SCHOOL OF LAW
Center for Families,
Children and the Courts

Benchbook on Substance Abuse and Addiction for Family Courts

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Introduction

The well-documented prevalence of substance abuse and addiction in the criminal justice system has drawn a robust response in the past few decades. Hundreds of drug court programs nationwide are transforming the lives of criminal defendants with effective treatment for substance abuse. It is perhaps surprising, therefore, that many family justice systems have not devoted comparable attention or resources to address the pervasive substance abuse and addiction among the children and families who find themselves in family court.

Substance abuse and addiction inflict upon families and children the same destructive and debilitating consequences as they do to those involved with the criminal justice system. Family court judges and staff routinely face children beginning to experiment with alcohol, tobacco, and illegal drugs for the first time; teenage addicts mired in environments that seem to offer no escape from addiction; and adults struggling with family crises made many times worse by addiction.

These complex family cases nearly always involve myriad other issues, such as abuse and neglect, delinquency, mental health problems, and truancy. For example, a significant correlation exists between drug use in the home and the occurrence of child abuse and neglect. The Maryland Citizens' Review Board for Children has found that over half of all cases in which children are removed from families because of abuse and/or neglect involve at least one parent who abuses alcohol or other drugs.[1]

Despite the high incidence of substance abuse and addiction among families in family courts, only a few of these courts document the extent of these disorders among family court litigants. The paucity of available family court data and the abundant statistics confirming the evidence of substance abuse and chemical dependency in the general population indicate that the problem of substance abuse remains largely unaddressed in the nation's family courts.

The University of Baltimore School of Law Center for Families, Children and the Courts (CFCC) was established by the University of Baltimore's School of Law to serve as a catalyst to improve the delivery of legal, social, court, community and other services to families entering the family justice system. In particular, CFCC aims to develop, introduce, guide, and implement new

[1]Maryland Department of Human Resources, Citizens Review Board for Children Out-of-Home Placement Annual Report, 2004, at 5 (2004).

approaches to the array of family crises found in family courts. CFCC achieves this through a combination of innovative thinking, community activism and outreach, academic rigor in evaluation, and volunteer leadership by members of the judicial and legal communities.

Recognizing that family courts increasingly face issues of substance abuse and addiction among families and children, CFCC has undertaken several initiatives to promote a greater awareness and a better understanding about the impact of substance abuse and addiction among families and children involved in family legal proceedings.

On September 23, 2005, CFCC, in partnership with the Maryland Administrative Office of the Courts (AOC), the Open Society Institute-Baltimore (OSI) and the American Bar Association (ABA) Standing Committee on Substance Abuse, took a groundbreaking step toward addressing the acute need among family court judges, masters, and court staff for more information on substance abuse and addiction. CFCC, the AOC, OSI, and the ABA co-sponsored a daylong conference on substance abuse and addiction for Maryland judges, court personnel, lawyers, and community service providers. The conference, entitled A Family Disease: The Impact of Addiction and Substance Abuse on Children, Families, Family Courts and Communities, addressed numerous topics related to addiction, including current research on the pathophysiology of alcoholism and chemical dependency, the effect of addiction on the family, and addiction as it relates to family court matters, among other issues.

The conference's primary goal was to create and strengthen linkages and collaboration between treatment systems and family courts. It aimed to achieve this by educating participants about addiction and substance abuse issues; providing information regarding best practices, resources, and science; and bringing together representatives from the family court system who are in a position to identify and address substance abuse and addiction among families and children. Participants included judges, masters, service providers, family law attorneys, prosecutors, public defenders, mediators, court administrators, and treatment providers, among others.

The conference was an unqualified success. CFCC, in partnership with its funders, designed the agenda to provide participants with substantive information regarding the science of addiction; guidance with respect to the role of the family court in addressing substance abuse and addiction; and practical information about programs, procedures, and other options available to family courts throughout Maryland.

Presenters included national leaders in the addiction field, such as H. Westley Clark, Director of the Center for Substance Abuse Treatment; David Lewis, founder of the Center for Alcohol and Addiction Studies at Brown University; Hon. Karen Freeman Wilson, then-Chief Executive Officer of the National Association of Drug Court Professionals; and Hon. Peggy Hora, Alameda County (California) Superior Court (ret.). Experts, leaders and advocates in addiction issues from Maryland also were represented throughout the conference program, including: Peter Luongo, Ph.D., Director of the Alcohol and Drug Abuse Administration; Robert Schwartz, then-Director of OSI's Drug Addiction Treatment Program; and Gray Barton, Executive Director of the Commission on Problem-Solving Courts of Maryland.

In a survey of Maryland Circuit Court judges and masters conducted by CFCC prior to the conference to determine the perceptions and information needs of family courts, nearly all the respondents indicated that substance abuse and addiction were factors in a significant number of their cases. Nearly sixty percent of the judges and masters in the Baltimore City Circuit Court said that over half of the child abuse and neglect cases involved parental alcohol and/or substance abuse. Almost fifty percent of the judges and masters throughout the state reported that abuse of alcohol and other drugs was a significant factor in the majority of domestic violence cases. Twenty-five percent indicated that the abuse of alcohol and other drugs was a factor in the majority of delinquency cases. The underlying message in all of the responses to the questions was the same: Substance abuse and addiction were major factors in many, if not most, of the cases in family court.

At the same time, only one quarter (24 percent) of the judges and masters asked court staff for information on an individual's use of alcohol and other drugs. In addition, just one-third (34 percent) referred a litigant for a drug and alcohol assessment if an allegation of substance abuse or addiction arose during a scheduling assignment. Nearly all respondents (90 percent) indicated they would send a litigant to a treatment provider under these circumstances. Other findings include the following:

◗ Over half of the judges and masters (58 percent) believed that substance abuse disorders and addiction should be treated primarily as a chronic disease. A substantial majority (82 percent) believed that early intervention was the most effective means to address substance abuse disorders and/or addiction.

◗ One-third of the respondents believed that a significant number (50–75 percent) of the abuse and neglect cases before them involved the abuse of alcohol and/or other drugs.

◗ Two-thirds indicated that programs addressing co-occurring disorders were lacking or in short supply in their jurisdictions.

◗ Only a little over half (55 percent) of respondents believed that limited access to treatment programs was a barrier in their jurisdictions. The barriers most often cited was lack of insurance coverage for treatment and affordability.

◗ A substantial majority (60 percent) stated that screening instruments would be useful on the bench. An even higher number of respondents (70 percent) felt that a benchbook on alcohol and other drugs would be useful.

CFCC took particular interest in the respondents' substantial demand for a benchbook providing information about substance abuse and addiction in the context of family court. CFCC subsequently developed this benchbook to assist judges and court personnel to manage family law cases involving an addicted family member.

The benchbook opens with a chapter on the science of addiction. In recent years, basic research in the fields of neurochemistry and neurobiology has yielded empirical evidence of altered brain chemistry and anatomy in addicted individuals. This research supports the notion

that alcoholism and drug dependence are chronic illnesses and are treatable, but not necessarily curable, disorders. Scientific studies of alcoholism have demonstrated not only alterations in body chemistry and function, but also have shown that some alcoholics have identifiable genetic markers that predispose them to process and experience alcohol differently from non-alcoholics. Research on drug dependent individuals has revealed that the characteristics of the addictive process vary depending upon the chemical make-up of the drug, how it is used (e.g. orally, injected, or inhaled), the user's psychological make-up, genetic factors, and the user's environment. This chapter explains how and why family court judges, masters, and staff should view addiction as a complex and lifelong disease that requires an individual's sustained commitment to recovery.

Given the remarkable inroads made by substance abuse and addiction researchers, it is not surprising that addiction treatment has undergone major changes in the past few decades. Chapter Two of the benchbook discusses the most recent developments in addiction treatment. As the understanding of the biochemical and genetic antecedents of addiction has become more sophisticated, so, too, has knowledge about treatment's efficacy. This chapter examines criteria to determine addiction and the effectiveness of specific treatment modalities. It also reviews various treatment settings, ranging from long-term inpatient placements to outpatient clinics offering programs of graduated intensity, and various programs for special populations, including women, adolescents, and addicts who suffer from mental illness.

Chapter Three offers a perspective of addiction that is family-focused. A family member who suffers from addiction or substance abuse has a profound impact on family dynamics. Family members sustain both physical and psychological effects from living with an alcoholic or substance-abusing spouse/partner, parent, or child. As the chapter explains, the physical effects of an alcoholic or addicted parent on children include premature birth, low birth weight, respiratory disorders, sleep disorders, sexually transmitted diseases, and increased risk of physical abuse and injurious accidents. Children of alcoholics are more prone to attention deficit spectrum disorders, conduct disorders, depression, poor academic performance, and anxiety. Adult partners of addicts often attempt to compensate for deficits in the addict's behavior and responsibilities, as do children, who may be thrust into parental roles. Finally, the chapter explains how, in light of the fact that all family members are affected by alcoholism and drug dependence, the entire family needs treatment.

Chapter Four examines adolescent alcohol and substance abuse. Although the rates of drug and alcohol use vary among teens in Maryland and across the nation, teenage drinking and illicit drug use is a significant public health problem. As the chapter points out, it is critical to distinguish between adolescent addiction and certain types of experimental teenage drug and alcohol use that do not necessarily call for intensive treatment. The chapter discusses the potential consequences of more serious adolescent substance abuse, including, for example, the greater likelihood of developing adult alcoholism and substance use disorders. The chapter explains why ado-

lescent drinking and substance abuse are particularly dangerous, given the development of the adolescent brain, and why alcohol and drug abuse among adolescents is characterized by a unique set of issues that place youth at greater risk for long-lasting physical, social, and psychological problems. Finally, the chapter describes the key components of effective treatment for adolescents.

The need to intervene early in the cycle of substance abuse, experimentation, and addiction among both adolescents and adults is without question. The family court is in a powerful position to act promptly and positively to affect the lives of litigants suffering from substance abuse problems. Chapter Five addresses several underlying issues that plague many families involved with the family court system. The chapter looks at the types of cases where substance abuse and/or addiction are an issue and makes several recommendations to develop and implement a holistic approach to substance abuse and addiction.

The appendix provides a list of additional resources available to assist families in recovery.

The Maryland family justice system enjoys a national reputation for its court-based and court-referred services to families and children in court. We hope that this benchbook serves as an important tool to guide judges and court staff as they grapple with the broad range of substance abuse and addiction issues that affect families and children in court.

Chapter One: The Science of Addiction

Chapter Highlights

I. Characteristics of Addictive Illnesses

◗ Dependency inducing drugs and alcohol are selectively addictive—most users do not become physically and psychologically dependent on them.

◗ Alcoholism and drug dependence are chronic illnesses. A chronic illness is treatable, but may not be curable.

◗ The course of chronic illnesses such as addiction may include periods of remission or abstinence and relapse (resumption of drug and/or alcohol use).

◗ Addiction may require a lifelong commitment to recovery, which may include treatment at the outset and ongoing participation in a supportive network of self-help, such as Alcoholics Anonymous or Narcotics Anonymous.

◗ If untreated, alcoholism and drug dependence may result in premature death.

II. Risk Factors for Addictive Illnesses

A. Alcoholism

◗ Alcoholism is a complex genetic disorder involving the interaction of a number of different genes.

◗ The composition of genetic material in some alcoholics affects:

—how alcohol is metabolized or broken down;

—how alcohol is experienced (alcoholics generally have a higher tolerance for alcohol, thus they must consume more to achieve a desired effect);

—how the brain functions (brain waves in alcoholics may differ from those of non-alcoholics);

—how the brain is structured (distortions in the size of at least one section of the brain appear to be transmitted to offspring of alcoholics).

◗ First-degree relatives, such as siblings, are three to five times more likely to become alcoholics. Twin studies demonstrate that, overall, twins are more likely than non-related individuals to develop alcoholism, even if they are raised apart.

Psychological Make-up

◗ There is no evidence for an alcoholic personality type.

Environmental factors

◗ The family and community milieu significantly influences individual attitudes about alcohol consumption.

B. DRUG DEPENDENCE

◗ The factors influencing a drug's abuse and dependence potential include:
—the drug's chemical composition
—the route of administration
—the user's environment
—the user's psychological make-up
—the effect of the drug on the central nervous system
—genetic factors

Chemical Composition

◗ Each drug's unique characteristics influence its potential for abuse and dependence. Some drugs, such as cocaine, are more powerfully reinforcing and, therefore, have a higher abuse and dependence potential because they reach their peak effect quickly.

Route of Administration

◗ Certain drugs, such as heroin and its derivatives and cocaine, may be used orally, nasally, intravenously or by smoking. Smoking and intravenous drug use produce the most rapid effects. As such, cocaine, methamphetamines and heroin, because they can be smoked or used intravenously, generally pose a greater risk for addiction.

Environment

◗ Some drugs are indigenous to certain neighborhoods and communities and are, therefore, more readily available to potential users.

Psychological Make-up

◗ Individuals with personality disorders, such as anti-social personality, and persons with mental illnesses, such as depression, are at greater risk for drug addiction.

Effect on the Central Nervous System

◗ An abusive pattern of drug intake interrupts regular brain functioning in that the drug replaces brain chemicals that normally mediate behavior.

◗ Drugs, such as cocaine and heroin, when used consistently, interfere with the chemicals that carry messages from one central nervous system cell to another, ultimately causing them to become deactivated.

◗ When a drug is abused, it becomes a necessary component for neurological functioning. This phenomenon accounts for some symptoms of addiction, which may include tolerance, depend-

ence, and withdrawal, as well as the aberrant behavior exhibited by addicts under the influence of drugs, such as euphoria, decreased inhibition, and mood swings.

Genetic Factors

◗ To date, there are several genetic variants that appear to be associated with a vulnerability to opiate and cocaine dependence.

III. Diagnostic Criteria

◗ The most widely accepted clinical criteria used to diagnose substance dependence and abuse are contained in the DSM-IV.

◗ Substance dependence and addiction are terms often used interchangeably, and addictive substances include both alcohol and other drugs.

◗ Tolerance (needing more of a drug or more alcohol to achieve the same effect) and withdrawal (specific symptoms occurring when drug or alcohol use is curtailed) are not required to make the diagnosis of substance dependence.

The Science of Addiction

Introduction

Addiction manifests itself as a chronic and progressive disease characterized by periods of uncontrolled drug and/or alcohol use and abstinence or, in extreme cases, continuous use that leads to premature death.[1] Researchers investigating the genetics of opiate and cocaine addictions describe them as "chronic relapsing diseases with complex etiologies, significant co-morbidities (e.g. human immunodeficiency virus, hepatitis B and C infections, depressive and anxiety disorders, and other psychiatric illnesses) and major socioeconomic consequences."[2]

Addictive diseases are multifaceted illnesses involving an array of risk factors that include genetic, psychological and environmental determinants.[3] Pathological drug and alcohol use is categorized by degrees ranging from abuse to dependence or addiction, terms often used interchangeably. Addictions frequently are classified according to the particular drug of choice, e.g. alcohol, opiate or cocaine addiction. Although the chemical composition and the physiological effect of the substance are drug specific,[4] all addictive diseases share many common characteristics, as well.

[1]*See generally* Vernon E. Johnson, *I'll Quit Tomorrow: A Practical Guide to Alcoholism Treatment* (1980) (explaining the dynamics of the disease of alcoholism).

[2]Mary Jeanne Kreek, Gavin Bart, Charles Lilly, K. Steven Laforge, & David A. Nielsen, *Pharmacogenetics and Human Molecular Genetics of Opiate and Cocaine Addictions and Their Treatments*, 57 Pharmacol. Rev.1, 2 (2005) [hereinafter Kreek et al.].

[3]*See generally* Charles P. O'Brien, *Research Advances in the Understanding and Treatment of Addiction*, 12 Am. J. on Addictions 536 (2003) (positing a multi-factorial explanation for vulnerability to addictive illnesses).

[4]*See id.* at 537–38 (explaining that the pharmacologic characteristics of drugs of abuse distinguish their effects and addictive properties).

The most widely accepted clinical criteria for diagnosing addictive diseases are contained in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) published in 1994. According to the *DSM-IV*: "Substance dependence is contingent upon the presence of three or more of the following symptoms occurring within the same 12-month period:

—Tolerance, defined by the need for increased amount of substance to achieve the desired effect or diminished effect with continued use of the same amount of substance;

—Development of a characteristic withdrawal syndrome when the substance is stopped or the use of the substance to prevent the onset of withdrawal;

—Increased or prolonged use;

—A desire or unsuccessful attempts to cut down or control use;

—Significant time spent in activities related to drug procurement, use, and recovery;

—Important social, occupational, or recreational activities are sacrificed because of substance use; and

—Ongoing use despite knowledge of ongoing physical or psychological harm related to substance use.[5]

The DSM-IV distinguishes substance dependence from substance abuse in the following ways, one of which must significantly interfere with normal functioning during a 12-month period:

—Substance use results in failure to fulfill major work, school or home obligations;

—Recurrent substance use in hazardous situations;

—Recurrent substance-related legal problems; and

—Continued use despite persistent or recurrent social or interpersonal problems related to substance use.

Research in the field of addiction medicine generally has addressed either alcoholism or addiction to other drugs. In either case, it is important to note that not all users become physically dependent upon these substances. The individual's genetic composition, biochemical make-up, psychological profile, and social environment determine the variations in the rates of addiction.[6] Those variations also are impacted through the chemical composition of the drug and the manner in which it is administered.[7] We shall discuss alcoholism and addiction to other drugs separately. We use the terms "addiction" and "dependence" to describe pathological drug and alcohol use, as described in the DSM-IV classification of substance dependence.[8]

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[5]American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders IV* 182 (1994) [hereinafter DSM-IV].

[6]See O'Brien, *supra* note 3, at 536–38.

[7]*See id.*

[8]See DSM-IV at 182.

I. Alcohol Dependence

HISTORICAL OVERVIEW

Alcohol dependence is a leading cause of premature death in the United States.[9] It is a chronic and progressive disease with anatomical, physiological, genetic, and psychological components, and its course is characterized by physical, psychological, and family dysfunction. Alcohol dependence or abuse affects 14 million Americans.[10]

The causes of alcohol dependence first were brought to public attention by Alcoholics Anonymous (AA) in 1934.[11] Although epidemiological studies and basic research came later in time, the founders of AA drew on insights gained from their own experience with the illness. They understood that alcoholics fundamentally were different from other people who consumed alcohol and that, in order to stave off severe physical consequences and early death, these individuals needed to abstain from drinking alcohol.[12]

Unfortunately, the general public until recently has continued to view alcoholism as a moral failing.[13] With the publication in 1960 of E.M. Jellinek's book, *The Disease Concept of Alcoholism*,[14] public opinion has shifted to account for the fact that some people can consume alcohol responsibly, while others cannot stop drinking and suffer serious consequences as a result. Jellinek's book, which depicts treatment as a legitimate response to alcoholism, has galvanized professionals in the fields of medicine, psychology, and social work to pursue careers treating alcoholics and their families.

