin the healing process. (2)
 - In the initial crisis that often follows a disclosure, the counselor's most important task may be affect management, such as keeping the client calmer by using relaxation techniques. (2)
 - Clients who suffered severe childhood abuse may need to be reassured that they are in a safe environment and will not be abused in the present. They may also have to be taught techniques to stay focused in the present. (2)
 - Some clients may require medical supervision in inpatient or intensive outpatient programs (at least during the early stages of abstinence) in order to deal with their feelings of rage, anxiety, depression, or suicidality. (2)
 - Clients with past trauma should be reassured in treatment that they have the capacity to deal with traumatic memories or related destructive behaviors stemming from childhood abuse. (2)
 - Counselors must carefully pace the client's treatment by monitoring anxiety and depression levels and by taking other cues directly from the client. (2)
 - Counselors need to isolate the symptoms of substance abuse disorders caused by trauma due to childhood abuse. (2)
 - Counselors should search for and apply any available leverage to help clients endure the short-term pain--until some treatment benefits can be realized. Clients must be engaged in a way that will give them hope and increase their beliefs in their own power to create a new life. (2)
 - For clients entering substance abuse treatment, the mere act of completing a questionnaire acknowledging a history of abuse can be tremendously healing and can lead to change, even without the intervention of a counselor. For other clients, however, actively confronting the fact of childhood abuse may be highly disturbing, and counselors must be prepared to respond supportively. (2)
 - In acknowledging the client's history of childhood abuse and neglect, the counselor must validate the client's experience by recognizing the issue, refocusing the treatment, and addressing the issue. (2)
 - The counselor can help the client develop interpersonal skills through modeling behavior, by empathizing and respecting the client, and by setting boundaries. (2)
 - For victims of abuse, the process of reattaching--or attaching for the first time--to other individuals, to a community, or to a spiritual power has tremendous therapeutic value. (2)
 - Linkages between substance abuse treatment and mental health agencies are important if the two programs are to understand each other's activities. In the interest of the client, a case summary should be developed that includes the key issues that should be addressed in the next program. (2)
 - When symptoms indicate mental health problems that are beyond the scope of the counselor's ability to treat, a referral is clearly warranted. Suicidal thoughts, attempts at self-mutilation, extreme dissociative reactions, and major depression should be treated by a mental health professional, although that treatment may be concurrent with substance abuse treatment. (2)
 - Counselors should prepare clients for mental health treatment by helping them realize:
 - That their history of childhood abuse or neglect has contributed to some of their errors in thinking, behavior, and decision making

- That they self-medicated with substances in order to avoid dealing with emotions
- That they are not alone and that there are resources to help (2)
- Working with at-risk clients in today's litigious climate requires counselors to adhere closely to the accepted standards and ethics of practice as well as the legal requirements of their position. Creating a multidisciplinary team and using proper supervision will help ensure that the counselor maintains such standards. (2)
- Substance abuse counselors always must evaluate the appropriateness of including childhood abuse and neglect survivors in group therapy for other clients in substance abuse treatment. Abuse survivors may not be able to handle the group process until they are able to deal effectively with their attachment issues. (2)
- It is a delicate matter to discuss past abuse in the presence of family members who participated in or were present during it. When such a decision is made, the counselor must bear in mind that he does not, and should not, have the role of confronting the perpetrator or perpetrators. (2)

Therapeutic Issues for Counselors

It is inevitable that the counselor will react to the client in ways that are not completely objective. Working with this population may evoke powerful feelings in the counselor. It is important that counselors be aware of and manage their own countertransference reactions and seek supervision as necessary. The Consensus Panel offers the following suggestions to help counselors deal with personal issues when working with clients with childhood abuse and neglect histories.

