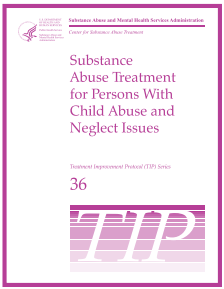
Quick Guide

For Clinicians

Based on TIP 36

Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues



Substance Abuse and Mental Health Services Administration
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Contents

Quick Guide

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Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues

This Quick Guide is based entirely on information contained in TIP 36, published in 2000. No additional research has been conducted to update this topic since publication of the original TIP.

WHY A QUICK GUIDE?

The purpose of a *Quick Guide* is to provide succinct, easily accessible information to busy clinicians.

This *Quick Guide* is based on *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues*, number 36 in the Treatment Improvement Protocol (TIP) Series, published by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration. It will help substance abuse treatment providers recognize and treat clients presenting with a history of child abuse and neglect or clients who are currently maltreating their children.

The *Quick Guide* is divided into sections to help readers quickly locate relevant material. For more in-depth information on the topics in this *Quick Guide*, readers should refer to TIP 36.

WHAT IS A TIP?

The TIP Series was launched in 1991. The goal of these publications is to disseminate consensus-based, field-tested guidelines on current topics to substance abuse treatment providers.

TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues*

- Defines child abuse and neglect
- Describes screening and assessment tools for identifying individuals with child abuse and neglect issues
- Presents comprehensive plans for treating adult survivors
- Discusses ways to break the intergenerational cycle of child abuse
- Explains legal responsibilities and recourse.

To order a copy of TIP 36 and other related products, see the inside back cover of this Quick Guide.

INTRODUCTION

Physical, emotional, and sexual abuse and neglect during childhood can increase a person's risk of developing substance abuse disorders. Children of substance-abusing parents, in turn, are more likely to be abused or neglected, resulting in an intergenerational cycle.

The reported cases of abused and neglected children increased from 1.4 million in 1986 to more than 3 million in 1997. Substance abuse was involved in more than 70 percent of these cases. Substance abuse severely complicates efforts by children's protective service (CPS) agencies to protect children and rehabilitate families.

ISSUES

Compared with other substance users, clients with childhood abuse histories

- Have more severe substance abuse disorders
- Started using substances at a younger age
- Use substances for reasons that differ from those of other clients
- Have a higher attempted suicide rate
- Show more posttraumatic stress disorder (PTSD)

- Have personality or relationship problems that make them hesitant to accept help
- Are more vulnerable to relapse.

(For more information, see TIP 36, pages 1–8.)

Definitions

The Child Abuse Prevention and Treatment Act defines child abuse and neglect as any recent act or failure to act that results in "imminent risk of serious harm, death, serious physical or emotional harm, sexual abuse or exploitation" to a child below the age of 18, or (except in sexual abuse) below the age specified by the child protection law of the State, by a parent or caretaker (including any employee of a residential facility or any staff person providing out-of-home care) who is responsible for the child's welfare.

Types of child maltreatment are

- **Neglect**—failure to provide basic physical, educational, medical, or emotional needs.
- **Physical abuse**—injury inflicted by deliberate actions.
- **Sexual abuse**—engaging a child in sexual activities that the child cannot comprehend, consent to, or be prepared for developmentally. It includes all forms of sexual contact,

nontouching abuse (exhibitionism, voyeurism), and commercial exploitation. Incest is the imposition of sexual acts, or acts with sexual overtones, on a child by persons who have authority through ongoing emotional bonding with that child. Some States define abuse as an act perpetrated by a caregiver and assault as an act committed by a noncaregiver. However, it is commonly held that any use of force constitutes sexual assault.

- **Emotional or psychological abuse**—an act of commission or omission that causes serious behavioral, cognitive, emotional, or mental disorders; it is the most difficult form of abuse to identify.

The counselor should consider the meaning of the trauma or abuse to the client, the effect on the client, and not just legal definitions.

Childhood trauma can

- Increase the intensity of treatment services required
- Lengthen the time needed for treatment
- Increase the number of sessions needed.

(For more information, see TIP 36, pages 9–14.)