With the advent of more sophisticated treatment models for alcoholism,[15] there was a proliferation of laboratory studies on the genetic, biological, and neurochemical levels. In 1989, a large-scale study was undertaken to investigate genetic links to alcoholism. The Collaborative Study on the Genetics of Alcoholism (COGA), a continuing study in six sites nationwide, gathered information from families in which one or more members were diagnosed with alcoholism.[16]

To date, COGA has demonstrated that there are areas on six chromosomes that appear to predispose an individual to alcoholism and other addictions.[17] Although there is no conclusive

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[9]*See* Tatiana Foroud & Ting-Kai Li, *Genetics of Alcoholism: A Review of Recent Studies in Human and Animal Models*, 8 Am. J. on Addictions 261 (1999).

[10]*See* Scott Edwards & Alison Forsythe, *Examining the Neurobiological Consequences of Alcoholism*, 11 The Harvard Mahoney Neuroscience Inst. Ltr. 1 (2005).

[11]*See* http://www.time.com/time/time100/heroes/profile/wilson01.html.

[12]*See* Alcoholics Anonymous, The Story of How Thousands of Men and Women Have Recovered From Alcoholism, 21 (4th ed. 2001) [hereinafter Alcoholics Anonymous] (explaining, in what has become the handbook for alcoholics in recovery and also is known as the "Big Book," that at some point all alcoholics lose control over alcohol consumption).

[13]*See id.* at 140 (noting the common misunderstanding that alcoholics are weak-willed individuals).

[14]*See* E. M. Jellinek, The Disease Concept of Alcoholism (1960) (proposing that alcoholism should be considered a chronic illness, which is susceptible to specific treatment interventions).

[15]*See id.*

[16]*See* Foroud & Li, *supra* note 9, at 263.

[17]*See* Kreek et al., *supra* note 2, at 5.

evidence regarding the causes of addiction, there is enough empirical data to support the view that genetics play a significant role in one's vulnerability to alcoholism.[18]

RISK FACTORS FOR ALCOHOLISM

Alcohol is a powerful stimulant that induces agitation and a relaxant that sedates the centers of the brain governing behavior and thought.[19] A propensity for alcohol abuse and dependence is contingent upon the psychological make-up of the individual, the environment, and genetic composition.

GENETIC/ENVIRONMENTAL FACTORS

Alcoholism is a family disease in that it affects the dynamic relationships between and among family members. Genetic mapping, which demonstrates correlations between specific genes and hereditary diseases, has led scientists to describe alcoholism as a familial disorder, as well. Large-scale studies of alcoholic patients demonstrate that certain families are prone to the disease.[20] For example, first-degree relatives of alcoholics, such as siblings, are between three and five times more likely to become alcoholics.[21] Controlled studies, which include families where children have been cared for outside the home, demonstrate the same degree of risk of alcoholism for them as for those siblings raised in the same household as the alcoholic member.[22] Studies of twins demonstrate that an identical twin is more likely to develop alcoholism if his/her twin is alcoholic, as is a fraternal twin under the same circumstances. Twins, whether identical or fraternal, are more likely than non-related individuals to develop alcoholism, even if they have been raised apart.[23]

Geneticists suggest that alcoholism is a complex genetic disorder involving the interaction of a potentially large number of genes, each of which has some effect on risk for alcohol abuse or dependence.[24] There also are environmental risk factors for developing the disease. As is the case with other medical conditions, such as adult onset diabetes and hypertension, both genetic and environmental components are important factors in determining the origins of the disease and in promoting a greater acceptance of alcoholism as a chronic illness rather than a willful destructive behavior.[25] Genetic factors likely account for 40–60 percent of the risk for alcoholism,[26] while environmental factors account for the remainder.[27]

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[18]*See* Foroud & Li, *supra* note 9, at 261; See also Mark A. Schuckit, *Genetics of the Risk for Alcoholism*, 9 Am. J. on Addictions 103, 104 (2000) (positing that alcoholism is caused by a number of genetic variants).

[19]*See* Edwards & Forsythe, *supra* note 10, at 1 (describing the effects of excessive alcohol intake including impaired motor skills, speech and memory deficits, and personality changes).

[20]*See* Foroud & Li, *supra* note 9, at 263 (describing COGA, a multidisciplinary six-site study of alcoholic families).

[21]*See id.* at 261.

[22]*See id.*

[23]*See id.* (noting "estimates of heritability ranging from 50–60 percent").

[24]*See id.*

[25]*See* O'Brien, *supra* note 3, at 540, 541(suggesting that addiction should be treated as a chronic disease and included within the category of other chronic illnesses such as hypertension, diabetes and asthma).

[26]*See* Schuckit, *supra* note 18, at 104; *But see* Foroud & Li, *supra* note 9, at 261 (suggesting that the heritability risk is as much as 50–60 percent).

[27]*See* Schuckit, *supra* note 18, at 104.

BIOCHEMICAL FACTORS

Enzymes are biochemical products that assist the body with processing (metabolizing) food, vitamins, alcohol, and other drugs. When alcohol is ingested, the metabolic process first yields acetaldehyde, which causes the unpleasant side effects of drinking, such as skin flushing, increased heart rate and blood pressure, and nausea.[28] Researchers have found that some forms of the enzyme responsible for converting acetaldehyde work more quickly and efficiently and others virtually are non-functional.[29] People who carry the non-functional enzyme develop very high levels of acetaldehyde while consuming small amounts of alcohol.[30] In most cases, these individuals do not generally drink alcohol because of its noxious side effects and, therefore, are thought to have virtually no risk of developing alcoholism.[31] In sum, biochemical processes, controlled by predetermined genetic factors, may have a significant impact on who develops the disease.

RESPONSE TO ALCOHOL INGESTION

Reports of alcoholic drinking patterns demonstrate that "early in their drinking careers [alcoholics] required large amounts of alcohol to have an effect."[32] Researchers, using this information, have hypothesized that a genetic deviation—a low level of response to alcohol (LR)—may influence the amount of alcohol a person needs to achieve a desired result.[33] Subsequent studies examining children of alcoholics indicate a strong correlation between LR and a family history of the disease.[34]

ELECTROENCEPHALOGRAPHY PATTERNS

As scientists have learned more about the way the brain works, specific electroencephalography (EEG) patterns or waves have been identified and linked to certain cerebral functions such as information processing and disinhibition.[35] Abnormal brain waves have been observed among subjects with mood disorders and alcohol dependence.[36] In fact, a significant subgroup of alcoholics exhibit the same abnormal brain wave pattern even after remaining abstinent from alcohol for long periods of time.[37] This observation has led researchers to suspect that there is a genetic trait that predisposes an individual to alcoholism.[38]

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[28]*See id.* at 106.

[29]*See id.*

[30]*See id.*

[31]*See id.*

[32]*Id.* at 107.

[33]*See id.*

[34]*See id.* at 108.

[35]*See id.*

[36]*See id.*

[37]*See id.*

[38]*See id.*

NEUROCHEMICAL FACTORS

Various human genetic research studies suggest that there are markers for predicting vulnerability to the disease of alcoholism. All of the scientific reports reviewed in preparing this material begin with the premise that the disease is a genetically complex disorder. Further research is needed to isolate and identify the specific genes that are relevant to alcoholism and how they factor into clinical manifestations of the disease.

ANATOMICAL FACTORS

Alcohol influences areas of the brain controlling cognition, memory, motor function, and emotions.[39] Brain imaging scans demonstrate diminished amounts of both gray and white matter (brain tissue) in the brains of alcoholic subjects.[40] The result is that alcoholics have smaller brains and suffer deficits in cerebral functioning.[41]

Anatomical studies on adolescent offspring of alcoholics have shown structural deficits in the brain even before the onset of drinking. These adolescents have a smaller amygdala,[42] the area of the brain that controls emotion and motivation, leading researchers to conclude that the reduced capacity of the brain to facilitate a feeling of well-being contributes to a predisposition for alcoholic drinking.[43] This anatomical variance also helps to support a link between heredity and alcoholism.

II. Drug Addiction

Research inquiries into how addictive drugs induce cravings, compulsive drug seeking, and loss of control recently have proliferated, generating a body of literature that demonstrates genetic links to certain molecular changes that likely account for the behavior of drug addicts.[44] It is important to note, however, that although research on drug dependence is separate and distinct from research on alcoholism, evidence of a genetic link in both conditions has influenced scientific inquiry into addiction to other drugs.[45] In addition, as mentioned later in this chapter, neuroscientists are beginning to note the similar effects of alcohol and other drugs on neurotransmission.[46]

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[39]*See id.*

[40]*See id.*

[41]*See id.*

[42]*See id.*

[43]*See id.*

[44]*See id.*; *See also* Eric J. Nestler, *Molecular Neurobiology of Addiction*, Am. J. of Addictions, 201, 203, 212 (2001) (describing neuro-cellular changes that may be caused by addictive substances).

[45]*See* Kreek et al., *supra* note 2, at 5.

[46]*See id.* at 3.

RISK FACTORS FOR DRUG ADDICTION

Molecular and Neurobiological Factors

Since opiates (e.g., heroin) and cocaine are responsible for much of the adverse health and social consequences of addiction, they frequently are the subjects of scientific investigation into the links between genetics and drug addiction.[47]

According to the 2010 National Survey on Drug Use and Health, there were 140,000 persons aged 12 or older who had used heroin for the first time in the past year.[48] Cocaine addicts number 1 million Americans, according to a 2010 survey conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), and 700,000 people aged twelve and older received treatment for cocaine use in 2010.[49] Cocaine and heroin addictions provide the context for the following discussion about the genetics of addiction.

The mechanism by which opiates and cocaine affect human beings can be understood in several domains: (1) the pharmacology of the drug; (2) the user's environment; (3) the user's psychological make-up; (4) the interaction of the drug with neuro-chemicals and structures in the central nervous system (brain); and (5) genetic factors.[50] These variables influence individual responses to drugs of abuse and are useful tools to predict substance dependence.[51]

Pharmacologic Factors

All drugs of abuse (including alcohol), by definition, make the individual (or even the laboratory animal) want to take them again because the drugs make them feel good. Each drug has its particular set of characteristics, such as how quickly it takes effect, how long that effect persists, and how it is administered—whether by mouth, injection or inhalation.[52] Consequently, some drugs have a greater potential for abuse than others do.[53]

Cocaine is a drug with an especially high risk of addiction. It has a rapid onset, producing euphoric effects rather quickly, which accounts, in part, for its popularity.[54] Cocaine also is short acting in that its peak effect lasts 15–30 minutes, prompting a powerful urge to use again.[55] More frequent and concentrated exposure increases the abuse potential as well.[56] The route of administration is an additional factor in addiction potential—a drug is more powerful in its effect and, therefore, more compelling as a drug of choice, depending on the rate it is absorbed by the brain.[57]

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[47]*See id.*

[48]*See* Substance Abuse and Mental Health Services Administration, *Results from the 2010 National Survey on Drug Use and Health: National Findings* (2011) http://oas.samhsa.gov/nsduh/2k10nsduh/2k10ResultsP.pdf (noting updated data for drug use patterns).

[49]*See id.*

[50]*See* O'Brien, supra note 3, at 537–540; *See also* Kreek et al., *supra* note 2, at 19 (noting that there appears to be some correlation for genetic links to opiate and/or cocaine addictions).

[51]*See id.* See also Kreek et al., supra note 2, at 19.

[52]*See* O'Brien, *supra* note 3, at 538.

[53]*See id.*

[54]*See id.*

[55]*See id.*

[56]*See id.*

[57]*See id.*

For this reason, crack, an inhalable cocaine by-product, has a high addiction potential because it is rapidly absorbed and, therefore, its effects are nearly immediate.[58]

ENVIRONMENTAL FACTORS

The environment surrounding the user, including neighborhood demographics and ecology, influence whether drug use is prevalent and what drugs are used.[59] In the case of heroin, the fact that it is endemic to certain neighborhoods and regions of the country is well documented. Baltimore City, for example, frequently is cited as having a heroin problem of epidemic proportions.[60] Within Baltimore, certain neighborhoods and even specific areas within neighborhoods, such as the one described in the book, *The Corner*, are more conducive to heroin use.[61]

The availability of drugs in the marketplace also affects patterns of use.[62] Crack cocaine is endemic to inner city neighborhoods,[63] while methamphetamine use is more prevalent in the rural Midwest.[64] Other variables within an individual's environment that are associated with drug use are found within family and social networks.[65] Peer groups significantly can influence individual behavior, particularly among adolescents, exerting pressure to experiment with drugs.[66] Other influences include role models such as parents, entertainers, and sports figures, as well as song lyrics and movies that glamorize the drug culture.[67]

PSYCHOLOGICAL FACTORS

Personality types are shown to be significant predictors of addiction.[68] Once again, data from studies of drug use patterns demonstrate that many more persons try drugs than become dependent upon them.[69] This variation in rates of dependence is explained in part by personality types. Individuals prone to "risk-taking behavior" are more likely to continue drug use after initial exper-

[58]*See id.*

[59]*See id.* at 539.

[60]*See* Barbara A. Babb & Judith D. Moran, *Substance Abuse, Families and Unified Family Courts: The Creation of a Caring Justice System*, 3 Journal of Healthcare Law & Pol'y 1, 19 n.97 (1999) (citing data from a 1997 study of Baltimore City arrestees demonstrating that rates of heroin use among this population were higher than for any other city testing the same group).

[61]*See generally* David Simon & Edward Burns, *The Corner: A Year in the Life of an Inner City Neighborhood* (1997) (chronicling the authors' study of a neighborhood gathering place for drug dealers and addicts in Baltimore, Maryland).

[62]*See* O'Brien, *supra* note 3, at 539.

[63]*See* http://www.nida.nih.gov/Infofacts/cocaine.html (noting that NIDA's Community Epidemiology Work Group found in 2002 that crack/cocaine was endemic in almost all areas studied, including Chicago, Baltimore, Dallas, Newark, Atlanta, Boston, San Francisco and New York).

[64]*See* Monica Davey, *Grisly Effect of One Drug "Meth Mouth,"* N.Y. Times, June 11, 2005 at A1 (describing the prevalence of methamphetamine use in the Midwestern United States). *See also* Kate Zernike, *A Drug Scourge Creates Its Own Form of Orphan*, N.Y. Times, July 11, 2005 at A1.

[65]*See* O'Brien, *supra* note 3, at 539.

[66]Interview with Charlanne Zepf Bauerlein, LCSW, Director of the Adolescent Programs, The Freedom Institute, in New York City, N.Y. (July 1, 2005).

[67]*See* O'Brien, *supra* note 3, at 539 (noting the environmental forces that influence drug use).

[68]*See id.* at 538.

[69]*See id.* at 540 (summarizing results from the National Comorbidity Study).

imentation,[70] as are anti-social personality types.[71] Mental illness also appears to be a risk factor for chemical dependence—some researchers observe that people suffering from mental illness "self-medicate" with drugs.[72] For example, cocaine is an antidote to the lethargy induced by depressive illnesses.[73] Mood-altering substances also appear to contribute to psychiatric disturbances.[74] In sum, personality as a factor in addiction is best understood as a co-morbid condition that either accounts in part for the genesis of the disease or develops as the addictive illness takes hold.

NEUROCHEMICAL AND NEUROBIOLOGICAL FACTORS

An abusive pattern of drug intake interrupts regular brain functioning in that the drug takes the place of brain chemicals that normally affect behavior.[75] Drugs, such as cocaine and heroin, enter the brain and disrupt neurotransmission (the messaging system between cells) by taking the place of the chemical that assists with transferring messages from one brain cell to another.[76] In order for addiction to take place, the drug must be used repeatedly, causing the usual messaging system to adapt to the changes in brain chemistry and allowing the replacement (cocaine or heroin) to take over. The chemicals that normally transmit messages are deactivated and replaced; consequently, the drug becomes essential for neural functioning.[77] This process helps explain some of the symptoms of addiction: tolerance, dependence and withdrawal, and the behavior characteristics of addicts under the influence of mood altering chemicals, such as euphoria, decreased inhibition, and mood swings.[78]

A more speculative explanation of addiction comes from studies of opiates and their effect on neurogenesis, the growth and development of new central nervous system cells (neurons).[79] Stimulants, like cocaine, increase the output of dopamine, the neural chemical that promotes pleasurable feelings.[80] Increased amounts of dopamine change the anatomical structure of neural cells, specifically the structures known as dendrites (branchlike structures attached to the cell body, which facilitate uptake of neural chemicals), enabling them to absorb more dopamine. As the cells are then able to take in more of the dopamine that produces these sensations, cocaine

[70]*See id.* at 538.

[71]*See* Arnold M. Washton, *Cocaine Addiction: Treatment, Recovery and Relapse Prevention*, 25 (1989) (explaining that among the substance abusing population, personality disorders are prevalent).

[72]*See* O'Brien, *supra* note 3, at 539.

[73]*But see* Washton, *supra* note 71, at 25 (noting that numerous cocaine addicts do not suffer from pre-existing psychiatric disorders and in fact psychiatric symptoms may be a consequence of altered brain chemistry resulting from cocaine use).

[74]*See id.* at 25.

[75]*See* generally Nestler, supra note 44 (detailing changes in cellular structures that may be influenced by cocaine and opiates).

[76]*See id.*

[77]*See id.* at 201.

[78]*See id.* at 201, 202 (noting that the changes in neurotransmission prompted by drugs of abuse likely occur at the molecular and cellular level leading to the abnormal constellation of behaviors that characterize drug addicts).

[79]*See* Nestler, *supra* note 44, at 213.

[80]*See* Washton, *supra* note 71, at 42.

intake is reinforced, as well.[81] Similarly, researchers have found that opiates decrease the number of neurons in the portion of the brain governing learning and memory, accounting for the diminished mental functioning typical of addicted patients.[82]

GENETIC FACTORS

Although the physiology of drug use and the addictive cycle generally is understood, there is no scientific consensus regarding the genetic factors that predispose individuals to drug addiction. Only a small percentage of casual drug users progress to a stage that can be categorized as substance dependence.[83]

There are numerous genes currently identified as having possible links to opiate or cocaine addiction and there is demonstrable evidence regarding a few genetic variants associating them with a vulnerability to opiate or cocaine dependence.[84]

III. Implications for Family Court Judges

Scientific advances in understanding the genetic, biochemical, psychological, and environmental factors contributing to substance use disorders are important in providing useful background information for judicial decision-making in family law cases involving an addicted family member(s). Judges should consider the following:

◗ Alcoholism is a complex genetic disorder. As such, the alcoholic may have grown up in an alcoholic family and may transmit the illness to his/her children.

◗ Owing to the possibility of the genetic transmission of alcoholism, children of alcholics are at risk for the illness and already may be using alcohol.

◗ Although there is no evidence of an alcoholic personality type, environmental factors within the family and in the community influence drinking behaviors.

◗ Drug dependence also is a complex disorder involving the chemical make-up of the user's drug of choice, the route of drug administration, the user's psychological and environmental profile, and his/her genetic inheritance.

◗ Owing to the complexities of alcoholism and drug dependence, comprehensive assessments on measures implicated by basic research findings are critical components of an accurate diagnosis and treatment regimen.

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[81]*See id.* at 42.

[82]*See* Nestler, *supra* note 44, at 213.

[83]*See* O'Brien, *supra* note 3, at 540.