- In order to teach and model appropriate and healthy interactions, counselors should establish and maintain clear and consistent boundaries with their clients. Adult survivors of child abuse or neglect often need a great deal of affection and approval, and counselors must make clear to the client that they are not responsible for directly meeting all those needs. (2)
- Counselors should focus on empowering the client, recognizing that getting overinvolved will rob clients of the opportunity to draw on their own inner resources. (2)
- Clients' previous experiences may cause them to be mistrustful and suspicious of others, including the counselor. To facilitate the development of a trusting relationship, the counselor should not personalize negative responses but be open, consistent, and nonjudgmental whenever interacting with the client. (2)
- The level of violence and cruelty in disclosures about childhood victimization and exploitation may be very disturbing to counselors. When counselors find themselves manifesting symptoms of anxiety or depression, they should seek direction and support through supervision or peer support. (2)
- Counselors must recognize their personal and professional limitations and not attempt to work with abused clients if they lack the clinical expertise or are not able to manage their own countertransference reactions. (2)
- Burnout, or secondary trauma responses, affects many counselors and can shorten their effective professional life. If counselors meet with a large number of clients (many with trauma histories), do not get adequate support or supervision, do not closely monitor their reactions to clients, and do not maintain healthy personal lifestyles, counseling work of this sort may put

them at personal risk. To minimize the likelihood of burnout, counselors should not work in isolation and should seek to treat a caseload of individuals with a variety of problems, not only those who have experienced childhood trauma. (1)

- Alcohol and drug counselors are often subject to great stress. They can be expected to function well and provide effective treatment only if their agency gives them the appropriate support. The agency's leadership should strive to impart a sense of vision to staff members that communicates how important their work is as part of the larger effort to break the cycle of abuse and neglect and its impact on society. (2)

Breaking the Cycle

While many adults with substance abuse disorders do not abuse their own children, they are at increased risk of doing so. When children who are victims of maltreatment become adults, they often lack mature characteristics: the ability to trust, to make healthy partner choices, to manage stress constructively, and to nurture themselves and others. Adults with child abuse histories are then more likely than the general population to develop substance abuse disorders. This intergenerational cycle of substance abuse and child abuse and neglect reflects both the direct and indirect relationship between parental substance abuse and family dynamics, child and adult maltreatment, and second-generation substance abuse. Unless effective intervention occurs, there is an increased likelihood that these patterns will be repeated in future generations. The following list offers recommendations to address this cycle.

- Interventions aimed at breaking the cycle of substance abuse, child neglect, and maltreatment are more successful when they are family centered. (1)
- Counselors can elicit information on a client's childhood experience, which can be useful in predicting the nature of current family relationships. (2)
- Just as counselors can expect that substance-abusing parents often will deny their drug use, they can also expect parents to deny neglecting or abusing their children. Counselors should help parents understand that their parenting behaviors may not be appropriate and that these behaviors can negatively influence their children's future development, especially their ability to trust others and to develop self-esteem and pride. (1)
- Counselors should remember to articulate the positive aspects of clients' lives. (1) Focusing only on the negative or risk factors results in shame and a sense of futility and is counterproductive. Increasing clients' self-esteem and self-efficacy (their effectiveness and ability to take responsibility) is a primary step to acceptance of the child-rearing role.

In addition, it is critical that counselors be able to distinguish between actual cases of child abuse and neglect and situations that arise due to cultural differences, poverty, and lack of education. Providers who work with clients from different cultures should try to develop an understanding of that culture's norms concerning child rearing and discipline.

Legal Issues

Because many parents who abuse substances also neglect or abuse their children, it is common for clients in substance abuse treatment to have some involvement

with the child protective services system. Some substance-abusing parents will be drawn into the child protective services system during treatment; others will be compelled into substance abuse treatment by a child protective services agency. In either case, it is critical that treatment providers become familiar with the laws governing the child protective services system, including

- How child abuse and neglect are defined in their State
- Whether, when, and how a counselor must report a parent or other primary caretaker--or a parent who was maltreated in childhood--to a child protective services agency or police
- What happens after a report is made
- How State-mandated family preservation services operate

Although inappropriate child-rearing practices should be addressed in treatment, they may not, in and of themselves, constitute grounds for an abuse or neglect report. However, if counselors have a reasonable suspicion or firm belief that abuse or neglect has occurred, they are required to make a report (2). It is important for counselors to bear in mind that a parent who abuses substances is not able to adequately supervise a child and, unless other adults are known to be caring for the child, the counselor should alert the child protective services agency regarding potential neglect. It will then be the child protective services agency's responsibility to decide whether or not to investigate the matter (2).