SCREENING AND ASSESSING ADULTS FOR CHILDHOOD ABUSE OR NEGLECT

Childhood abuse and neglect often alter a child's perception of the world, leading to feelings of betrayal, an inability to trust, low self-esteem, and great shame.

The following reactions, symptoms, or disorders may result:

- Self-mutilation
- Depression (thoughts of death, suicidal ideation, feeling hopeless)
- Dissociative responses
- Aggressive behavior or "acting out," including
  - Early sexual activity or sexualized behavior
  - Physically abusing or harming animals
- Poor relationships with one or both parents
- Attachment disorder, difficulty trusting others
- Excessive passivity
- Passive/aggressive behavior
- Blacked-out timeframes—no memory of periods during childhood
- Excessive nightmares, extreme fear of the dark, or requests for locks on doors

- Posttraumatic stress disorder
- Eating disorders
- Borderline personality disorders
- Excessive anger or shame
- Anxiety
- High tolerance for inappropriate behavior
- Arousal, hyperreactivity
- Age regression
- Derealization/depersonalization
- Emotional and sensory numbing.

Screening and assessment should be done

- In a safe, nonthreatening environment
- Early in the comprehensive assessment process
- At different times during treatment.

Several factors make accurate screening a challenge:

- Underreporting or overreporting of trauma histories or symptoms
- Repressed memories
- Coexisting psychiatric disorders.

Ongoing screening elicits more information about traumatic experiences—especially after trust has been established in the therapeutic relationship.

No one should screen for childhood trauma without proper training and supervision.

Counselors should learn to

- Understand the effects of childhood maltreatment on the adult's feelings and behaviors
- Identify individuals with symptoms of abuse or neglect.

Clinicians are more likely to ask female clients about past childhood maltreatment, but many male clients also were neglected and abused (including sexually) as children.

Screening Methods

Exhibit 36–1 lists information about a sample of screening instruments. Screening can be done by asking direct questions (see exhibit 36–2) or by using standardized instruments.

(For more information, see TIP 36, pages 15–25 and pages 169–172.)

Exhibit 36–1
Standardized Screening Instruments

Instruments	Description	Contact
Addiction Severity Index (ASI)	161-item structured, clinical questionnaire, frequently used during intake	http://www.ntis.gov
Childhood Trauma Questionnaire (CTQ)	28-item self-report questionnaire	http://www.psychcorp.com/sub0300/ctq.html
Parental Acceptance and Rejection Questionnaire (PARQ)	brief self-report questionnaire concerning parental affection, hostility, neglect, and rejection	http://home.earthlink.net/~rohner_research

Parent-Child Relationship Inventory (PCRI)	78-item self-report questionnaire assessing parenting, parental satisfaction, communication, limit setting, and autonomy	http://portal.wpspublish.com/portal/page?_pageid=53,53086&_dad=portal&_schema=PORTAL
Screen for Posttraumatic Stress Symptoms (SPTSS)	17-item self-report tool, useful for clients with multiple traumas or an unknown trauma history	Eve Carlson, PhD National Center for PTSD (334-PTSD) 795 Willow Road Menlo Park, CA 94025 Email: eve.carlson@va.gov
Trauma Symptom Checklist-40 (TSC-40)	40-item self-report tool with 6 subscales that evaluate anxiety, dissociation, and sexual concerns	http://www.johnbriere.com/tsc.htm

Exhibit 36–2
Direct Questions To Use in Childhood Abuse or Neglect Screening

Questions about traumatic events
When you were a child

- Were there any significant traumatic events in your family while you were growing up? For example: deaths, hospitalizations, or incarcerations of a parent or sibling; divorces; or chronic diseases?
- Were you treated harshly?
- Did you ever experience physical, sexual, or emotional abuse?
- Did you experience inappropriate physical or sexual contact with an adult or person at least 5 years older than you?
- Was there violence in your household, such as battering of siblings, a parent, or his or her partner?
- Do you feel that your parents neglected you? Did you have adequate food, clothing, shelter, or protection?
- Did your parents frequently use alcohol or drugs? Did you ever use alcohol or drugs with them?