[84]*See id.*

Chapter Two: Addiction Treatment

Chapter Highlights

I. Treatment Matching

Patient Placement Criteria (PPC-1) propounded by the American Society of Addiction Medicine (ASAM) measure six dimensions of addictive illnesses and offer a guide to place addicted individuals in the appropriate level and type of care. These dimensions include: intoxication/withdrawal, biomedical, emotional/behavioral, treatment readiness, relapse/continued use potential, and recovery environment.

II. Alcoholism Treatment

◗ No single demonstrably effective treatment approach appears to be superior to any other.

◗ Clinically tested effective treatment modalities include: brief interventions, motivational enhancement therapies, GABA and naltrexone therapies, the community reinforcement approach, bibliotherapy, behavior contracting, social skills, behavior marital treatment, and case management.

◗ Specific treatment protocols demonstrated to be effective in the treatment of alcoholics include: cognitive behavioral, motivational, and twelve-step focused interventions.

◗ Treatment experts stress the value of incorporating a variety of the above- mentioned strategies in an overall treatment regimen.

◗ Group therapy has been shown to be universally effective in the treatment of all addictive illnesses.

◗ The degree to which treatment specialists communicate empathic concern to their patients is also an important treatment outcome factor.

III. Opiate Addiction Treatment

◗ Methadone and the more recent opiate agonist drug, buprenorphine, are the most effective treatment interventions for opiate addictions.

◗ The effectiveness of pharmacological interventions is dependent upon dosage and length of treatment.

◗ The risk of relapse attendant to discontinuation of methadone and buprenorphine is high; thus, for many patients long-term, individualized maintenance may be indicated.

◗ Naltrexone, an opiate antagonist (blocker), can be administered orally and is an effective treatment. Its limitation is that patients generally show poor compliance with prescriptions for its use.

◗ In addition to medications, counseling, both psychosocial and employment- focused, and twelve-step-program participation may enhance positive treatment outcomes.

IV. Cocaine Addiction Treatment

◗ No drug therapies have been shown to be useful in the treatment of cocaine addictions.

◗ The most successful treatment modality for cocaine addicts appears to be behavior therapies structured around a system of incentives to promote abstinence.

◗ The incidence of co-occurring mental illness, including ADHD, depression, and antisocial personality disorder, is greater in stimulant abusers than in the general population.

V. Abstinence v. Moderation in Alcoholism Treatment

◗ In addition to abstinence-focused treatment, some experts support controlled drinking as a treatment goal.

◗ Controlled drinking is controversial. Supporters claim that it reduces the likelihood of the harmful effects of drinking, such as traffic accidents and chronic health problems. Critics of controlled drinking are concerned about how to determine which alcoholics will not be harmed further by this treatment strategy.

VI. Treatment Settings

A. Therapeutic Communities

◗ Therapeutic communities offer intensive long-term residential treatment in a structured and closely monitored environment.

B. Inpatient Treatment

◗ Inpatient treatment occurs either in a hospital-based alcohol/drug treatment facility or in a freestanding treatment center. These centers have the capacity to provide medically supervised detoxification.

◗ Treatment centers employ various types of treatment modalities, including the psychiatric model, the behavioral model and the twelve-step, abstinence-focused model.

◗ Multi-modal programs incorporate a full range of treatment interventions, including inpatient care, medications (e.g., buprenorphine and/or methadone), outpatient brief treatment, vocational and educational programming, family therapy, group and individual psychotherapy, and behaviorally focused interventions.

C. Outpatient Treatment

◗ Outpatient treatment incorporates many of the same techniques as inpatient treatment in a less intensive regimen.

◗ Generally, outpatient treatment is more appropriate for less seriously impaired alcoholics and drug-addicted individuals or as aftercare for an inpatient. The incorporation of buprenorphine into these outpatient programs may make them as successful as methadone programs for patients with opiate addiction.

VII. Treatment for Special Populations

A. Women

◗ Women account for 40 percent of the country's substance abusing population.

◗ Treatment strategies for women should take into account that often women seek treatment later, primarily because of concerns about losing custody of their children in child welfare proceedings.

◗ Addiction in women is complicated by the fact that many have suffered physical and verbal abuse.

B. Adolescents

◗ A hallmark of adolescent drug and alcohol treatment interventions is prevention programs, often found in school settings.

◗ Prevention programs that focus on life skills training, which promote a teenager's capacity to navigate social networks while refusing to take drugs, are the most effective.

◗ Although outcome studies for adolescent treatment are fewer in number than for adults, researchers have concluded that treatment can be effective.

◗ A significant number of teens who abuse and are dependent on drugs and alcohol also have co-occurring mental disorders.

C. Mentally Ill

◗ Significant numbers of alcohol and drug addicted individuals have co-occurring psychiatric illnesses.

◗ The relationship between the disorders is complex and individuals suffering from both need treatment that specifically incorporates modalities from the psychiatric and substance abuse fields.

◗ Screening and assessment for addiction should include screening for mental disorders.

Addiction Treatment

Introduction

In the early days of Alcoholics Anonymous (AA) and prior to its inception, alcoholics were sent to psychiatric institutions to "dry out" with the hope that this experience would generate a resolve to stop drinking.[1] This process was ineffective. In fact, AA was established as a reaction to the founders' negative experiences with medical intervention for alcoholism.[2]

"Treatments for alcohol abuse and dependence have changed substantially during the past decade, and the broad scope of demonstrably effective treatment modalities offers hope with regard to these troubling problems."[3] As addiction treatment has become more professional,

[1]*See generally* Alcoholics Anonymous, The Story of How Thousands of Men and Women Have Recovered From Alcoholism (4th ed. 2001) [hereinafter Alcoholics Anonymous].

[2]*See id.*

[3]Reid K. Hester, Ph.D. & Daniel D. Squires, M.S., M.P.H., *Outcome Research, Alcoholism, in Textbook of Substance Abuse Treatment* 129 (Marc Galanter, M.D. & Herbert D. Kleber, M.D. eds., 2004).

prompted in part by the establishment of the field of addiction medicine,[4] it has become more widely available and more focused.

In 1991, the American Society of Addiction Medicine (ASAM) proposed objective criteria for placing patients in the appropriate treatment setting. These criteria, known as Patient Placement Criteria (PPC-1), measured six dimensions of addictive illness: intoxication/withdrawal, biomedical, emotional/behavioral, treatment readiness, relapse/continued use potential, and recovery environment.[5] ASAM also defined types of treatment, known as "Levels of Care," which "were distinguished by the degree to which they provided medical management, structure, security and treatment intensity."[6]

Many of the strategies for treating addictions are used in treatment protocols for both alcoholism and drug addiction. Group therapy is perhaps the most common treatment intervention for alcoholism or other drug dependencies. "The group approach—in its powerful capacity to support and confront, to comfort and to challenge, and to involve its members in encounters that vividly heighten awareness of interpersonal and characterological problems and provide a safe place for change—is now viewed as the treatment of choice for addiction."[7]

The following discussion of specific treatment modalities is organized around three of the most prevalent addictions—alcoholism, opiate addiction, and cocaine dependence.[8]

I. Alcoholism Treatment

Several treatment interventions have demonstrated positive outcomes for individuals suffering from the spectrum of alcohol problems.[9] Treatment for alcoholism, no matter what type, is never universally effective, and no single approach has been found to be superior to all others.[10]

BRIEF INTERVENTIONS

Brief interventions "hold great promise for affecting drinking behaviors of individuals with alcohol-related problems."[11] This type of intervention can take place outside of alcohol treatment programs, enabling primary care physicians and other healthcare providers to give individualized

[4]*See* http://www.asam.org. (describing the mission of ASAM).

[5]*See* David R. Gastfriend, M.D. & Sandrine Pirard, M.D., *Patient Placement Criteria*, in Textbook of Substance Abuse Treatment 121–22 (Marc Galanter, M.D. & Herbert D. Kleber, M.D. eds., 2004).

[6]*Id.* at 122.

[7]Edward J. Khantzian, M.D., Sarah J. Golden-Schulman, Ph.D., & William E. McAuliffe, Ph.D., *Group Therapy* in Textbook of Substance Abuse Treatment 391, 401 (Marc Galanter, M.D. & Herbert D. Kleber, M.D. eds., 2004).

[8]*See* Charles P. O'Brien, *Research Advances in the Understanding and Treatment of Addiction*, 12 Am. J. on Addictions 536 (2003) (citing the National Comorbidity Survey, which includes data on the estimated prevalence of drug dependence among 15–54 year olds).

[9]*See id.* (noting a preference for the term 'alcohol problems,' which allows the disease to be considered on a continuum of presenting problems instead of 'alcoholism,' which implies a "unitary condition").

[10]*See* Shelly F. Greenfield, M.D., M.P.H. & Grace Hennessy, M.D., *Assessment of the Patient*, in Textbook of Substance Abuse Treatment 101 (Marc Galanter, M.D. & Herbert D. Kleber, M.D. eds., 2004).

[11]Hester & Squires, *supra* note 3, at 130.

and objective information to a patient about his/her drinking behavior.[12] Brief interventions share common features denoted by the acronym FRAMES,[13] which stands for Feedback, Responsibility, Advice, Menu of options, Empathic concern, and Self efficacy.[14]

MOTIVATIONAL ENHANCEMENT THERAPIES

This strategy is similar to the brief intervention, but it includes additional follow-up sessions with a professional treatment provider to encourage the patient to take action.

Y-AMINOBUTYRIC (GABA) AND NALTREXONE THERAPIES

These pharmacological therapies, in combination with other treatments, such as counseling, are used to increase the likelihood of abstinence and to reduce the chances of one slip becoming a binge-drinking episode. These medications reduce cravings for alcohol, although their effectiveness has not been evaluated in isolation from other interventions, and these drugs may be contraindicated for some patients, such as those with liver impairments.[15]

THE COMMUNITY REINFORCEMENT APPROACH

This treatment model is consistent with addressing the role of psychological and environmental factors that contribute to problem drinking.[16] Its approach involves the patient and the therapist in the exploration of the patient's drinking behavior, e.g., the role of alcohol in the patient's life, the environmental triggers that set into motion bouts of drinking, and the environmental factors that support ongoing alcohol abuse.[17] Once these psychological and environmental factors are identified and understood, the patient and the therapist develop and implement problem-solving techniques to reduce the impact of these stressors on the patient's abstinence. This treatment strategy has its roots in AA and other twelve-step programs. These programs focus on building awareness of negative thoughts and environmental forces, as well as effective strategies to overcome the influences that jeopardize sobriety.[18]

BIBLIOTHERAPY

One of the hallmarks of twelve-step programs is the study of recovery literature. *The Big Book*[19] is required reading for AA members. It outlines a practical guide to maintaining abstinence and achieving a sober lifestyle. Many treatment programs use literature as an adjunct to support the recovering alcoholic. Hazelden, one of the premier treatment centers in the United States, pub-

[12]See id.

[13]See id.

[14]See id.

[15]See id.

[16]See generally O'Brien, supra note 8.

[17]See Hester & Squires, supra note 3, at 131.

[18]See generally Alcoholics Anonymous, supra note 1.

[19]See id.

lishes a complete library of self-help literature[20] to aid those addicted to alcohol and other drugs and their families.[21] Studies to determine the effectiveness of bibliotherapy conclude that it is a useful tool in aiding the alcoholic to set goals, self-monitor, and learn coping skills.[22] Bibliotherapy has not been shown to benefit seriously ill alcoholics.[23]

BEHAVIOR CONTRACTING

Behavior contracting entails marshalling the support of significant persons in the addict's life—family members and/or a therapist—to reinforce abstinence. The specifics of these interpersonal contracts involve creating contingency plans to avert episodes of drinking.[24] This model has been used successfully in twelve-step programs, in which the alcoholic establishes a relationship with a sponsor, who usually is a well-established program member. Sponsors can be called upon for help and support at critical moments during the alcoholic's recovery period.[25]

SOCIAL SKILLS

Training recovering alcoholics to create and maintain interpersonal relationships has been found to be another useful tool in effective treatment.[26] Social isolation and inhibitions are significant issues for individuals in recovery.[27] Interpersonal skills, such as listening, assertiveness, and problem-solving techniques, are taught in group therapeutic settings and help reinforce recovery.[28] Given the demonstrated value of these skills and the fact that group therapy is an effective venue for learning and reinforcing them, it is not surprising that most treatment for alcoholism includes group work.[29]

MARITAL THERAPY

Therapeutic strategies to address marital issues between the alcoholic and his/her spouse are important treatment interventions. Marital therapy in the context of alcoholism treatment emphasizes the development of effective communication and problem-solving skills.[30] Therapy can take

[20]*See* http:// www.hazelden.org [hereinafter Hazelden].

[21]*See id.*

[22]*See* Hester & Squires, *supra* note 3, at 131.

[23]*See id.*

[24]*See id.*

[25]*See* Interview with Judith D. Moran, former clinical director, The Freedom Institute, May 10, 2006 in New York City [hereinafter Moran].

[26]*See* Hester & Squires, *supra* note 3, at 131.

[27]*See* Moran, *supra* note 25.

[28]*See* Hester & Squires, *supra* note 3, at 131.

[29]*See* Hazelden, supra note 20, (noting group therapy among the treatment modalities employed at the treatment center). See Khantizian, Golden-Schulman & McAuliffe, *supra* note 7, at 392 (explaining that the "most widely accepted treatment approach for addiction is the group," however, empirical studies documenting its effectiveness are limited).

[30]*See* Hester & Squires, *supra* note 3, at 132.

place either in joint sessions between the couple and a therapist or among couples in therapist-directed group sessions.[31]

CASE MANAGEMENT

Case management involves multiple brief follow-up contacts with the patient after the completion of short-term treatment. The therapist initiates phone calls to the patient to check on progress and to intervene early to address potential problems during the early recovery period.[32]

Overall, the research demonstrates that all of these interventions have merit, and that "no one treatment is more effective than all others."[33] Accordingly, treatment experts stress the value of incorporating a variety of strategies in a treatment regimen,[34] which is how many treatment programs are structured.[35] Similarly, three specific treatment protocols—cognitive behavioral, motivational, and twelve-step programs—have been found to support positive treatment outcomes.[36] Finally, and not surprisingly, the extent to which the treating therapist communicates empathy for the alcoholic during treatment encounters is a significant factor in achieving positive treatment results.[37]

II. Opiate Addiction Treatment

AGONIST MAINTENANCE THERAPY

Agonist (imitating the action of an opiate, such as heroin, but not producing the euphoria associated with these drugs) maintenance treatment for opiate addicts usually is conducted in outpatient settings, often called methadone treatment programs. In these programs, a long-acting synthetic opiate medication, usually methadone, is administered orally for a sustained period at a dosage sufficient to prevent opiate withdrawal symptoms. The medication blocks the effects of illicit opiate use and decreases opiate craving. Patients stabilized on adequate, sustained dosages of methadone can function normally.

METHADONE MAINTENANCE THERAPY

The most effective treatment intervention for addiction to opiates, such as heroin and oxycodone, continues to be methadone and the newer opioid agonist drug, buprenorphine.[38] Such treatment reduces opiate drug use and its adverse consequences, including mortality, morbidity,

[31]*See id.*

[32]*See id.*

[33]*Id.* at 134.

[34]*See id.*

[35]*See* Hazelden, *supra* note 20.

[36]*See* Hester & Squires, *supra* note 3, at 134.

[37]*See id.*

[38]Richard Steven Schottenfeld, *Maintenance Treatment*, in Textbook of Substance Abuse Treatment 291 (Marc Galanter, M.D. & Herbert D. Kleber, M.D. eds., 2004). *See also* Benedict Carey, *Between Addiction and Abstinence*, NY Times, May 7, 2006 at Sec. 4, 1 (describing buprenorphine as the latest pharmacological treatment option for opiate addictions).

HIV infection, and criminality. Methadone also has been proven to enhance social and vocational functioning.[39] Although methadone treatment is the most studied of all drug abuse treatments and has been widely available throughout the world since the 1960s, its acceptance has been compromised by public prejudice, political opposition, and urban myths (e.g., methadone rots bones).[40]

Methadone must be provided in specially licensed programs, which are highly structured and regulated. They require initially daily attendance, weekly or bi-weekly urine testing, and counseling. For these reasons, some patients do not find methadone appealing. Buprenorphine, approved by the U.S. Food and Drug Administration (FDA) for the treatment of opioid addiction, provides an alternative for patients who do not do well on methadone or who are not willing to take it. The efficacy of methadone and other pharmacotherapies depends on the dosage and length of treatment.

A recent randomized clinical study involved a group of heroin addicts being treated with a six-month methadone detoxification accompanied by very intensive and comprehensive counseling for 12 months. The study included a control group being treated with 12 months of methadone accompanied by counseling only once a week. The study showed a higher rate of relapse in the group that was treated with methadone for only six months.[41]

In any event, the "risk of relapse following discontinuation of methadone maintenance remains high, even for patients who have been maintained on methadone for prolonged periods, have made substantial changes in lifestyle, and achieved stable recovery while receiving treatment."[42] In other words, generally speaking, longer-term methadone treatment may be indicated for many patients.[43]

As with treatment for alcoholism, treatment modalities, like counseling, and supportive environmental structures, such as family support, job placement, and twelve-step program participation, are predictive of positive treatment outcomes.[44]

BUPRENORPHINE THERAPY

Buprenorphine is one of the most recent treatments for opiate dependence and addiction. In 2002, the FDA approved its use as a narcotic to treat opioid-dependent men and women who are not pregnant. Like methadone, it blocks the opioid from reaching the brain receptors and producing euphoria, but it has fewer side effects than methadone and milder withdrawal symptoms upon cessation. Physicians are allowed to prescribe buprenorphine in an office-based practice or health clinic after completing special training to prescribe the medication and agreeing to treat no more than 30 patients at a time in an office setting. Patients may pick up the medication in any

[39]*See* Schottenfeld, *supra* note 38, at 296.

[40]*See id.* at 296 (noting that notwithstanding the empirical evidence supporting its effectiveness, methadone programs are not sufficiently available to treat all of the addicts who otherwise would enroll in them).

[41]*See id.* at 297.

[42]*Id.*

[43]*See id.*

[44]*See id. See also* Moran, *supra* note 25.

local pharmacy. Physicians also must refer patients to appropriate counseling and support services. With the advent of buprenorphine therapy, patients dependent on heroin or prescription painkillers, such as oxycodone, now can receive treatment in their doctors' offices rather than being required to make daily visits to a centralized methadone clinic.

NALTREXONE THERAPY

Naltrexone also is effective against opiate addiction. It is a long-acting synthetic opiate antagonist (a drug that prevents other drug molecules from binding to opioid receptors). Naltrexone blocks all the effects of self-administered opiates, including euphoria. The theory behind this form of medication is that the repeated lack of the desired opiate effects, coupled with the perceived futility of using the opiate, gradually results in breaking the opiate addiction. While naltrexone itself is not addictive, patient noncompliance is a common problem. The most favorable treatment outcome requires that there also is a positive therapeutic relationship with a treatment provider, effective counseling or therapy, and careful monitoring of medication dosage compliance.