Clients should be informed about the mandatory reporting laws at the time of admission and provided with written documentation regarding both the Federal regulations regarding confidentiality and the counselors' duty to report suspected abuse or neglect. The Consensus Panel recommends that the client be required to acknowledge receipt of such notice in writing (1). Counselors are usually not under any obligation to report childhood abuse experienced by an adult client many years ago. However, if the known perpetrator now has custody of--or access to--other children, the program should seek advice about its responsibility to report potential abuse or neglect (2).

Programs should ask staff members who are mandated reporters to consult a supervisor or team leader before calling a child protective services agency to report suspected child abuse or neglect, unless the emergency nature of the situation requires immediate action. Clinical supervisors can help determine whether the staff members are dealing with countertransference issues or inappropriate attachment. Staff members should be guided primarily by a trained understanding of the Federal requirements and the written procedures established by the treatment program. Other staff members can offer support, especially when the decision to report is difficult (2). Treatment organizations and agencies should provide orientation for all new staff members to inform them about reporting policies and procedures. It is recommended that these policies include provisions requiring staff members to notify their supervisor or appropriate program personnel whenever they make a report (2).

It is the decision of the client and his lawyer, not the counselor, to determine whether communication or cooperation with a child protective services agency will benefit the client. Therefore, it is essential that the counselor communicate with the client's attorney before taking it upon herself to communicate with a child protective services agency, except when there is a legal mandate to report (2). If

a lawyer calls with questions about a client's treatment history or current treatment, the counselor must avoid giving any information (even that the client is indeed in treatment), unless the client has consented in writing to the counselor's communicating with the lawyer (2).

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Recommendations are based on a combination of clinical experience and research-based evidence.

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Reducing or stopping the cycle of addiction, child abuse and neglect
- Decreasing the probability of relapse of substance abuse
- Improving a client's overall psychological and interpersonal functioning.
- Improving program treatment outcomes

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The effects of childhood abuse and neglect perpetrated by family members and the intergenerational transmission of the cycle of substance abuse and child abuse and neglect are the focus of this Treatment Improvement Protocol. However, not all clients in treatment have a history of childhood abuse, not all children who are maltreated become substance abusers or child abusers, and not all child abusers have a history of childhood abuse or current substance abuse. Although these are common factors that often arise in substance abuse treatment, they are not present in every case.
- The most pervasive form of child maltreatment is neglect (60 percent); however, because most research has focused on childhood physical and sexual abuse, this Guideline primarily addresses these two forms.
- Throughout this Treatment Improvement Protocol, the term "substance abuse" has been used in a general sense to cover both substance abuse

disorders and substance dependence disorders (as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition [DSM-IV]). Because the term "substance abuse" is commonly used by substance abuse treatment professionals to describe any excessive use of addictive substances, in this Treatment Improvement Protocol it is used to denote both substance dependence and substance abuse disorders. The term relates to the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs in order to determine what possible range of meanings it covers; in most cases, however, the term will refer to all varieties of substance use disorders as described by the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Treatment Improvement Protocols are distributed to facilities and individuals across the country.

The original Treatment Improvement Protocol document includes resources to help providers implement the recommendations in the Treatment Improvement Protocol.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Treatment Improvement Protocol Series 36 Consensus Panel. Substance abuse treatment for persons with child abuse and neglect issues. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment; 2000. (Treatment improvement protocol (TIP) series; no. 36). [353 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2000

GUIDELINE DEVELOPER(S)

Substance Abuse and Mental Health Services Administration (U.S.) - Federal Government Agency [U.S.]

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

Treatment Improvement Protocol (TIP) Series 36 Consensus Panel

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Available from the [National Library of Medicine Health Services/Technology Assessment Text \(HSTAT\) Web site](#).

Print copies: Available from the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20852. Publications may be ordered from [NCADI's Web site](#) or by calling (800) 729-6686 (United States only).

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on December 18, 2000. It was verified by the guideline developer as of January 25, 2001.

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