Exhibit 36–2 (continued)

Questions about circumstances suggestive of traumatic events

- Have you or has anyone in your family ever been involved with children's protective services?
- Did you ever live away from your parents? Were you or your siblings ever in foster care?
- Did you ever feel unsafe or in danger?
- Have you ever felt that abuse or neglect was your fault and that you deserved it?

Adapted from TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues*, page 24.

Assessment

A positive screen indicates that more information and a thorough assessment are needed. Also consider

- The client's readiness to discuss the issue
- The input of members of the treatment team
- The family's involvement.

Family-of-origin characteristics to consider during an assessment include

- A history of parental substance abuse and/or violence

- CPS involvement
- The placement of children in foster care
- The use of severe discipline during childhood
- Traumatic family separations and losses.

(For more information, see TIP 36, pages xvii–xx.)

Ask for information about

- The type of abuse
  - Physical, sexual, or psychological abuse
  - Neglect
  - Exploitation
  - Multiple forms of abuse
- Whether the perpetrator was a parent, other relative, stranger, teacher, or caregiver
- The frequency and duration of abuse (i.e., ages at onset and cessation)
- The context of the trauma, including the use of force or fear
- The family's knowledge of and response to the abuse

- Any mental health counseling or other treatment as a child
- How and when the abuse was disclosed
- Its social and legal consequences.

(For more information, see TIP 36, pages 25–39.)

Special Considerations

Treatment programs should have written protocols that describe

- The who, when, and where of screening and assessments
- The information required
- Confidentiality and reporting regulations
- Each treatment team member's role
- Screening instruments to use
- How to present, discuss, document, and interpret findings
- How to incorporate findings into treatment plans.

Standardized tests should be used as guidelines to conduct screening and assessments. Exhibit 36–3 presents a sample of assessment tools.

(For more information, see TIP 36, pages 39–41.)

Exhibit 36–3
Assessment Tools

A. Mental Health Assessments

Name	Description
Beck Depression Inventory (BDI)	21-item scale; measures depression severity
Brief Symptom Inventory (BSI)	53-item tool/10 minutes
Profile of Mood States (POMS)	65-point objective rating scale; measures mood states
Symptom Checklist-90-Revised (SCL-90-R)	90-item brief multidimensional inventory; screens for psychopathology/15 minutes
Mini International Neuro-psychiatric Interview (MINI)	120-question structured interview; screens for major psychiatric disorders
Psychiatric Research Interview for Substance and Mental Health Disorders (PRISM)	diagnostic interview; based on *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM–IV)/90 to 150 minutes

Schedule for Affective Disorders and Schizophrenia (SADS)	used for evaluation, diagnosis, determining prognosis and severity
Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I)	comprehensive interview tool; reviews all DSM-IV Axis I disorders

B. Trauma-Oriented Tools

Name	Description
Assessing Environments III, Form SD	170 items, 7 scales; determines clients' perceptions of maltreatment
Childhood Maltreatment Questionnaire (CMQ)	focuses on psychological abuse and neglect; assesses physical and sexual abuse
Trauma Assessment for Adults (TAA)-Self-Report	17-item tool/10 to 15 minutes

(continued on next page)

Exhibit 36–3 (continued)

Name	Description
Traumatic Events Scale (TES)	evaluates 30 specific traumas
Dissociative Experiences Scale (DES)	28-item tool; elicits information on pathological and normative dissociative experiences/5 to 10 minutes
Modified PTSD Symptom Scale: Self-Report Version (MPSS-SR)	17-item tool/10 to 15 minutes
Penn Inventory for Posttraumatic Stress Disorder	26-item tool/5 to 15 minutes
Posttraumatic Stress Diagnostic Scale (PDS)	49-item tool; assesses all DSM-IV criteria for PTSD/10 to 15 minutes
Trauma Symptom Inventory (TSI)	100-item test; evaluates consequences, identifies problems needing immediate attention (suicidal ideation/behavior, psychosis, self-mutilation)/20 minutes