III. Cocaine Addiction Treatment

As with all drug treatment programs, it is important for cocaine addiction treatment programs to include the diagnosis and treatment of co-occurring mental disorders.[45] The incidence of mental disorders, such as attention deficit hyperactivity disorder (ADHD), depression, and antisocial personality disorder, proportionately is greater among those who abuse stimulants than in the general population.[46] Although medications such as anti depressants have not been proven effective in treating cocaine addiction alone, studies demonstrate that antidepressant drug therapy is effective in reducing cocaine use and cravings in cocaine addicts diagnosed with a depressive illness.[47]

IV. Abstinence v. Moderation

Traditional therapeutic perspectives on addiction treatment have stressed total abstinence over moderating drug and/or alcohol use.[48] In recent years, however, the notion of "harm reduction" or "controlled drinking" has become more prevalent in the treatment community.[49] Whereas current drug policies primarily measure success in addressing addiction and substance abuse by change in use rates, "harm reduction"[50] or "moderate use"[51] strategies focus on reducing the adverse

[45] *See id.*

[46] *See id.*

[47] *See id.*

[48] *See generally* Carey, *supra* note 38 (explaining that abstinence is the "dominant approach in the United States to resolving alcoholism and drug abuse").

[49] *See* Stanton Peele, http://www.peele.net/lib/cdvsabs.html (noting that controlled drinking has a legitimate role in alcoholism treatment, that it is an "appropriate goal for the majority of problem drinkers who are not alcohol dependent and that it often is a feature of the harm reduction model for treatment").

[50] *See id.*

[51] *See id.*

consequences of heavy use, such as deaths, crime, health problems,[52] accidents,[53] and child abuse and neglect.[54] Moderation-based recovery is the sustained reduction in an individual's use of alcohol and other drugs to a sub-clinical level—a level that no longer meets the DSM-IV criteria for substance abuse or dependence.[55] A recent study of "moderate use" treatment involving nearly 1,400 chronic drinkers found that this treatment produced good clinical outcomes in about three-quarters of the sample under investigation.[56]

Moderation-based recovery is controversial. At least one expert in the field believes that "moderate use" is "becoming more accepted in judging treatments."[57] The concern among many treatment professionals is the difficulty in identifying the types of addictions and personality types for which "moderate use" is a safe and effective treatment intervention.[58] If the goal of treatment is a choice between abstinence and moderate use, clearly the latter is more easily achievable and, therefore, considered by some experts to be more appealing than the former.[59]

In sum, the empirical findings regarding moderation-based treatment are limited. The most prudent course of action may be to turn to this treatment in limited circumstances,[60] such as a means to initially engage a patient in treatment.

V. Treatment Settings

The aforementioned interventions are incorporated into a wide range of therapeutic programs designed to treat alcohol and substance dependent individuals. The following descriptions are illustrative of the types of treatment programs that are available to addicts and their families.

THERAPEUTIC COMMUNITIES

Therapeutic communities (TCs) offer intensive long-term residential treatment in a structured and closely monitored environment.[61] TCs focus on the "re-socialization" of the individual and use the program's entire "community," including other residents, staff, and the social context, as active

[52]*See* National Center on Addiction and Substance Abuse (CASA) at Columbia University, Family Matters: Substance Abuse and the American Family (2005) at 19 (noting the illnesses common to substance abusers such as AIDS and hepatitis).

[53]*See id.* at 11 (describing the types of accidents common to alcohol and drug abusers).

[54]*See id.* at 2, 20.

[55]William White, M.A. & Ernest Kurtz, Ph.D., *The Varieties of Recovery Experience: A Primer for Addiction Treatment Professionals and Recovery Advocates*, in The Varieties of Recovery Experience, Great Lakes Addiction Technology Transfer Center 12–13 (2005).

[56]*See* Carey, *supra* note 38.

[57]*Id.* (quoting Dr. Edward Nunes, Professor of Clinical Psychiatry at Columbia University).

[58]*See* Moran, *supra* note 25. *See also id.*

[59]*See* Carey, *supra* note 38 (explaining that moderate use may be a convincing argument for subsidizing substance abuse treatment).

[60]*See id.* (citing experts who embrace moderate use as a first step in addiction treatment).

[61]*See* National Center for State Courts, Judicial Education on Substance Abuse: Promoting and Expanding Judicial Awareness and Leadership (citing the Treatment Protocol Effectiveness Study, Executive Office of the President, Office of National Drug Control Policy, Barry R. McCaffrey, Director, March, 1996) [hereinafter National Center for State Courts].

components of treatment. Addiction is viewed in the context of an individual's social and psychological deficits. Treatment emphasizes developing personal accountability and responsibility. Treatment is highly structured and can be confrontational, with activities designed to help residents examine damaging beliefs, concepts, and patterns of behavior and to adopt more constructive ways to interact with others. Many TCs are comprehensive, including employment training and other support services on-site.

Phoenix House, a large national network of residential treatment facilities that employ the TC treatment model, describes its program as follows: "Residents participate in one-on-one counseling therapy, group therapy, seminars, vocational training or educational programs, and supervised recreational activities."[62] Progress in treatment is characterized by achieving increasing levels of responsibility and freedom. Conversely, residents are held accountable for inappropriate behavior and lose privileges accrued over time in the program.[63] This rigorous and extended treatment modality is recommended for seriously addicted individuals with long-term drug dependencies.[64]

INPATIENT TREATMENT

Inpatient treatment occurs either in a hospital-based alcohol/drug treatment facility or a dedicated treatment center. These facilities have the capacity to provide medically supervised detoxification and drug treatment.[65] Among the largest and most well known treatment centers in the United States are the Betty Ford Center[66] in California, Hazelden[67] in Minnesota, and the Caron Foundation[68] in Pennsylvania. The centers offer residential treatment programs incorporating a vast array of modalities. Hazelden, for example, describes its treatment regime as follows: "peer interaction, individual counseling, group therapy and, based on individual needs, may involve specialty groups such as relapse prevention, anger issues, eating issues, cognitive behavioral therapy, women's issues, men's issues, gender issues, assertiveness, twelve-step group study, family issues and similar topics."[69]

The length of treatment in inpatient facilities depends on the patient's needs. A basic program incorporates the above-mentioned treatment modalities, sometimes referred to as primary treatment. That may be followed by intermediate and extended stay programs for individuals whose addictions involve more complex issues, such as mental illness, chronic relapse, or the use of multiple dependency-inducing drugs.[70]

The focus of treatment in inpatient settings is variable. Some programs are based on a psychiatric model, which uses "talking therapies" like group therapy, individual counseling and family

[62]http://www.phoenixhouse.org/National GetHelp/AboutTreatment.html.

[63]*See id.*

[64]*See* National Center for State Courts, *supra* note 61.

[65]*See id.*

[66]*See* http://www.bettyfordcenter.org.

[67]*See* Hazelden, *supra* note 20.

[68]*See* http:// www.caron.org.

[69]*See* Hazelden, *supra* note 20.

[70]*See id.* (describing the scope of Hazelden's treatment offerings).

therapy, and behavioral techniques incorporating relaxation and exercise.[71] Others are based on a twelve-step orientation, focused on maintaining abstinence and working through the AA steps.[72] Both the therapy-based model and the twelve-step model appear to be more effective with middle-age participants.[73] Finally, there are programs that incorporate several models—"inpatient treatment, medical care, outpatient brief treatment, vocational training, educational enhancement for adolescents, family therapy, adult or adolescent therapeutic communities, methadone maintenance, group psychotherapy, individual psychotherapy, drug education, and stress coping techniques."[74]

OUTPATIENT TREATMENT

Numerous outpatient treatment opportunities are available for drug and alcohol dependencies. These programs incorporate many of the same techniques utilized in inpatient programs. Although they often provide a less intensive regimen of therapeutic services, they vary in the time demands on patients.[75] Generally, outpatient treatment is more successful with less seriously impaired individuals and for those who have intact family structures and are employed.[76]

VI. Treatment for Special Populations

WOMEN

Women comprise 40 percent of the nation's chemically dependent population.[77] They often seek help for addictions in the later stages of the illness and require treatment accordingly.[78] Women avoid getting treatment for addiction because of childcare issues, fear of criminal prosecution for drug use during pregnancy, and fear of losing their children in child welfare court proceedings.[79] Treatment for women who are drug and alcohol dependent also must address issues relating to domestic abuse and family violence.[80]

MENTALLY ILL

The incidence of co-occurring psychiatric and substance use disorders was demonstrated in two large-scale epidemiological studies.[81] In a 1990 study, 45 percent of the participants with an

[72]*See id.*

[73]*See id.*

[74]*Id.*

[75]*See* Moran, *supra* note 25.

[76]*See id.*

[77]*See* Hazelden, *supra* note 20.

[78]*See id.* (noting that women respond better to "gender specific, warm and nurturing environments that allow sharing and self-renewal in women-only groups.").

[79]*See* National Center for State Courts, *supra* note 61.

[80]*See* Hazelden, supra note 20 (citing data estimating that 70 percent of chemically dependent women have been abused).

[81]*See* Kathleen T. Brady, M.D., Ph.D. & Robert J. Malcolm, M.D., *Substance Use Disorders and Co-occurring Axis I Psychiatric Disorders*, in *Textbook of Substance Abuse Treatment* 529 (Marc Galanter, M.D. & Herbert D. Kleber, M.D. eds., 2004) [citing the Epidemiological Catchment Area (ECA) study sponsored by the National Institute of Mental Health and the National Comorbidity Survey (NCS)].

alcohol use disorder and 72 percent of those with a substance use disorder had at least one co-occurring psychiatric illness.[82] In the other study, conducted in 1994, 78 percent of alcoholic men and 86 percent of alcoholic women "met lifetime criteria for another psychiatric illness."[83]

Clearly, there is a substantial connection between addiction and mental illness in the adult population. The relationship between substance use disorders and psychiatric illness is not only statistically significant, but otherwise complex in the following ways:

1. Substance use/dependence may pre-date and be a causative factor of mental illness or exacerbate its symptoms.
2. The disorders may co-exist independently.
3. Psychiatric illness may cause or worsen substance abuse/dependence.
4. Withdrawal from drugs and/or alcohol can mimic psychiatric disorders.[84]

Treatment for individuals harboring both mental illness and substance abuse or addiction must be tailored specifically to incorporate "treatment modalities from both the psychiatric and substance abuse fields."[85] Treatment strategies found to be most effective include psychosocial treatments,[86] such as talking therapies, and pharmacotherapies.[87] In addition, the frequent co-occurrence of substance abuse/dependence and mental illness means that patients entering treatment must be thoroughly assessed so that mental illness, if it exists, is addressed early on in the treatment process.[88]

VII. Implications for Family Court Judges

Individuals diagnosed with alcohol and substance use disorders must have access to specialized treatment that takes into account gender, type of addiction, and social, psychological, and economic factors. Accordingly, judges should consider the following when confronted with a family law case involving an addicted family member(s):

◗ Successful treatment outcomes, in part, are dependent upon matching the addict with an appropriate treatment modality.

◗ Treatment matching includes the following dimensions: symptoms of intoxication/withdrawal, treatment readiness, potential for continued use/relapse, and the environment where the addict will live during outpatient treatment or return to inpatient treatment.

◗ Community resources for drug/alcoholism treatment should be investigated thoroughly, cultivated, and updated to ensure the adequacy of court orders/referrals.

◗ As alcoholism and drug addiction are chronic illnesses, abstinence monitoring, relapse prevention, and support during periods of relapse must be part of the court process.

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[82] *See id.* (citing the ECA study).

[83] *Id.* (citing the NCS study).

[84] *See id.*

[85] *Id.* at 530.

[86] *See id.*

[87] *See id.*

[88] *See* Moran, *supra* note 25.

Chapter Three: Addiction and the Family

Chapter Highlights

I. Addiction is a Family Disease

◗ The family is an interactive and interdependent unit made up of individual personalities. Each family member takes on a role that contributes to the overall functionality of the family system.

◗ An addicted family member significantly disturbs normal family functioning.

◗ Family members often are invested in compensating for the addict's irresponsible behavior. Spouses or partners and children assume new and different responsibilities with the hope of preserving the family's ability to provide and care for its members.

◗ Family members need treatment and support that parallels treatment for the addict.

◗ Families may be helpful in facilitating treatment for the addict by participating in an intervention, which is a structured encounter with the impaired family member designed to confront him/her with the effect of the illness on the family.

II. Physical Effects of Addiction on the Family

◗ Alcohol use during pregnancy is harmful to the developing fetus, causing neurological deficits that affect the child's ability to learn and, in severe cases, may cause mental retardation.

◗ The effects of parental drug use on children include low birth weight, premature births, seizure disorders, respiratory disorders, sleep disorders, sexually transmitted diseases, increased risk of abuse and neglect, and increased risk of injuries from accidents.

III. Psychological Effects of Addiction on the Family

◗ Children growing up in families where alcoholism is a factor are more likely to suffer from attention deficit disorder, conduct disorder, depression, and anxiety.

◗ Alcoholism and drug addiction cause changes in the family ecosystem: spouses or partners take on more responsibility for the family enterprise to compensate for the addict's incapacity and often make excuses for their irresponsible acts; children take on parental roles and become overly responsible, or they may act in self destructive ways, such as experimenting with drugs and alcohol.

◗ A child's school performance often declines when a parent actively uses drugs and/or alcohol.

IV. The Effect of Early Recovery from Addiction on the Family

◗ The period of early recovery is difficult for both the addict and for family members.

◗ Family members experience anxiety about whether the addict will maintain abstinence.

◗ Abstinence alone does not change the maladaptive behaviors that accompany drug and alcohol dependence. Addicts who merely are abstinent often exhibit the same behaviors, but for drug and alcohol use, as active users.

◗ Abstinence is not sustainable without the participation of the addict and the family in a recovery program. Family members need treatment and/or twelve-step support in order to alleviate anxiety and to learn how to live with a recovering family member.

◗ Spouses/partners may have difficulty sharing family responsibilities with a newly sober family member and may experience envy for the positive regard that the addict receives for his/her recovery efforts.

◗ Children may feel ignored as parents focus on their recovery programs and may have difficulty adjusting to the resumption of parental authority.

◗ Efforts must be made to support children during the early recovery period.

Addiction and the Family

Introduction

The growing acceptance of alcoholism as a disease and the opportunities for its treatment have facilitated the ability of professionals working with recovering alcoholics to make observations about family dynamics in the context of addiction and substance abuse.[1] They have demonstrated that family members of alcoholics also exhibit symptoms of the disease and that it is possible to address these symptoms with a specific set of treatment modalities.[2] Inpatient treatment for the alcoholic has included a family component since 1965, in which family members spend several days at the treatment center participating in group, individual, and family counseling targeted to address their particular recovery issues.[3]

In the 1940s, well before family treatment for alcoholism was available, a group of mostly women who were spouses of alcoholics recognized that families suffered from the alcoholic's behavior.[4] This realization gave rise to self-help groups for the family, including Al-Anon, followed by Alateen and Adult Children of Alcoholics (ACOA) groups.[5] Their purpose was, and continues to be, to provide a network of support for families to help them cope with the effects of living with an addicted family member. Legions of family members participated in these twelve-step programs, including spouses and partners of drug addicts who belonged to Nar-Anon, a self-help support group for relatives and friends of individuals suffering from drug addiction or a substance use problem.

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[1] *See generally* Claudia Black, *It Will Never Happen to Me* (1981) (discussing the author's experience treating adult children of alcoholic parents). *See also* Janet G. Woititz, *Adult Children of Alcoholics* (1983).

[2] *See id.* (discussing the myriad effects of alcoholism on family members).

[3] *See* William L. White, *Fire in the Family: Historical Perspectives on the Intergenerational Effects of Addiction*, 6 Counselor Magazine 20, 24 (2005) (noting the proliferation of family treatment programs linked to inpatient rehabilitation centers). *See also* Interview with Judith D. Moran, former clinical director, Freedom Institute, New York City, NY (July 13, 2005).

[4] *See id.* at 21 (describing the history of addiction treatment and the family support movement).

[5] *See id.*

Initially, treatment and self-help for alcoholism and drug dependence evolved independently of each other. As treatment facilities for alcoholics began to proliferate in the 1980s, professionals working with drug addicts established protocols for their treatment as well, leading to the establishment of long-term residential facilities and therapeutic communities where addicts could seek help for their addiction in supportive environments.[6]

The independent advancement of self-help and treatment opportunities for the two groups—drug addicts and alcoholics—has supported separate inquiries about the effects of drug addiction and alcoholism on families. Consequently, the family disease concept—that alcoholism affects the relationships among family members—has been documented only recently in the context of drug addiction.[7] On the other hand, the physical consequences of drug addiction on family members have been documented for more than a decade.[8] The following discussion of the effects of addiction on families looks at both physical and psychological impacts.

I. Physical Effects of Addiction on the Family

Drug use has a very real physical impact on the most vulnerable family members—infants and young children. According to the 1992 National Pregnancy and Health Survey, 50 percent of women who use drugs are of childbearing age.[9] The Substance Abuse and Mental Health Administration reports that about 11 percent of pregnant women drink, 3.7 percent engage in binge drinking (five or more drinks at one sitting), and one percent report frequent drinking (consuming seven or more drinks per week).[10]

ALCOHOLISM

The effects of alcoholism on the fetus are well established. Fetal Alcohol Spectrum Disorder (FASD) ranges from the mildest form, Fetal Alcohol Effect (FAE), to the most severe manifestation, Fetal Alcohol Syndrome (FAS).[11] Depending on the extent of the pregnant mother's use, alcohol affects the embryo's developing brain and nervous system, resulting in learning disorders and, in extreme cases, retardation.[12]

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[6]*See* Moran, *supra* note 3.

[7]*See generally* National Center on Addiction and Substance Abuse at Columbia University (CASA), Family Matters: Substance Abuse and the American Family (2005) [hereinafter CASA, Family Matters]. *See also* White, *supra* note 3, at 22 (explaining that "most of what we know about addiction and the family is based on studies of alcoholism and may or may not be applicable to other patterns of addiction and recovery.").

[8]*See* http://www.nida.nih.gov/

[9]United States Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, *National Pregnancy and Health Survey: Drug Use Among Women Delivering Live Births* (1992)

[10]Substance Abuse and Mental Health Services Administration, *Results from the 2011 National Survey on Drug Use and Health: National Findings* (2011) http://oas.samhsa.gov/nsduh/2k10nsduh/2k10ResultsP.pdf

[11]*See* CASA, Family Matters, supra note 7, at 8.

[12]*Id.*

OTHER ADDICTIVE SUBSTANCES

The long-term effects of cocaine and heroin on the embryo are less well understood than they are for alcohol. Babies born to heroin-addicted mothers may exhibit withdrawal symptoms that mimic adult reactions.[13] Infants born to cocaine-addicted mothers and babies exposed to heroin may exhibit similar neurological symptoms, such as hyperirritability, tremors, and irregular sleep patterns.[14] Infants born to methamphetamine-addicted mothers may have difficulty breast feeding and forming maternal child attachments. Their mother's preoccupation with drug seeking and drug taking behaviors may place these babies at risk for child neglect and abuse.[15]

There is a wide spectrum of physical side effects of the most popular addictive substances, ranging from cigarettes to cocaine,[16] including retarded or delayed motor development, low birth weight, premature delivery, and other delivery complications.[17] Other possible effects are seizures, respiratory distress, sleep problems, infectious diseases, such as HIV/AIDS, genital herpes and tuberculosis, increased risk of child abuse and neglect, and increased risk of injuries from accidents.[18] Clearly, the physical effects of alcohol and drug use on families, particularly infants and children, often are severe and pose significant public health problems for society.

II. Psychological Effects of Addiction on the Family

MENTAL HEALTH

Children of substance-abusing parents tend to have two types of psychiatric disorders: behavioral problems that are directed outward toward others, such as attention deficit hyperactivity disorder, conduct disorder and oppositional defiant disorder; or problems that are directed inward, such as depression or anxiety.[19]

There are different mental health risks for children of alcoholics and for children of illicit drug users. Children of alcoholics (COAs)—particularly sons of alcoholics—tend to exhibit symptoms of stress and anxiety and have lower self-esteem than children raised in households where neither parent is an alcoholic.[20] Pre-school COAs are more likely than non-COAs to be shy, perhaps due to a biological predisposition to anxiety or a home life that promotes fear and uncertainty.[21] The

[13]See Interview with Amy Moran Durocher, LCSW, Baltimore, Md. (July 14, 2005) (describing her observations of babies born to heroin-addicted mothers at Johns Hopkins Hospital).

[14]See Arnold M. Washton, *Cocaine Addiction: Treatment, Recovery & Relapse Prevention* (1989) at 31.

[15]See Kate Zernicke, Drug Scourge Creates its Own Form of Orphan, N.Y. Times, July 11, 2005 at A1 (describing the substantial increase in child welfare rolls in states such as Oklahoma and Tennessee as a result of the surge in methamphetamine addiction in rural areas in the Midwest, Northwest and California).

[16]See CASA, Family Matters, supra note 7, at 7–13.

[17]See id at 10.

[18]See id. .

[19]Id. at 11, 12.

[20]See id. at 12.

[21]See id.

children of two alcoholic parents are more vulnerable to mental health problems than those with one alcoholic parent.[22]

Children of illicit drug users are more likely than children of non-drug users to engage in immature, impulsive, or irresponsible behavior; to have lower IQ scores and more absences from school; and to have behavioral problems, depression, and anxiety—all signs of risk for substance abuse.[23] Children of drug-abusing parents, especially drug-abusing mothers, are more likely to be disobedient, aggressive, withdrawn and detached. These children also tend to have fewer friends, lower confidence in their ability to make friends, and a greater likelihood of avoidance by their peers.[24]

FAMILY DYNAMICS

Growing numbers of individuals in treatment settings have begun to report using and abusing an assortment of illegal drugs in combination with alcohol[25]—a fact that is underscored by the growing use of the term "chemical dependency" to indicate the increase in poly-substance abuse and to avoid artificial distinctions between various drugs, including alcohol (despite the fact that its use is legally permissible).[26] The following discussion addresses the psychological and relationship issues facing families when chemical dependency, in any form, is present.

As is discussed later in this section, the addict's use of drugs and alcohol significantly affects the family. In turn, family members can have significant influence on the addicted member to enter treatment or otherwise participate in recovery from the illness. The seminal book, *I'll Quit Tomorrow*, by Vernon Johnson, the Johnson Institute's founder, details a process by which the family becomes the instrument to propel the alcoholic into treatment.[27] This process is known as "intervention"—a structured encounter between the alcoholic and family members during which the alcoholic is confronted with the consequences of his/her drinking.[28] The intervention gives family members, and often friends and employers, the opportunity to describe for the alcoholic, under the direction of a trained individual or "interventionist," specific instances in which the alcoholic's drinking affected them.[29] The result of the encounter is often the alcoholic's acknowledgement that she or he needs treatment for the disease.[30]

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[22]See id.

[23]*See id.*

[24]*See id.*

[25]*See* Moran, *supra* note 3.

[26]*But see* Charles P. O'Brien, *Research Advances in the Understanding and Treatment of Addiction*, 12 Am. J. Addictions 536 (2003) (commenting that the term addiction may be less "confusing" to non-addiction professionals).

[27]*See generally* Vernon E. Johnson, *I'll Quit Tomorrow: A Practical Guide to Alcoholism Treatment* (1980) [hereinafter Johnson].

[28]*See* Interview with Constance B. Murray, Executive Director, Freedom Institute, in New York, N.Y. (July 13, 2005).

[29]*See id.*

[30]*See id.*

FAMILY SYSTEMS THEORY AND THE ALCOHOLIC FAMILY

The effects of alcoholism and other drug dependence on families are best understood in the context of family systems theory: the family, like a living organism, functions as an amalgam of interdependent units.[31] Each member of the family performs a particular role. More specifically, parents take on caretaking roles, and children, according to their birth order and physical and character attributes, develop distinct familial roles as well.

In a family in which one of the members actively is using drugs and/or alcohol, family functioning is derailed.[32] Sharon Wegscheider Cruse, one of the pioneers in studying the alcoholic family, uses a mobile to illustrate what happens when a family unit accommodates an addicted family member.[33] Each part of the mobile contributes to a perfectly balanced artistic whole, but this harmonious design quickly deconstructs when one of its elements is disturbed.[34] Addiction affects even the most balanced families, creating disturbances in the way the family functions.[35] As the parts of the lopsided mobile scatter in an attempt to regain balance, family members also try to adapt to an addicted family member by assuming new roles.[36] Children take on parental roles, and spouses or partners assume new and different responsibilities with the hope of keeping the family functioning.[37]

SPOUSE/PARTNER ROLE

One of the classic syndromes characterizing alcoholic families is codependency.[38] Codependency manifests itself differently in each family member, but generally it refers to the specific, and often inflexible, rules developed by family members, each in their own way, to help them cope with the adverse effects of the addict's behavior.[39] In the case of an adult spouse or partner, these behaviors may include: making excuses for the addict's irresponsible actions, such as when the addict misses work or acts inappropriately in social situations; checking the home for drugs and alcohol; isolating the family from social engagements; attempting to explain the addict's erratic

[31]*See* Peter Steinglass, Linda A. Bernstein, Steven J. Wolin & David Reiss, *The Alcoholic Family* (1987) at 44–46 (describing the family systems theory as a construct for understanding the interrelatedness of family members) [hereinafter *Alcoholic Family*]. See also Stephanie Brown & Virginia Lewis, *The Alcoholic Family in Recovery* 85 (1999). [hereinafter Brown & Lewis].

[32]*See Alcoholic Family, supra* note 31, at 44–46.

[33]Ann M. Richards, Address at a benefit for Freedom Institute, New York City, N.Y. (May 17, 2005) [hereinafter Richards] (noting the contribution of Sharon Wegscheider Cruse to the understanding of the dynamics of the alcoholic family system).

[34]*See id.*

[35]*See* Brown & Lewis, *supra* note 31, at 85.

[36]*See* Richards, *supra* note 33.

[37]*See* Black *supra* note 1, at 50–62.

[38]*See generally* Melody Beattie, *Codependent No More* (1992) [hereinafter Beattie] (describing the author's early experiences with the codependent population). *But see* White, supra note 3 (noting that the syndrome as it was extended to include nonalcoholic family members has generally fallen out of favor among treatment professionals). *See also* CASA, Family Matters *supra* note 7, at 18 (describing concerns about the empirical validity of the term, that it implies illness and that future research should focus on what behaviors promote a partner's substance abuse rather than incorporating them under the rubric of a syndrome).

[39]*See generally* Beattie, *supra* note 38.

behavior as "normal" when discussing it with the children; and assuming roles that traditionally were performed by the addict—all with the hope of maintaining the family's equilibrium.[40]

These efforts ultimately are unsuccessful and support the addict's harmful use.[41] "Keeping up appearances" also is hard work and results in feelings of anxiety, depression and resentment.[42]

CHILDREN'S ROLES

Children in alcoholic families also develop coping mechanisms and take on new and different roles. Younger children, as noted above, are more likely to be shy.[43] Adolescents may become surly and distant, and may engage in risk-taking behavior to a degree that extends beyond what is normally expected for this age group.[44] In addition to acting in ways usually perceived as destructive, children in these families also may engage in very constructive pursuits.[45] They become academic over-achievers, caretakers for their younger siblings,[46] wage earners to compensate for the addict's inability to maintain steady employment, and even in-house entertainers to provide comic relief as a distraction from the family's preoccupation with the addict's disease.[47]

Wegscheider Cruse, who is also an expert on the psychology of COAs, has described four role classifications based upon her observations of children in alcoholic families:

◗ The hero who, like the responsible child, takes on adult caretaking roles and likely is an over-achiever.

◗ The mascot, frequently the youngest child, who serves to deflect the family's attention from the painful circumstances associated with the addict's behavior.

◗ The lost child, who may retreat into solitary pursuits as a means to avoid confronting the family's problems.

◗ The scapegoat or troubled child who acts out through academic failures or anti-social behavior, which can serve as an "explanation" for the family's problems.[48]

Each of these roles enables the child and, in the case of the scapegoat and mascot, the entire family to avoid dealing directly with the alcoholic's disease.

A family struggling with a member's addictive illness may display obvious dysfunction—children are unkempt, they perform poorly in school, and the house and the family affairs are in dis-

[40]*See* Moran, *supra* note 3. *See also* CASA, Family Matters, *supra* note 7, at 18 (describing the enabling behavior of the codependent spouse).

[41]*See* Moran, *supra* note 3.

[42]*Id.*

[43]*See* CASA, Family Matters, *supra* note 7, at 12.

[44]*See id.* at 12 (describing behavioral problems associated with children of alcoholics, which include conduct disorder and oppositional defiant disorder).

[45]*See* Black, *supra* note 1, at 8 (asserting the author's contention that most children reared in alcoholic families lead responsible lives).

[46]*See* CASA, Family Matters, *supra* note 7, at 18 (describing the parentification phenomenon wherein children take on adult responsibilities to compensate for the addict's incapacities).

[47]*See generally* Black, *supra* note 1, at 98 (articulating the various roles taken on by children in alcoholic family systems).

[48]*See generally* Sharon Wegscheider Cruse, *Another Chance: Hope and Health for the Alcoholic Family* (1989).

array.[49] In other cases, a family may seem to function well[50]—the bills are paid, the children are cared for and perform well in school, and the home is orderly. In either case, the family is not healthy, and the members need treatment as much as the addict does.[51]

In addition to the intra-familial effects of addiction, there also are effects on the family stemming from the physical and mental toll of addiction.[52] Addiction increases the likelihood of divorce, the risk for substance abuse among children,[53] the exposure of children to severe illness,[54] the risk of family violence, and child abuse and neglect. Clearly, these consequences are harmful to adults and children, but they also pose challenges for community systems such as family courts[55] and child welfare agencies.

III. The Newly Sober Alcoholic and the Family

It may be reasonable to conclude that once the alcoholic stops drinking and the drug addict stops using drugs, all is well in the family. As one commentator suggests, however, there is no immediate relief for the family when the alcoholic member stops drinking.[56] In fact, the effect on the family of the newly sober family member often is indistinguishable from that of the active alcoholic. Confusion and insecurity also characterize the family system in early recovery from alcoholism.[57] The family, like the alcoholic or addict, needs time and support to regain a healthy equilibrium.[58]

THE ALCOHOLIC'S PARTICIPATION IN A RECOVERY PROGRAM

There are many factors that affect how family members experience recovery, but all families will experience difficulties in varying degrees and for some period of time.[59] For example, the choice that an alcoholic makes—whether to commit to and participate in a recovery program or merely abstain from using alcohol and drugs without the aid of treatment and support—influences the family's experience of recovery and also affects whether the addict will suffer a relapse.[60] The rea-

[49]*See* CASA, Family Matters, *supra* note 7, at 15 (describing the economic impact of substance abuse on the family).

[50]*See* Alcoholic Family, *supra* note 31, at 177 (explaining that families often adapt to alcoholism in such a way as to create "a family environment of remarkable stability.").

[51]*See* White, *supra* note 3, at 24 (confirming the evidence-based imperative for family treatment for alcoholism).

[52]*See* CASA, Family Matters, *supra* note 7, at 17–22.

[53]*See id.* at 17 (explaining that the stressors attendant to family break-ups and the weakened familial bonds may lead children to experiment with drugs and alcohol).

[54]*See id.* at 19 (noting that children risk the loss of a parent to AIDS, hepatitis or drug/alcohol overdose).

[55]*See generally*, Barbara A. Babb & Judith D. Moran, *Substance Abuse, Families and the Courts: The Creation of a Caring Justice System*, 3 J. Health Care L. & Pol'y. 1 (1999) (discussing the challenges that addiction and substance abuse pose for family courts).

[56]*See* Brown & Lewis, *supra* note 31, at 211.

[57]*See id.*

[58]*See* Moran, *supra* note 3.

[59]*See id.*

[60]*See* Alcoholic Family, *supra* note 31, at 124.

sons alcoholics relapse often are grounded in the fact that the alcoholic has resorted to drinking to meet the challenges of daily life.[61] Without support and guidance regarding alternative ways to address life's challenges, such as twelve-step meetings and counseling, the alcoholic may resume drinking. The family once again is faced with the consequences.[62]

"DRY DRUNKS"

Even if the alcoholic or addict is able to resist relapse without rehabilitative support, his/her behavior often is no different, but for the physical symptoms, than during the active phase of the disease. These individuals are known as "dry drunks" and they may be angry, combative, distant, and depressed. They cause family members the same or similar consternation as when they drink. Alcoholics Anonymous (AA) members distinguish between a "dry alcoholic" and a "sober alcoholic" to underscore that, while being "dry" is the result of abstinence, being sober is the goal of recovery because it is the result of personality growth and change—the ability to respond to life and its problems using sound coping mechanisms.[63]

FAMILY PARTICIPATION IN RECOVERY

Another factor in the family's recovery is whether family members themselves are involved in treatment and/or twelve-step support.[64] During the acute phase of inpatient treatment and even in many outpatient programs, family members are invited to participate in group sessions with the alcoholic, during which they all confront painful aspects of family interactions.[65] These sessions are difficult and initially may result in more anguish, as family members no longer can use the mechanisms that once shielded them from the alcoholic's effect on the family system.[66] In addition, family members also may be forced to confront their own enabling or dysfunctional behavior and no longer can blame all of the family's problems on the alcoholic.[67]

Despite the rigors of full family involvement in recovery programs, it is imperative that everyone receives help. First, the alcoholic who is in the beginning stages of abstinence is extremely vulnerable to relapse.[68] In order to cope with these urges to drink, which are expected at this stage of recovery, the alcoholic needs to be surrounded by family members and close friends who appreciate and understand this circumstance.[69] Second, family members also need to learn new ways to cope with and support the changes in the home.[70] Without family involvement, the alcoholic's

[61] *See* Moran, *supra* note 3.

[62] *See id.*

[63] *See* Brown & Lewis, *supra* note 31, at 252.

[64] *See id.* at 124.

[65] *See* White *supra* note 3, at 24 (describing the growth of family treatment programs in rehabilitation centers).

[66] *See* Moran, *supra* note 3.

[67] *See* Brown & Lewis, *supra* note 31, at 209.

[68] *See* Johnson *supra* note 27, at 109 (discussing the inherent perils of relapse for alcoholics).

[69] *See* Moran, *supra* note 3.

[70] *See generally* Brown & Lewis, *supra* note 31.

recovery is compromised. It is possible, however, that the length of time the alcoholic has drunk and the number of attempts he/she has made to become sober can affect family members' ability to provide support for renewed attempts at abstinence.[71] The longer the drinking persists, the more entrenched is the family's behavior pattern,[72] making it more difficult for family members to establish healthy interactions and an optimal recovery environment.

Each family member experiences a distinct reaction to the addict's sobriety, which poses its own set of challenges for the individual and the family as a whole. These issues are addressed in the following discussion.

THE SPOUSE/ PARTNER

Although many committed relationships do not withstand an addictive illness,[73] much has been written about the partnerships and marriages that endure the early recovery period.[74] The spouse or partner of the active alcoholic often assumes the role of the primary decision-maker for the family.[75] Once the alcoholic stops drinking and becomes a competent partner in the relationship, this role changes. The spouse must share or cede responsibilities that once were solely hers or his.[76] Family decision-making that was once unilateral becomes collaborative and involves an individual who is capable and interested in participating in family life. Adapting to a new dynamic in a relationship poses difficulties for most couples.

A spouse or partner also may experience isolation and feelings of being left out, as the alcoholic finds emotional and psychological support from AA "kinsmen" while his/her partner is on the periphery.[77] Spouses often complain that the alcoholic basks in the "limelight"[78] of sympathy and support in his or her AA group meetings, while they are left to suffer in silence. Overall, the partner or spouse of a recovering alcoholic is called upon to make a substantial change in the way in which she or he participates in the family and relates to her or his partner.[79]

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[71] *See* Moran, *supra* note 3.

[72] *See* Alcoholic Family, *supra* note 31, at 70 (explaining that for some families the result of living with a chronic alcoholic is that the pathological changes in the family system are so entrenched as to support the continuance of drinking).

[73] *See* Brown & Lewis, *supra* note 31, at 3.

[74] *See id.*

[75] *See infra* CASA, Family Matters, *supra* note 7, at 18 and accompanying text.

[76] *See* Brown & Lewis, supra note 31, at 211 (describing the altered relationships between couples once the alcoholic enters recovery).

[77] *See id.* at 245 (noting that spouses may harbor feelings of being abandoned for AA and competitiveness with the bonds that the alcoholic forms with his twelve-step cohorts).

[78] *See id.* at 209.

[79] *See id.*

THE CHILDREN

The effects of early recovery from alcoholism on children are analogous to those documented in studies of children of divorce.[80] When the alcoholic family member begins to participate in a recovery program, the family is confronted with profound changes, which are frightening or, at the very least, cause anxiety for children.[81] As is often the case in divorce, children whose parents are attempting to recover from alcoholism or another substance use disorder often are ignored as the parents focus on themselves and their partners. Parents may become heavily involved in self-help groups and other forms of therapeutic intervention.[82] Children may feel neglected and suffer feelings of abandonment as their parents pursue these opportunities.[83] This phenomenon speaks to the need for children to participate in support programs that address their unique needs.

As the spouse or partner must adapt to a new role in the family, children also must get used to a new set of behavioral expectations. The child who once was the family hero is forced to compete with a parent now able to shoulder family responsibilities.[84] This may cause the child to become confused and angry, often provoking challenges to parental authority.[85]

Children also must accommodate changes in relationships with their siblings. For example, the authority of an older sibling who previously assumed a parental role is diminished, as the recovering alcoholic is interested in and able to act in such a capacity. Obviously, the shift in power yet again calls for an adjustment in the family structure and poses confusion for the children.[86]

Mental health professionals working with alcoholic families in recovery have documented a constellation of symptoms peculiar to children in these transitional circumstances. These symptoms include depression, sleep disturbances, emotional liability, acting-out behaviors, underage drinking, and illicit drug use.[87]

In sum, addiction is a family disease from the time it manifests itself in the individual family member until that individual is solidly in recovery. It affects the physical and emotional well-being of all family members. Family members experience their own symptoms in response to the addictive process, whether physical, emotional, or psychological, and they need to participate in their own recovery programs as well. Spouses and partners can benefit from participation in twelve-step programs such as Al-Anon, while teens should consider attending Alateen meetings. Children exhibiting the effects of in utero exposure to alcohol should be enrolled in special education and behavioral therapy to meet their needs.