Child Maltreatment Interview Schedule (CMIS)	46-items; assesses emotional, physical, and sexual abuse
Childhood Trauma Interview (CTI)	49 items plus multiple followup probes/30 to 90 minutes
Trauma Assessment for Adults (TAA)	13-item tool; evaluates potentially traumatic events
Evaluation of Lifetime Stressors (ELS)	56-item self-report questionnaire + semistructured interview
National Women's Study Event History (NWSEH)	7 screening items with probes for positive answers/15 to 30 minutes
Clinician-Administered Posttraumatic Stress Disorder Scale (CAPS)	30-item structured interview/30 to 60 minutes to administer

COMPREHENSIVE TREATMENT

Acknowledging past child abuse helps clients break through secrecy and shame resulting from abuse. Talking to a sympathetic listener can be an important first step in the healing process.

Counselors should

- Show their unconditional regard, nonjudgmental attitude, and sincerity
- Be sensitive to the client's cultural background
- Be a sympathetic listener
- Acknowledge and validate the client's experience by recognizing the issue and refocusing the treatment to address the issue
- Provide a link to mental health services, if the client needs additional treatment
- Adhere closely to accepted standards of practice, ethics, and legal requirements
- Delicately discuss past abuse in the presence of family members who were involved
- Disclose abuse with tact and sensitivity
- Explain the treatment itself and when and how abuse issues will be addressed.

Clients' subjective experience of and feelings about the abuse can shape their psychological response more than the actual circumstances of it. It is normal for clients to be uncertain about the abuse or not remember all that happened. The counselor should

- Support the client's recall
- Reinforce that the feelings about the trauma are the most significant aspect of the experience
- Consider the client's coping strategies and their effectiveness.

Substance abusers generally go through three stages when dealing with their childhood maltreatment issues, which may take years to complete. They are

- **Stage 1 (0–30 days)**—Substance abuse treatment begins. In-depth attention to childhood trauma issues is not appropriate.
- **Stage 2 (31 days–2 yrs.)**—The client may be able to address childhood issues.
- **Stage 3 (2+ yrs.)**—The client is able to deal with a broad range of issues.

Never force clients to confront abuse issues. This may create an abusive situation and retraumatize

the client. Whether to address childhood abuse is the client's choice and depends on the client's symptoms and ability to stay sober.

Some individuals with childhood abuse issues may not do well in group settings, so group therapy may not be appropriate. Gender-specific groups are generally more beneficial.

For most clients, therapeutic work in addition to substance abuse treatment is required for full resolution of the issue.

Tell clients

- Their history of child maltreatment may have contributed to some of their errors in thinking and decisionmaking.
- They may have medicated themselves with substances to avoid dealing with their feelings.
- They are not alone, and resources are available to help.
- They can learn better ways to cope and live a happier life.

(For more information, see TIP 36, pages 43–50.)

Involving the Family in Treatment

If a client and the treatment team agree to include family therapy in substance abuse treatment, it should be conducted by a licensed mental health professional with specific training in childhood abuse and neglect. Whether family therapy is appropriate depends on

- The family's knowledge and acknowledgment of the abuse
- The client's feelings and preferences
- The current relationships among family members.

Counselors should be cautious about discussing child abuse issues with family members. This may not be therapeutic or essential for every client.

Mental Health Treatment Services

Counselors should consider their limitations when working with clients who were severely abused. Although it is best to treat substance abuse and other mental health issues in the same venue, this is not always possible. When a client's mental health problems are beyond the counselor's treatment ability, a referral must be made to an appropriate provider.

Clients should be immediately evaluated by a psychiatrist if they have or show

- Active, severe depression or anxiety
- Self-mutilation tendencies
- Suicidal ideation or behavior
- Extreme dissociative actions
- A history of other psychiatric crises.

(For more information, see TIP 36, pages 50–58.)

THERAPEUTIC ISSUES FOR COUNSELORS

Many clients raised in abusive households learned how to function in an unhealthy environment and did not learn healthy interpersonal behavior skills. Counselors should model these behaviors and

- Expect their clients to do well
- Be warm and respectful
- Be sensitive to cultural concerns
- Recognize potential language differences
- Not excuse parents' abusive or neglectful behavior because of cultural differences.