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[80]*See generally* Janet R. Johnston, *Building Multi-disciplinary Professional Partnerships with the Court on Behalf of High Conflict Divorcing Families and Their Children: Who Needs What Kind of Help*, 22 U. Ark. Little Rock L. Rev. 453, 454 (2000) (summarizing the result of the author's research on the effects of divorce conflict on children). *See also* Andrew Schepard, *Parental Conflict Prevention Programs and the Unified Family Court*, 32 F.L.Q. 95 (1998) (describing the emotional toll on children in contested divorce cases).

[81]*See* Brown & Lewis, *supra* note 31, at 211, 212.

[82]*See id.* at 212.[83]*See id.* at 212.

[84]*See id.* at 213.

[85]*See id.*

[86]*See id.* at 215.

[87]*See id.* at 248, 249.

IV. Implications for Family Courts

In light of what is known about the science of addiction and how the disease affects the family system, the following points may be useful for judges dealing with family law cases involving an addicted family member(s):

◗ Addiction is a disease for which diagnosis and treatment are essential to restore family functioning.

◗ Denial of the illness on the part of the addict and family members often is a feature of the disease.

◗ It is important to refer cases where substance abuse is suspected or confirmed to community-based treatment providers.

◗ It is important to schedule cases for regular court appearances to monitor compliance with treatment mandates and progress in recovery.

◗ Consider that mere abstinence from drugs, although a first step in the recovery process, is not sustainable without supportive treatment and/or self help.

◗ Support treatment for family members, as well as the addicted family member.

◗ Consider that children exposed to parental substance abuse and dependence are themselves at risk for using drugs and alcohol and also at higher risk for abuse and neglect.

◗ Support participation in twelve-step programs for both the addict and family members.

◗ Consider that relapse is often a component of recovery. The addict and family members must acknowledge a relapse immediately and implement steps to contain it. Denial is often a feature of relapse.

◗ Early recovery is an especially difficult period for the addict and the family. Frequent oversight by the court and more intensive treatment and twelve-step participation is important.

◗ Provide leadership to create a family court structure that incorporates a model to address substance abuse. This may include diagnostic services and regular training for judges and court personnel.

◗ Encourage court-community collaborations with treatment providers so that the court has ready access to an extensive and cooperative network of referrals available to the court.

Chapter Four: Adolescent Substance Abuse and Addiction

Chapter Highlights

I. Adolescent Substance Abuse in Maryland

◗ Adolescent substance abuse rates in Maryland are consistent with national trends in adolescent use of alcohol and other drugs.

◗ By twelfth grade, nearly 70 percent of Maryland's youth have used alcohol outside the home.

◗ Nearly 40 percent of the senior class in Maryland report using marijuana.

◗ Alcohol is the drug used most frequently by Maryland adolescents, followed by marijuana as the second most used drug.

II. What Distinguishes Adolescent Substance Abuse from Adult Substance Abuse?

◗ The human brain is still growing during adolescence.

◗ There is evidence that the brain continues to grow until age 24.

◗ Several characteristics of the developing brain, such as poor impulse control and heightened sensitivity to intoxication, may contribute to the initial decision to use drugs and make the experience rewarding.

◗ Adolescents with alcohol and drug use disorders often have co-occurring mental health disorders.

◗ It is essential to address co-occurring psychiatric problems as early as possible in an adolescent's life.

III. How Family and Juvenile Courts Can Address Adolescent Substance Abuse

◗ Courts should be aware of several key elements to incorporate into family courts to build a strong response to the needs of adolescents suffering from substance abuse and/or addiction.

◗ Family courts should establish an intake process that screens for the presence of substance abuse and should have access to a continuum of available treatment slots.

◗ Treatment is effective, but there is no one method of treatment that is best for youth. Treatment programs should be designed to meet the needs of a variety of young people.

◗ Successful family engagement is often critical to the long-term success of substance abuse treatment for adolescents.

◗ Adolescent treatment should involve the adolescent as an integral partner in his/her treatment.

IV. Follow-up Care and Wraparound Services Are Critical to Recovery

◗ Relapse rates among juveniles are often high following completion of treatment.

◗ Courts and attorneys should ensure that the recovering adolescent receives aftercare and/or wraparound services.

◗ Services should extend to the adolescent's family and support the strengths of the child and his/her family.

Adolescent Substance Abuse and Addiction

Introduction

Adolescent substance abuse is a critical public health problem in Maryland and in the nation. While there is a leveling-off in the statistics regarding adolescent substance abuse, the levels remain high.[1] Studies suggest that the age at which adolescents begin using drugs often determines the likelihood that a substance use disorder will develop later in that child's life. In fact, over 90 percent of adults with substance use disorders start using drugs and/or alcohol before they are eighteen years old, and half of those begin before they are fifteen. [2]

Adolescent substance use rates in Maryland are consistent with national trends in adolescent abuse of alcohol and other drugs.[3] By twelfth grade, two-thirds of Maryland's seniors have used alcohol outside their homes.[4] Two-thirds also say they have used some form of alcohol in the past year.[5] Maryland's twelfth graders report using alcohol slightly less than their peers nationally, while they report using marijuana, heroin, and ecstasy at similar percentages to their national counterparts.[6] The following tables provide snapshots of the extent of adolescent substance abuse in Maryland.

Overview of Alcohol Use

EXTENT OF USE:

— Alcohol use is higher in higher grades
— Two-thirds of twelfth graders have tried some form of alcohol; about two thirds of those used it in the last 30 days
— Half of tenth graders have tried alcohol; just over half of those drank during the last 30 days

[1]Physician Leadership on National Drug Policy, Adolescent Substance Abuse: A Public Health Priority (2002).

[2]*Id.*

[3]Md. Dept. of Ed., Maryland Adolescent Survey (2008).

[4]*Id.* at 33.

[5]*Id.* at 67.

[6]*Id.*

— One quarter of eighth graders have tried alcohol; about half of them have used it in the last 30 days
— Less than one in ten sixth graders report ever having used alcohol

CHARACTERISTICS OF DRINKERS:

Gender

— Females outnumber males as occasional drinkers of beer/wine and liquor
— Males outnumber females as frequent users of beer/wine and liquor
— Male and female students are equally as likely to be binge drinkers

Age at First Use

— 10.7% of twelfth graders who ever used alcohol started drinking beer/wine/wine coolers at age 12 or younger
— The largest percentage of twelfth graders (48.9%) report having first tried liquor between ages 15 and 16

Race/Ethnicity

— White and Hispanic twelfth grade students are more likely to be frequent beer drinkers than their African American and Asian/Pacific Islander peers
— White twelfth graders were more likely to be occasional users of liquor than their African American, Asian, and Hispanic peers *[Note: Asian/Pacific Islanders are referred to as Asian in the remainder of this document.]*

Binge Drinking

— Nearly half (46.9%) of twelfth graders report having had five or more servings of alcohol on the same occasion. Thus about 7 out of 10 twelfth graders who have ever used alcohol have tried binge drinking

Definitions:

— Occasional Drinking: Drank alcohol on 1 or 2 occasions in the last 30 days
— Frequent Drinking: Drank alcohol on 3 to 5 occasions in the last 30 days
— Heavy Drinking: Drank alcohol on 6 or more occasions in the last 30 days
— Binge Drinking: Drank 5 or more servings of alcohol on the same occasion

Source: 2007 Maryland Adolescent Survey, Maryland State Department of Education, September 15, 2008

Overview of Marijuana Use

EXTENT OF USE:

— Marijuana is the second most used substance by Maryland students in eighth, tenth, and twelfth grades
— 38.7% of twelfth graders have tried some form of marijuana
— For those reporting that they used marijuana, 27.2% of twelfth graders used marijuana six or more times within the last 30 days
— Less than two percent of sixth graders report ever having tried marijuana

CHARACTERISTICS OF MARIJUANA USERS:

Gender

— Twelfth grade females outnumber males as occasional users of marijuana
— Twelfth grade males outnumber females as frequent users of marijuana

Age at First Use

— 20.7% of twelfth grade marijuana users started using marijuana at age 12 or younger
— 38.2% of twelfth grade marijuana users started using marijuana at age 13–14

Race/Ethnicity

— White twelfth graders are more likely to have tried marijuana than their African American, Hispanic and Asian peers
— White and Hispanic twelfth graders had the greatest percentage of frequent marijuana users when compared to their Asian and African American peers

DEFINITIONS:

Occasional Use: Smoked marijuana on one or two occasions in the last 30 days
Frequent Use: Smoked marijuana on three to five occasions in the last 30 days
Very Frequent Use: Smoked marijuana on six or more occasions in the last 30 days

Source: 2007 Maryland Adolescent Survey, Maryland State Department of Education, September 15, 2008

I. The Adolescent Brain

New scientific discoveries have changed dramatically the understanding of adolescent behavior. Current research indicates that the human brain is still growing during adolescence, with changes continuing into the early twenties.[7]

The immature brain of the teenage years may explain not only why adolescents are prone to poor decision-making, but also may account for their elevated risk of harmful effects from drugs.[8]

There is accumulating evidence that the brain is not fully formed at puberty, as earlier thought, but continues important maturation that is not complete until about age 24.[9] For example, the nucleus accumbens, which controls motivated behavior, is responsible for how much effort the organism expends in order to seek rewards. In teenagers, an immature nucleus accumbens is believed to result in preferences for activities that require low effort yet produce high excitement. Real-world observations bear this out: many teenagers tend to favor activities such as playing video games, skate boarding, and, unfortunately, substance use.[10]

One of the last areas to mature is the prefrontal cortex, located just behind the forehead.[11] Sometimes referred to as "the seat of sober second thought," it is the area of the brain responsible for the complex processing of information, ranging from making judgments to controlling impulses, foreseeing consequences, and setting goals and plans.[12] An immature prefrontal cortex is thought to be the neurobiological explanation for why teenagers show poor judgment and too often act impulsively.[13]

The amygdala is responsible for integrating emotional reactions to pleasurable and aversive experiences. It is believed to be linked to the tendency of adolescents to react explosively to situations rather than with more controlled responses and to the propensity for youth to misread neutral or inquisitive facial expressions of others as a sign of anger.[14]

All these characteristics of the developing brain—poor impulse control; favoring low-effort, yet thrilling, experiences; and heightened sensitivity to the social benefits of intoxication—may contribute to an initial decision to use drugs and make the experience rewarding enough to repeat it. A growing body of research suggests that alcohol in particular causes more damage to the developing brains of teenagers than previously thought. According to a recent survey,[15] 47 percent of

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[7]Nora Volkow, *Exploring the Why's of Adolescent Drug Abuse*, 19 Natl. Inst. on Drug Abuse 1 (2004).

[8]Treatment Research Instit., *Immature Brain May Place Teenagers at Elevated Risk to Effects of Drug Use Argues Noted Substance Abuse Researcher, A. Thomas McLellan, Ph.D*, available at http://www.drugfree.org/Portal/DrugIssue/Features/Immature_Brain_Places_Teenagers_at_Risk_to_Drugs.

9Jessie Breyer & Ken C. Winters, *Adolescent Brain Development: Implications for Drug Use Prevention*, Center for Substance Abuse Research (2005).

[10]*Id.* at 2, 3.

[11]Id. at 3.

[12]Id.

[13]Id.

[14]Id.

[15]Ralph W. Hingson, Timothy Heeren & Michael R. Winter, *Age at Drinking Onset and Alcohol Dependence*, 160 Archiv. of Ped. & Adolescent Med. 739–746 (2006).

those who begin drinking alcohol before the age of 14 become alcohol dependent at some time in their lives, compared with nine percent of those who wait until at least age 21. A study conducted over eight years in San Diego has found that alcoholic teenagers perform poorly on tests of verbal and nonverbal memory, focusing attention, and exercising spatial skills, such as those required to read a map or assemble a pre-cut bookcase.[16]

Adolescents with alcohol and other drug-related disorders often have co-occurring mental-health disorders, as well. These cases typically have less successful drug treatment outcomes than those involving either addiction or mental health issues.[17] Adolescent patients with both mental health and substance abuse problems tend to drop out of treatment earlier than those with only alcohol or other drug disorders. Not surprisingly, they also tend to relapse following treatment more often and to experience more problems in other areas of their lives (such as legal issues) than those without co-occurring disorders.[18]

It is absolutely critical to address co-occurring psychiatric problems as early as possible in an adolescent's life because alcohol and other drug disorders are often chronic conditions that can last for decades. Of those adults with alcohol and other drug disorders, 90 percent start using as adolescents—half younger than the age of 15.[19] As one researcher notes:

Their use typically lasts for decades—lasting longer for those who start younger, shorter for those who go to treatment sooner—and it often takes three or more episodes of treatment before they can sustain recovery. This does not mean it is hopeless. What it means is that the sooner we intervene, the more effective the earlier treatment, and the more we proactively monitor and re-intervene if they relapse . . . all the better for the adolescent, their families, and society at large.[20]

II. What Can Family and Juvenile Courts Do to Address Adolescent Substance Abuse?

The following section is adapted from an article by Laura Nissen, Ph.D., M.S.W., Director, Reclaiming Futures, a national program funded by the Robert Wood Johnson Foundation. The program's mission is to promote new opportunities and standards of care in juvenile justice by bringing communities together to improve drug and alcohol treatment, expand and coordinate services, and find jobs and volunteer work for young people in trouble with the law. The article is available at: http://www.drugstrategies.com/teens_juvjustice.html.

The juvenile justice system has become the de facto substance abuse treatment provider for adolescents and young people facing detention. Maryland's Family Divisions are forced to meet a rapidly growing demand for services that help youths to change their lives.

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[16]Katy Butler, *The Grim Neurology of Teenage Drinking*, N.Y. Times, July 4, 2006, 3 at C1.

[17]Stacy A. Sterling & Constance Weiser, *Chemical Dependency and Psychiatric Services for Adolescents in Private Managed Care: Implications for Outcomes*, Alcoholism: Clin. & Experimental Research (2005) available at http://www.medicalnewstoday.com/medicalnews.php?newsid=24450.

[18]*Id.* at 14.

[19]*Id.*

[20]*Id.*

Despite our best efforts to get substance abuse treatment to the youths who need it, the gap remains wide between those who gain access to treatment and those who do not. Our communities pay for this shortage of services in many ways. Compared to their non-drug-using peers, those who use alcohol and other drugs are more likely to end up in emergency rooms, do poorly in school, engage in disruptive behavior, suffer from mental and physical health problems, find themselves in trouble with the law, or be arrested.[21]

During the last 15 years, the juvenile justice system has developed a variety of approaches to intervene in the lives of young people and place them in public health/substance abuse treatment systems. Best practices are beginning to emerge to guide the way for future justice system reform, including innovations such as community assessment centers, juvenile drug courts, and integrated treatment networks.

Nissen proposes key elements to incorporate into family and juvenile courts to build a strong response to the needs of adolescents suffering from addiction and/or substance abuse. They include the following steps that are particularly relevant to the family court setting.

III. Screening and Assessment

Court staff should establish an intake process that screens for the presence of substance abuse and related problems. In order to make a good referral "match" to treatment, a continuum of available treatment slots must be developed to meet the unique needs of adolescents and their families, ranging from brief counseling, which may be provided by court services, to residential and follow-up treatment for adolescents and their families.

Screening determines the need for a comprehensive assessment; it does not establish definitive information about diagnosis and possible treatment needs. The process should take no longer than 30 minutes and ideally is shorter.[22] When screening turns up "red flags" that indicate the adolescent may have a substance use disorder, the youth should be referred for a comprehensive assessment. The goal of screening is to identify accurately youth who can benefit from a full and complete assessment. At that time a trained professional can, if appropriate, make a determination of a substance use disorder and develop recommendations for intervention. If an adolescent shows warning signs of substance use, however, this does not confirm that he/she has a problem severe enough to warrant a formal diagnosis or referral to intensive drug treatment. Some adolescent substance involvement is temporary, and most young substance users do not develop serious problems as they get older.

Juvenile justice systems should clearly screen all adolescents at the time of arrest or detention. The most commonly used screening method is the interview. The screening interview is an efficient means to gather information on the prototypical red flags and offers an opportunity to observe the adolescent's behavior and gauge his/her verbal skills. While family courts cannot and

[21]Karen Hoffman Tepper, *Adolescent Substance Abuse*, Evaluating the National Outcomes: Youth (2001) http://ag.arizona.edu/fcs/cyfernet/nowg/ythsubabuse.html

[22]Ken C. Winters, *Screening and Assessing Adolescents for Substance Use Disorders*, 31 Treatment Improvement Protocol (TIP) Series, U.S. Dept. Health and Hum. Serv. 2 (1999), http://www.athealth.com/practitioner/ceduc/health_tip31e.html#header

should not be held responsible for medical assessments, court staff can be trained to provide brief screening to identify adolescents who may need further professional evaluation. There are several developmentally appropriate, valid, and reliable screening instruments available.[23] For example, the CRAFFT instrument[24] is a mnemonic screen consisting of six questions:

- **C** Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
- **R** Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?
- **A** Do you ever use alcohol or drugs while you are by yourself, alone?
- **F** Do you ever forget things you did while using alcohol or drugs?
- **F** Do your family or friends ever tell you that you should cut down on your drinking or drug use?
- **T** Have you ever gotten into trouble while you were using alcohol or drugs?

Many screening instruments can be administered in 15 minutes and require only a few minutes to score. Others are quite lengthy and require more administration, training, and scoring time. Furthermore, screening tools vary considerably in how many potential issues are revealed during the screening process.

Comprehensive assessment follows a positive screening for a substance abuse disorder and may lead to long-term intervention efforts. Screening procedures identify that a youth may have a significant substance abuse problem. The comprehensive assessment confirms the presence of a problem and helps illuminate other problems connected with the adolescent's substance abuse. Comprehensive information can be used to develop an appropriate set of interventions.

The assessor should be a well-trained professional who is experienced with adolescent substance abuse issues, such as a psychologist or mental health professional, school counselor, social worker, or a substance abuse counselor. The professional collects information from the adolescent through interview, observation, and specialized testing. In addition, information should be elicited, with the adolescent's consent, from well-informed parents, other family members (e.g., siblings), and adults and peers important to the youth.

IV. A Comprehensive and Integrated Treatment Approach

The needs of adolescents involved in substance abuse or addiction are complex and defy a solution by any one agency or professional. Community services, however, tend to occur within what have become known as funding and professional "silos." In order to meet the needs of youths and their families, state-of-the-art treatment in any youth service endeavor generally involves learning to work across and between these systems, as well as within them. A comprehensive and

[23] *See supra* note 1, at 23. (including the Personal Experience Inventory (PEI), Drug Abuse Screening Test for Adolescents (DAST-A), and Adolescent Drug Involvement Scale (ADIS), among others).

[24] *Id.*

integrated approach minimizes artificial barriers between systems and services and provides services that meet the needs of the people, not the systems involved. This approach also requires dynamic case management to support youths and their families through the legal complexities of family and juvenile justice, substance abuse treatment, and other services.

There is significant evidence that adolescent substance abuse treatment is medically effective and cost-effective.[25] Studies show that treatment reduces both drug use and crime by 40 to 60 percent, and that treatment for addiction is as effective as it is for diabetes, asthma and hypertension.[26] One study demonstrates that adolescents who receive drug treatment that is tailored for their age group report considerable reductions in the use of marijuana and alcohol one year after treatment, less criminal activity, improved school attendance and grades, higher self-esteem, decreased hostility, and fewer suicidal thoughts.[27]

There is no one method of treatment that is best for youth. Treatment programs should be designed to meet the needs of young people who suffer from substance use disorders in order to increase successful outcomes. Options for youth can include family programming, psychiatric services, recreational activities, coordination of care, and other health care services. By providing flexible and available options, communities can help more young people with substance abuse disorders find a recovery path that is best suited to their individual needs.

One barrier to achieving recovery is the limited availability of treatment programs designed to meet young people's specific needs. The reality is that teens with substance abuse disorders generally are overlooked. Communities can help reduce this barrier by promoting progressive assessment systems, providing additional funding to increase treatment capacity, implementing ongoing checkups to ensure a supportive recovery environment and encourage early re-intervention if necessary, and improving outreach to schools and health care professionals.

One of the most important components in an effective system to address adolescent and adult addiction/substance abuse is an integrated approach designed to meet the mental, physiological, psychological, and social needs of those suffering from these disorders. This approach is based on moving beyond screening, assessment, and treatment. It involves establishing organized systems of care both during and after treatment that are designed to meet the needs of the adolescent and involve a support network at home and in the community. The adolescent's family is central to this approach.

FAMILY INVOLVEMENT IN TREATMENT

Successful engagement of the family is often the key to the long-term success of youth in any type of formal service system. The fact that a family is involved in the family court system, regardless of the reason, often represents a crisis in which most families are frustrated, bewildered at the complexity of the system, and anxious regarding the fate of their child(ren). It can be even more

[25] *See supra* note 1, at 37.

[26] *Id.*

[27] Yih-Ing Hser, Christine E. Grella, Robert L. Hubbard, Shih-Chao Hsieh, Bennet W. Fletcher, Barry S. Brown, & M. Douglas Anglin, *An Evaluation of Drug Treatment for Adolescents in Four U.S. Cities*, 58 Arch. of Gen. Psych. 689–95 (2001).

complex and challenging if the youth or family members are involved in substance abuse, and the stigma associated with the combination of issues can impose additional burdens. Families in the family justice system often are financially challenged, and family members may have limited linguistic and/or geographic access to people making decisions regarding their child(ren). They may have substance abuse and/or other health problems themselves. They may have other children, jobs, or situations that require their attention, and they may not be able to focus on dealing with multiple systems. Considerable care, planning, and attention are essential to providing adequate outreach, support, education, information, and hope to families in this situation. They should be given the opportunity to be involved as full partners in any assessment and treatment of their child(ren.) Court staff consistently should give the message to these families that, although they are facing challenges, they can rise to the occasion and start anew as a family together.

DEVELOPMENTALLY APPROPRIATE PROGRAMS

Every service offered to a youth in the family justice system should reflect the adolescent's strengths, orientations and perspectives. Adolescents have a developmental need to be involved as partners in their treatment planning, and they often can provide powerful insights that professionals might miss. Besides developmentally appropriate treatment services, youths should have opportunities to extend beyond the traditional rehabilitative menu, including civic engagement, youth leadership, and service learning. Family court judges and staff should be wary of treatment/intervention models that are used only with adults. Until programs are adapted for youth specifically, they can be of little value and can even create additional problems.

FOLLOW-UP CARE/WRAPAROUND SERVICES

Treatment does not end with the adolescent's last appointment at a treatment center or with his/her release from confinement. Relapse rates among juveniles are often high following their completion of treatment, both voluntary and mandated.[28] Consequently, it is critical for the court to ensure that the adolescent receives continued aftercare or wraparound services.

Wraparound is a philosophy of care that includes a planning process involving the child and family. This process results in a unique set of community services and natural supports for the adolescent and his/her family to achieve positive outcomes. It is an approach based on an ecological perspective, meaning that improvement in the child's mental health occurs in the context of interactions between the child and his/her environment. To increase healthy functioning, environmental forces, including the family, the community, and services, must support the strengths of the child and family.[29]

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[28]Curtis J. VanderWaal, Duane C. McBride, Yvonne M. Terry-McElrath, & Holly VanBuren, *Breaking the Juvenile Drug-Crime Cycle: A Guide for Practitioners and Policymakers* (2001).

[29]Barbara J. Burns & Sybil K. Goldman, *Promising Practices in Wraparound for Children with Serious Emotional Disturbance and Their Families,* in *Systems of Care: Promising Practices in Children's Mental Health* 4, 13 (Barbara J. Burns & Sybil K. Goldman, eds., 1998).

Essential elements of wraparound include, among other features:[30]

— Wraparound must be based in the community.
— Services and supports must be individualized and promote success, safety, and permanence in home, school, and community.
— The process must be culturally competent, building on the unique values, preferences, and strengths of children, families, and their communities.

Families must be full and active partners at every level of the wraparound process. Families should be viewed as capable experts regarding their children's lives. If a child is in the custody of the state and the goal is family reunification, a continual effort must be made to involve the biological parents in all aspects of the planning process. If the plan does not include family reunification, then a committed caregiver (e.g. relative, adoptive parent) should be at the center of the planning process and provisions for child, sibling, and parent visitations should be explored when appropriate. If a child is not in the custody of the state, the biological parents must have access to all discussions related to the child's plans and must be allowed to voice their preferences.

The wraparound approach must be a team-driven process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualized service plan.

Wraparound plans must include a balance of formal services and informal community and family resources.

The plan should be developed and implemented based on an interagency, community-based, collaborative process.

The planning process identifies the strengths of the child and family, and it inventories needs across multiple settings including home, school, and community. Wraparound is not only for youth recovering from serious addictions; it is also an effective process for early intervention, as well.

The wraparound approach is consistent with the values and goals of Maryland's Family Divisions and family services programs, many of which have implemented a wraparound approach to address adolescent substance abuse and mental health, using a case management approach that is designed to ensure the thorough and holistic treatment of families.[31] More specifically, Maryland's Family Divisions and family services programs promote the following goals, all of which are integral to a wraparound approach:[32]

— stabilizing families in transition;
— promoting co-parenting relationships;
— fostering parents as primary family decision-makers;

[30]Sybil K. Goldman, *The Conceptual Framework for Wraparound,* in *Systems of Care: Promising Practices in Children's Mental Health* 4, 30–31 (Barbara J. Burns & Sybil K. Goldman, eds., 1998).

[31]Maryland Judiciary Department of Family Administration Administrative Office of the Courts, http://www.courts.state.md.us/family/circuitprograms.html (last visited October 1, 2010).

[32]*Id.*

— protecting adults and children at risk;
— preserving family relationships where possible;
— preserving and establishing support networks for parents and children;
— developing a familiarity with each family;
— providing judges complete information so they can make the best decision possible for a family when necessary; and
— ensuring equal access to justice for all Maryland citizens.

There are many strategies that a family court can develop and implement to strengthen its handling of cases involving substance abuse or addiction. They all, however, have in common an emphasis on early intervention, a less adversarial approach to adjudication, and case coordination that focuses on treatment and other services. This approach translates into a powerful network of services, follow-up care, judicial leadership, staff expertise, and other means to address holistically substance abuse and addiction.

Chapter Five: Substance Abuse, Addiction, and Families in Court

Chapter Highlights

I. Thousands of Young Children Live with an Adult Who Abuses Alcohol or Illegal Drugs.

◗ Half of all children under the age of eighteen live in a home where a parent or other adult uses tobacco, drinks heavily or binge drinks, or uses illegal drugs.

◗ Parents with substance abuse problems are more likely to abuse and/or neglect their children.

◗ Nearly fifty percent of judges and masters in Maryland report that abuse of alcohol and other drugs is a significant factor in cases of domestic violence, delinquency, custody, and child support.

II. The Unified Family Court (UFC) Approach: Holistic and Service-Based

◗ The UFC model calls for judges and court staff to address both the legal and non-legal issues that underlie a family's legal problems.

◗ The UFC's emphasis on early intervention and a less adversarial approach to resolving family issues translates into a powerful network of services and supports for families in family court.

◗ In addition, the operation of family divisions utilizes an ecological perspective, promoting outreach by the court to the other systems affecting children and families, e.g., schools, health providers, and communities.

III. When is Substance Abuse an Issue in a Family Court Case?

◗ Substance abuse and drug dependency in domestic cases stand out as special challenges for family court judges, masters, court staff, and attorneys.

◗ Family court judges and masters have difficulty obtaining proof of an allegation of substance abuse, particularly in cases where litigants are self-represented.

◗ Substance abuse is a significant factor in the majority of Child in Need of Assistance (CINA) cases. In those cases where substance abuse is a significant factor, attorneys may ignore other important issues, such as domestic violence.

IV. Recommendations for a Holistic Approach to Substance Abuse and Addiction in Family Courts

◗ Case managers and front-line court staff should receive training about how to recognize signs of potential substance abuse.

◗ Family court judges and staff should encourage and facilitate timely and appropriate treatment and services for parents and children with substance abuse or addiction problems.

◗ While the threat of losing custody of children can motivate some women to enter drug treatment, there are concerns regarding this method.

◗ There are important strategies that a family court and attorneys can use to encourage parents and caregivers to enter and remain in recovery.

— Court staff should receive regular training about current developments regarding substance abuse and addiction treatment.
— Courts should incorporate the latest research into drug treatment.
— Courts should establish or enhance culturally responsive service options and practices relating to drug treatment.
— Court staff should help parents and children in recovery to locate and follow through on community supports and programs geared to ensuring that they stay in recovery.
— Court staff and attorneys often need to reach out to other agencies to coordinate services for families struggling with substance abuse, addiction, and recovery.
— Court staff and attorneys should communicate clearly the treatment plan and options to the family.
— Court staff and attorneys should be sensitive to and help resolve cases where different agencies recommend or require conflicting courses of action.
— Court staff and attorneys should be trained to be aware of cultural barriers, different languages, and co-occurring medical or psychiatric disorders.
— Court staff and attorneys should reach out beyond the immediate family members to enhance the system of supports for families coping with drug addiction.

Substance Abuse, Addiction, and Families in Court

Introduction

Millions of young children live with a parent who abuses alcohol or drugs.[1] Many of these children suffer from parental neglect or outright child abuse. That is the grim reality of the impact of substance abuse and addiction on families and the justice system.

The facts of substance abuse in families speak for themselves:

◗ Half of all children in the United States under the age of eighteen live in a home where a parent or other adult uses tobacco, drinks heavily or binge drinks, or uses illicit drugs.[2]

◗ Parents with substance abuse problems are three times more likely to abuse their children and four times more likely to neglect their children than are parents without substance abuse problems.[3]

[1]The National Center on Addiction and Substance Abuse at Columbia University, Family Matters: Substance Abuse and The American Family ii (2005)

[2]*See id.*

[3]Kelly Kelleher, Mark Chaffin, Janice Hollenberg, & Ellen Fischer, *Alcohol and Drug Disorders Among Physically Abusive and Neglectful Parents in a Community-Based Sample*, 84 Am. J. Pub. Health 1586 (1994).

A survey of state child welfare administrators found that parental substance abuse was a factor in at least fifty percent of substantiated cases of child abuse and neglect. Eighty percent of the respondents reported that substance abuse and poverty were the two primary factors contributing to abuse and neglect.[4]

Recognizing that the complex web of substance abuse problems affecting families is addressed adequately only through a coordinated approach to break the cycle of substance abuse and child maltreatment, a number of practitioners in juvenile dependency courts, child protective services, and substance abuse treatment systems have begun to develop and implement a more holistic approach to intervention. The family dependency treatment court model has developed as a cooperative effort in which court, treatment, and child welfare practitioners collaborate in a non-adversarial setting to conduct comprehensive child and parent needs assessments.

As the family dependency treatment court model has gained popularity, family court judges, attorneys, and court staff have realized that the family justice system in general can contribute significantly to improve the lives of families struggling with problems of addiction. Moreover, the oversight of a specially trained and interested judge, along with a team of court service providers who offer necessary support, has proven to be a successful intervention in promoting recovery for the addicted family member and stability for the children.

I. The Unified Family Court Approach

The Unified Family Court (UFC) model, adopted by Maryland's family divisions and numerous jurisdictions around the country, calls for judges and court staff to address both the legal and non-legal issues that underlie a family's legal problems.[5] In a traditional family law decision-making process, courts often fail to address substance abuse and addiction, focusing solely on the adjudication of legal matters. Given the chronic nature of addiction and substance abuse—with relapse frequently occurring on the road to recovery—families often need court intervention to assist them with medical, social, psychological, and other needs associated with recovery.[6] Maryland's family divisions and family courts, for example, have adopted this approach, driven by an overarching mission:

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[4]Judy Howard, *Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues*, 36 Treatment Improvement Protocol (publication of the U.S. Dept. Health & Human Serv. 1 (2000).

[5]Barbara A. Babb, *Fashioning an Interdisciplinary Framework for Court Reform in Family Law: A Blueprint to Construct a Unified Family Court*, 71 S. Cal. L. Rev. 469, 477 (1998) (proposing a model structure to create a Unified Family Court system based on an ecological and therapeutic approach to family law adjudication). Professor Babb has written extensively on family court reform and the creation of Unified Family Courts based on a therapeutic model that incorporates the ecology of human development. *See generally* Barbara A. Babb, *An Interdisciplinary Approach to Family Law Jurisprudence: Application of an Ecological and Therapeutic Perspective*, 72 Ind. Law L.J. 775 (1997) (detailing changes in the structure and function of the American family in the past few decades and proposing a paradigm for family law jurisprudence that utilizes an ecological and therapeutic perspective to family law decision-making).

[6]Barbara A. Babb and Judith D. Moran, *Substance Abuse, Families and Unified Family Courts: The Creation of a Caring Justice System*, 3 J. Health Care L. & Pol'y 1, 6,7 (1999).

"[To] provide a safe and efficient forum for the resolution of family disputes within the justice system through:

— early intervention and provision of services

— emphasis on less adversarial dispute resolution

— improved case coordination and case management procedures."[7]

What does this mean in those cases where parents, caregivers and/or children are struggling with addiction and/or substance abuse? The family divisions' emphasis on early intervention, a less adversarial approach to adjudication, and case coordination translates into a powerful network of services, follow-up care, therapeutic court programs, specialty courts, judicial leadership, court staff expertise, and other means to holistically address substance abuse and addiction.

Moreover, in keeping with the holistic approach, the operation of Maryland's family divisions is informed by an ecological perspective, the belief that each individual is nested in various systems,[8] and each of these systems has an impact on the individual's life.[9] Thus, a court working with an individual suffering from addiction or substance abuse reaches out to family, peers, treatment providers, non-family support sources, and the workplace. This approach is consistent with family therapy's understanding of human behavior in terms of interactions within and among the various systems in a person's life. Treatment consists of family-level assessment and intervention and uses the strengths of families to bring about changes in a range of diverse problems associated with substance abuse/addiction.[10] In short, the court must address both the legal and non-legal aspects of addiction/substance abuse—as well as a full range of other psychological, social, and economic issues.

A wonderful example of translating therapeutic jurisprudence and the ecological approach into practice is found in the case management practices developed and implemented by Maryland's Family Divisions. While other courts in Maryland do not have the resources or the structure to incorporate this approach on a systemic basis, the team approach adopted by the family divisions can serve as a model for every court that hears family law cases. In the Baltimore City Circuit Court's Family Division, for example, a separate unit in the court clerk's office processes family law cases, enabling the court to give prompt attention to these cases. In addition, various court personnel, including social services professionals, are involved with these cases. In fact, services are the primary means to address a family's non-legal issues. The capacity to offer these services supports a judge's ability to create a solution to a family's legal and non-legal problems.

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[7]Dept. of Fam. Admin., Md. Admin. Off. of Cts., Performance Standards and Measures for Maryland's Family Divisions 5 (2002).

[8]Edward Kaufman and Marianne Yoshioka, *Substance Abuse Treatment and Family Therapy*, 39 Treatment Improvement Protocol 3 (2004).

[9]*See* Babb, *supra* note 5.

[10]*See* Kaufman, *supra* note 8, at 4,5.

II. When is Substance Abuse an Issue in a Family Court Case?

DOMESTIC CASES

"Of the many issues that arise in domestic cases, the problem of substance abuse and dependency stands out as a special challenge, particularly for judges and masters in urban areas," notes Baltimore City District Court Judge Miriam Hutchins.[11] While recent research has focused on abuse and neglect and domestic violence cases, there are many other types of family court cases where substance abuse and addiction are pressing concerns, including divorce, custody, visitation, and child support. Moreover, as Judge Hutchins points out, this situation is made even more complicated because many litigants suffering from substance abuse and/or addiction who appear before the court are self-represented.[12]

All divorce and some custody and visitation cases are filed with the civil equity clerk.[13] After a party is served, the domestic or family division case coordinator screens it and sets a scheduling conference before a master or judge. The review and scheduling conference is the court's first opportunity to focus on, evaluate, and potentially resolve the addiction/substance abuse issue(s) raised in the pleadings or by the parties.

Family court judges often face difficulty in obtaining proof of an allegation of substance abuse, especially in self-represented cases where parties appear without witnesses who can substantiate their allegations. In these circumstances, the court orders evaluations of the parties for substance abuse and, if appropriate, counseling and/or a psychological evaluation. Until these evaluations are completed, which can take weeks, the court may grant temporary custody to one of the parties. If a master finds the child is at risk in the custody of either party, the Department of Social Services (DSS) is notified to initiate shelter care proceedings.

There are several scenarios where the court has no choice but to order an evaluation. For example, a father who is a recovering addict may seek visitation with the child. He may file for contempt because the mother refuses to permit visitation on the grounds that she has seen or heard that the father is using illegal drugs and/or abusing alcohol. Other scenarios involve family members filing cases where one or both parents abuse alcohol or other drugs.

JUVENILE COURT

Adolescents in the juvenile justice system are much more likely to have substance abuse problems than adolescents in the general population.[14] More than two million youth are charged with delinquency offenses and enter the juvenile justice system each year.[15] Sixty-two percent of these

[11]Miriam B. Hutchins, *Substance Abuse and an Urban Court's Family Division: A View from Baltimore City*, 3 J. Health Care L. & Pol'y 127 (1999).

[12]*See id.* at 127 (reporting that over a six-month period, the author heard or held settlement conferences for 23 custody and visitation cases in which a parent's substance abuse was an issue. In 10 of those cases, one or both parties were unrepresented).

[13]Md. Code Ann., Fam. Law § 10201 (1999).

[14]Physicians and Lawyers for National Drug Policy, *Alcohol and Other Drug Problems: A Public Health and Public Safety Priority* 72 (2008) [hereinafter Physicians and Lawyers for National Drug Policy].

[15]*Id.*

young people report alcohol and other drug problems.[16] Moreover, availability of treatment is a serious problem. There is, however, a concerted effort on the part of the juvenile justice system in Maryland to provide programs that meet this pressing need.[17]

While the juvenile justice system has its own procedures, administration, and services, family divisions and family services coordinators may have access to some of the same types of programs, including, for example, weekly peer group counseling, individual and family counseling, and referrals to twelve-step programs.

CHILD IN NEED OF ASSISTANCE (CINA) CASES

A 1999 study of CINA cases in three Maryland counties (Montgomery, Anne Arundel, and St. Mary's Counties) and Baltimore City concluded that substance abuse by either the mother or her partner was a predominant factor in many CINA cases in Maryland.[18] The authors found that substance abuse was present in a majority of cases. When substance abuse was a major factor, attorneys often ignored domestic violence in CINA proceedings and they did not bring the domestic violence issue to the attention of the Department of Social Services (DSS) or the judicial officers.[19]

CINA cases generally begin with a report of abuse or neglect, at which point child protective workers from DSS conduct an investigation.[20] If abuse and/or neglect allegations are substantiated, there is a shelter care hearing to determine whether the child should be placed temporarily in a home or institutional setting. Since the late 1990s, Maryland has created a presumption that a child is neglected if born "addicted" or with a "significant presence" of cocaine, heroin, or a derivative in the child's blood.[21]

Following the shelter care hearing, an adjudicatory hearing is held to determine whether the allegations set forth in the CINA petition are supported. If so, the case moves to disposition, when the court may return the child to the parent under a specific order, place the child in foster care, or award custody and guardianship to someone who can provide appropriate care.

Since November, 1997, the Adoption and Safe Families Act (ASFA) has become the federal standard for removing children.[22] It shifts the emphasis in CINA cases from reunification with parents to permanency planning. ASFA has had a profound impact on cases where parents suffer from

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[16]*Id.*

[17]For example, Baltimore Substance Abuse Systems (BSAS) provides prevention, intervention, and treatment services to adolescents and adults in Baltimore. BSAS funds seven adolescent treatment programs that can serve 325 youths at any given time. Baltimore also has a juvenile drug court program with the capacity to serve 200 youths. BSAS also oversees the Juvenile Court Early Intervention Program, which conducts assessments and provides referrals for counseling and/or treatment. A special group of Narcotics Anonymous has been formed to meet the needs of juveniles in recovery.

[18]Jane C. Murphy and Margaret Potthast, *Domestic Violence, Substance Abuse, and Child Welfare: The Legal System's Response*, 3 J. of Health Care L. & Pol'y 110 (1999).

[19]*See id.* at 116.

[20]*See* Md. Code Ann., Fam. Law §§ 5–704, 5–706 (1999).

[21]*See* Md. Code Ann., Fam. Law § 5–313(d)(1)(iv) (1999).

[22]The Adoption and Safe Families Act of 1997, Pub. L. No.105–89, 111 Stat. 2115, conditions a state's receipt of federal funding on their adherence to new timelines that reduce the time allowed to resolve cases of child abuse or neglect from eighteen to twelve months. See Department of Health and Human Services, Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection (1999).

addiction or substance abuse. While courts recognize that addiction is a disease, ASFA precludes incorporating that recognition into the operation of the court with respect to parents who are addicts. ASFA fails to acknowledge that addiction is a chronic disease that often entails relapse as part of the recovery process. Instead, ASFA imposes the often unrealistic expectation that a parent suffering from addiction cannot relapse. If he or she does relapse, ASFA punishes him or her for "failure" to succeed in treatment.

III. Recommendations for Developing and Implementing a Holistic Approach to Substance Abuse and Addiction

In order to begin to address the substance abuse and/or addiction that underlie so many cases in family courts, a family division or court must have several procedures and programs in place. While circuit courts in Maryland generally do not have the resources available to Maryland's family divisions, they still have a high percentage of cases involving substance abuse and addiction. The following recommendations are a "recipe" for an effective approach to families and children suffering from addiction and substance abuse, recognizing that not all jurisdictions have the same capacity to implement these practices.[23]

SCREENING AND ASSESSMENT

Every case manager and designated front-line court staff must be trained to recognize the signs of substance abuse, engage a parent or caregiver in a conversation about it, know when to refer for drug screening or testing (and know the difference between the two), and respond adequately to a parent or caregiver seeking help. This does not mean that court staff must evaluate the severity of a substance abuse problem, or even whether such a problem exists; rather, he/she must be able to recognize the possibility of a substance abuse or addiction problem, understand when to send an individual for screening and/or assessment, and know how to respond to a family member who desires help.

TIMELY AND APPROPRIATE TREATMENT

Family court judges and court staff should encourage and facilitate timely and appropriate treatment and services for parents suffering from substance abuse or addiction. Treatment programs generally should include mental and physical health services for women, childcare assistance, pediatric services for children, individual and single-sex group therapy, marital or family counseling, parenting education, literacy programs, and job training.

[23]See Susan E. Foster and Margaret Long Macchetto, *Providing Safe Haven: The Challenge to Family Courts in Cases of Child Abuse and Neglect by Substance-Abusing Parents*, 3 J. Health Care L. & Pol'y 44, 52–57 (1999).

STRATEGIES TO MOTIVATE PARENTS AND CHILDREN TO ENTER AND STAY IN RECOVERY

The threat of losing custody of children can and does motivate women to enter treatment and remain sober and drug-free,[24] but, as mentioned above with respect to ASFA, there are legitimate concerns regarding this method. Given the nature of addiction as a chronic disease and recovery as a long-term process that often includes relapse, it is critical that family court judges, masters, court staff, and attorneys understand that relapse is an integral part of the chronic disease called "addiction," rather than an indication that an individual has failed at treatment.[25]

The following are strategies that a family court and attorneys can develop and implement to encourage parents and caregivers to enter and remain in recovery:

◗ Provide referrals for medical services, parenting classes, and gender-specific counseling and/or self-help groups.

◗ Make space available in the courthouse for Alcoholics Anonymous, Narcotics Anonymous, Association for Children of Alcoholics, and other self-help and support groups.

◗ Make available staff and counselors who are knowledgeable about the particular issues confronting parents in recovery, especially to help pro se litigants.

◗ Provide supervised visitation for families where one or both parent(s) are in recovery.

◗ Educate the family and provide easily accessible information, pamphlets, brochures, and other publications that explain issues relevant to addiction and substance abuse and include information on the nature of addiction, local support and self-help groups, parenting classes, job skills training, local health clinics, and other resources. In addition, families benefit from education on types and purposes of treatment, coping strategies to deal with other family members who may be involved in the abuse of alcohol and/or other drugs, and working with the mental health and/or addiction treatment system in order to address their needs.

◗ Develop and implement programs that help juveniles expelled from school for substance abuse. For example, The Hon. Sheila Murphy (ret.) established an educational program in the Cook County, Illinois, courthouse for teenagers expelled from school for bringing illegal drugs or weapons into the school. Judge Murphy enlisted the assistance of the business community to install computers into the classrooms and to provide internships to the students. By the end of the first year of the "school's" operation, the students were performing better than the county average on standardized tests.

The Baltimore Family Recovery Program is a local example of a comprehensive strategy based on a case management system for parents suffering from substance abuse. The program aims to accelerate reunification with the child or assist the court in establishing other permanency options for the child. It supports the recovery of parents involved in CINA cases with at least one child

[24]*See* Karen Bell, Darci Cramer-Benjamin & Jeane Anastas, *Predicting Length of Stay of Substance-Using Pregnant and Postpartum Women in Day Treatment*, 14 J. Substance Abuse Treatment 393, 394 (1997).

[25]*See* National Center on Addiction and Substance Abuse (CASA) at Columbia University, *No Safe Haven: Children of Substance Abusing Parents* (1999). *See also* Richard C. Boldt, *Evaluating Histories of Substance Abuse in Cases Involving the Termination of Parental Rights*, 3 J. Health Care L. & Pol'y 142–148 (1999).

aged zero to five entering the foster care system for the first time. A case manager from Mental Health Systems, Inc. (MHS) assesses treatment needs for participating parents, refers them to appropriate treatment, and monitors their progress. The case manager performs random drug tests of the parent twice a week and provides the court with reports twice a month on the parent's progress in substance abuse treatment. These reports serve as a factual basis for compliant parents to accelerate reunification with their children (barring any outstanding issues threatening the safety and well-being of the child) or assist the court in establishing other permanency options for the child. The project, developed as an inter-agency collaboration with the Baltimore City Health Department and Baltimore Substance Abuse Systems, ensures that participants have immediate access to substance abuse treatment through publicly funded treatment slots and/or direct purchase of additional treatment slots. The Department of Social Services case manager has primary responsibility for the CINA case, while the MHS case manager focuses on treatment issues. The juvenile court assigns incentives and consequences to Family Recovery Program parents, based on their compliance with their recovery service plan.

QUALIFIED STAFF

As mentioned above, court staff must be trained to recognize the possibility of substance abuse and addiction among adolescents and adults and have a basic understanding of how to address these and related issues. Without regular training on new approaches, administrators and court staff may base their decisions on outdated models that attempt to "scare" youth "straight." They may adopt a disease model that fails to reflect the particular conditions of a given situation or ignores the needs of a specific individual. Effective court management calls for court staff to become regular consumers of the research on improvements and innovations in treatment.

GENDER AND CULTURAL COMPETENCE

Courts should recognize opportunities to build more culturally responsive service options and capacities. Judicial education and staff training should cover culturally-relevant best practices, including the modification of treatment to meet an individual's specific needs. Court staff should be trained to recognize the impact of a variety of factors, including gender, culture, socioeconomic status, ethnicity, language, literacy, and physical or cognitive ability.[26]

Another concern is the significant increase in the number of women entering the justice system without any corresponding increase in the number and quality of treatment programs available to them.[27] Research has shown that females are more likely than males to have a mental health disorder and trauma-related problems in addition to a substance abuse problem. They are also more likely to be affected by poverty, physical or sexual abuse, unstable social supports, and medical problems such as HIV.[28]

[26]*See* Physicians and Lawyers for National Drug Policy, *supra* note 14, at 44.

[27]*Id.*

[28]*Id.*

CONTINUING CARE

Substance abuse and addiction treatment works best when it extends beyond a brief active intervention phase and continues to support a youth once he/she begins to put new alcohol and drug-free identity-building skills to work following the treatment process. Court staff should help youth find adequate and effective supports to maintain a lifestyle that is free of drugs and alcohol.

COLLABORATION WITH SOCIAL SERVICE AGENCIES/YOUTH SERVICES

While a family court can provide numerous pre- and post-adjudication services, such as crisis counseling, emergency shelter, substance abuse screening, treatment referrals, and other intake services, court staff often need to reach out to other agencies to coordinate services for the families struggling with addiction and/or substance abuse. Court staff may have to coordinate appointments, paperwork, and requirements so that family members understand them. This can be challenging. The following touches on some of the potential issues that arise as a family learns to live with a member who is in recovery and suggests ways to address these issues.[29]

Families involved with several agencies can become confused about who provides what services or which deadlines are in effect. It is important for court staff to coordinate their efforts with services providers and clearly communicate the treatment plan to the family. When possible, a formal staff meeting with all services providers and the family can facilitate that communication.

Different agencies may recommend or require conflicting courses of action. For example, the social worker may tell an adolescent in treatment to go to school, the probation officer may suggest that he/she get a job, and the child's school may prefer him/her to stay at home while in treatment. Court staff are in a position to resolve such conflicting demands by working with all services providers to develop a plan that prioritizes tasks.

Court staff serve diverse clients with a broad spectrum of issues relating to addiction/substance abuse, including cultural barriers and co-occurring medical and/or psychiatric disorders, among others. These issues must be addressed from the very first contact with a family member. Court staff should develop awareness of and participate in training designed to enhance their knowledge of these issues and the importance of the family as a strong and positive resource in treatment.

While the court typically comes into contact with several family members, staff may reach out to other members of that family's support network in order to strengthen the family and improve chances for recovery. La Bodega de la Familia, a community-based storefront program for offenders with substance abuse disorders and their families, implemented Family Partnering Case Management (FPCM), an approach that may be adopted by court staff.[30] Court-involved family members are encouraged to define their "family" in the broadest sense in order to capture the entire potential support network. Participants and their families help design and implement their

[29]These recommendations are adapted from guidelines and methods suggested by Edward Kaufman and Marianne R.M. Yoshioka. *See* Kaufman and Yoshioka, *supra*, note 8, at 76.

[30]Carol Shapiro, *La Bodega de la Familia: Reaching Out to the Forgotten Victims of Substance Abuse*, Bureau Just. Assistance Bull. 1–3 (1998).

service plans, increasing the likelihood of compliance and success in treatment and reconnecting with the community.

Most family court settings will need to push for changes both within their own organizational boundaries as well as across a broad spectrum of youth and adult services (education, mental health, substance abuse treatment, child welfare, etc.) in order to develop and implement a systemic approach to substance abuse and addiction. They will need to address barriers such as scarcity of resources for services and service development, "turf battles," lack of linkages and coordination between agencies, and the slow acceptance of best practices and youth/family centered approaches. They will need to involve the community differently to reflect the needs of these youths as a community challenge over and above the day-to-day operation of the family court.

RESOURCES

Addiction Technology Transfer Center (ATTC)

www.nattc.org
The ATTC Network's mission is to disseminate the latest science on addiction to the treatment community. Its website includes links to information about cultural competence in substance abuse treatment.

NIATx (Removing Barriers to Treatment and Recovery)

www.actioncampaign.org
Aims to increase access to treatment for individuals in need and to keep those in recovery engaged in treatment.

American Academy of Addiction Psychiatry

www.aaap.org
A national association of addiction psychiatrists and other health professionals with a specialty in treating mental health and substance abuse disorders.

ASAM Patient Placement Criteria

www.asam.org/PatientPlacementCriteria.html
The American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders offers practice guidelines for matching addiction patients to appropriate levels of care.

Brown University Center for Alcohol and Addiction Studies

www.caas.brown.edu
Promotes the identification, prevention, and effective treatment of alcohol and other drug use problems through research, education, training, and public advocacy.

Center for Court Innovation

www.courtinnovation.org
A non-profit think tank that helps courts aid victims, reduce crime, and improve public trust in the justice system. Projects include: community courts, drug courts, reentry courts, domestic violence courts, and mental health courts.

Center for Substance Abuse Treatment

http://samhsa.gov/about/csat.aspx
Includes a range of information and publications about substance abuse and addiction, treatment, statistics, and community-based services.

Cultural Competence in Substance Abuse Treatment, Policy Planning, and Program Development

http://www.mocmhc.org/documents/bibliography%20of%20cultural%20competence%20in%20substance%20abuse%20treatment.pdf
A bibliography that provides background information on cultural competency, culturally competent treatment, information on why it is an important component of counseling, and implications for program development.

Faces and Voices of Recovery (FAVOR)

www.facesandvoicesofrecovery.org
A national campaign of individuals and organizations advocating for recovery services.

Institute of Medicine of the National Academies

http://www.iom.edu/
Published "Reducing the Harms of Underage Drinking: A Collective Responsibility," a report that says reducing underage drinking requires a cooperative effort from all levels of government, alcohol manufacturers and retailers, parents, and other members of the community.

JEHT Foundation

www.jehtfoundation.org
Works to bring the latest research and best practices to make the criminal justice system more effective in ensuring public safety.

Johnson Institute

www.johnsoninstitute.org
Dedicated to improving and expanding the public's understanding of addiction as a treatable disease.

Legal Action Center

www.lac.org
The only non-profit law and policy organization whose sole mission is to fight discrimination against people with histories of addiction, HIV/AIDS, or criminal records, and to advocate for public policies in these areas. Offers a wide range of publications and educational materials on alcohol and drugs, HIV/AIDS, and criminal justice.

Maryland Department of Health and Mental Hygiene

http://www.dhmh.maryland.gov
Provides a comprehensive listing of businesses and healthcare providers specializing in treatment of substance abuse and addiction.

Monitoring the Future

www.monitoringthefuture.org
An ongoing study of the behaviors, attitudes, and values of American secondary school students, college students, and young adults.

National African American Drug Policy Coalition

www.naadpc.org
Twenty-three organizations representing lawyers, psychologists, psychiatrists, social workers, dentists, law enforcement, and other professionals interested in promoting more effective drug policies and practices.

The National Center on Addiction and Substance Abuse at Columbia University

www.casacolumbia.org
Includes a wide range of professional disciplines studying substance abuse and addiction. Publications and initiatives aim to inform about the economic and social costs of substance abuse and addiction and to remove the stigma of recovery.

National Council of Alcohol and Drug Dependence (NCADD)

www.ncadd.org/
Includes state chapters and provides information and education about alcohol and drug dependence.

National GAINS Center

http://gainscenter.samhsa.gov/html
Primary focus is on expanding access to community-based services for adults diagnosed with co-occurring mental illness and substance abuse disorders at all points of contact with the justice system. The Center emphasizes the provision of consultation and technical assistance to help communities achieve integrated systems of mental health and substance abuse services.

National Institute on Alcohol Abuse and Alcoholism

http://www.niaaa.nih.gov/
Provides information about causes, consequences, and treatment of alcohol-related problems.

National Institute on Drug Abuse

http://www.nida.nih.gov/
Provides a wealth of information and links to additional resources on the science of addiction and substance abuse. Includes links to pages of information about commonly abused drugs, articles on addiction, and research on the latest developments in the addiction and substance abuse field.

Office of National Drug Control Policy

www.whitehousedrugpolicy.gov/
Establishes policies, priorities, and objectives for the national drug control strategy. The website offers information about drugs, drug policy, prevention, and treatment.

Physicians and Lawyers for National Drug Policy

www.plndp.org
A non-partisan group of leading physicians and attorneys, whose mission is to promote and support public policy and treatment options that are scientifically-based, evidence-driven, and cost-effective.

Reclaiming Futures

www.reclaimingfutures.org
An effective and innovative approach to helping young people to cope with substance abuse and addiction. Reclaiming Futures promotes opportunities and standards of care in juvenile justice, and fosters pilot programs that improve the ways in which the law enforcement and justice systems collaborate to provide treatment and support for young people.

Substance Abuse and Mental Health Services Administration (SAMHSA)

www.samhsa.gov
Offers a national toll-free referral service for locating drug and alcohol abuse treatment programs operated by the Center for Substance Abuse Treatment. Call: 800-662-HELP

SAMHSA Co-Occurring Center for Excellence

www.coce.samhsa.gov
Provides technical assistance, training, products, and resources to support the dissemination and adoption of best practices in systems and programs that serve individuals with co-occurring disorders.

Treatment Research Institute Law and Ethics Program

www.tresearch.org/law_ethics/law_ethics.htm
Evaluates the impact of legal policies and ethical mandates on substance abuse clients, their families, and the community. The program develops tools to foster clinically suggested improvement in supervision of clients.

University of Baltimore School of Law Center for Families, Children and the Courts

http://law.ubalt.edu/cfcc
Creates, fosters, and supports a national movement to integrate communities, families, and the justice system in order to improve the lives of families and the health of the community. CFCC is a national leader in promoting the concept of a unified family court system, which resolves family conflicts in a therapeutic, ecological and service-based manner.