The violence and cruelty clients experienced upsets many counselors and results in intense reactions. Counselors should be aware of

- The effect a client's story has on them
- Their own countertransference reactions
- Any judgmental or insensitive attitude
- The need to seek supervision.

The counselor must be aware of the following:

- **Transference**—feelings and issues that clients project onto a counselor during therapy.
- **Countertransference**—a counselor's reactions and responses to a client's issues. The counselor loses objectivity and becomes overwhelmed, angry, or bereft about a client's experience.
- **Secondary Traumatization**—symptoms of trauma that are brought about by repeated confrontations or disclosures of victimization and exploitation.
- **Burnout**—when work pressure erodes a counselor's well-being and interferes with his or her personal life.

Counselors should

- Not work in isolation
- Seek to treat individuals with a variety of problems
- Keep a manageable caseload
- Receive support from their agency
- Recognize when they are unable to work with a specific client and refer that client to another provider.

An agency can support counselors by

- Providing a sense of mission
- Providing ongoing clinical supervision
- Supporting their efforts to keep their caseloads manageable.

The Treatment Frame

Develop a *treatment frame*—the set of conditions necessary to support a professional relationship with the client. Its parameters might include

- Specifying regular appointment times in advance
- Enforcing set starting and ending times for each session

- Declining to give out a home phone number or address to clients
- Canceling sessions if a client arrives under the influence of alcohol or psychoactive drugs
- Not having client contact outside the therapy session
- Not having sexual contact or interactions with a client that could reasonably be interpreted as sexual
- Terminating counseling if violence is threatened
- Establishing and enforcing a clear policy regarding payment.

Building Trust

Because adults who were abused or neglected by their parents have experienced betrayal in their most significant relationships, they often cannot trust others. The counselor should

- Remain consistent and available
- Help allay clients' fears of abandonment and rejection
- Show unconditional positive regard
- Maintain a nonjudgmental attitude.

(For more information, see TIP 36, pages 61–71.)

BREAKING THE INTERGENERATIONAL CYCLE

Children whose parents abuse substances are more likely to be abused or neglected than other children, to grow up and abuse substances themselves, and to abuse their own children.

Adults who were victims of childhood maltreatment often have difficulty parenting because of their inability to

- Trust
- Choose emotionally healthy partners
- Manage stress
- Nurture themselves or others.

Family-centered interventions are the most successful at breaking the cycle of substance abuse, child neglect, and child maltreatment.

Just as substance-abusing parents often deny their drug use, they may deny neglecting or abusing their children.

(For more information, see TIP 36, pages xxii and xxiii.)

Who Abuses and Why

Characteristics shared by parents who abuse their children include

- Considering child rearing difficult and unenjoyable
- Using excessively controlling disciplinary techniques
- Not encouraging autonomy in their children while maintaining high standards of achievement
- Promoting an isolated lifestyle for themselves and their children
- Expecting their children to take on the role of caretaker.

Other characteristics of abusive parents include

- Poverty, substance dependence, mental illness
- Feelings of inadequacy and self-reproach, often related to early negative experiences
- Depression, difficulty articulating their needs or feelings, anxiety
- Seriously arrested development
- A sense of incompleteness resulting from a failure to internalize a separate identity (manifested by clinging to their children)

- Having other abusive and unfullfilling relationships
- An inability to tolerate being alone
- Fear of taking responsibility and making decisions
- Severe difficulty with verbal communication
- Difficulty in seeking or obtaining pleasure
- Extreme narcissism, gross immaturity, and dependence
- An impaired ability to empathize with a child's needs.

Some children avoid becoming part of the cycle of abuse. These children tend to exhibit "resilience" factors such as

- **Insight**—sensing that life in the troubled family is not "normal"
- **Independence**—separating from the troubled family
- **Other relationships**—fulfilling needs not met by the troubled family through others
- **Initiative**—attempting to overcome negative feelings
- **Creativity**—transforming pain into something worthwhile

- **Humor**—making tragedies into something funny
- **Morality**—understanding common mores of good and bad as they exist both inside and outside the family.

(For more information, see TIP 36, pages 73–76.)

Role of the Counselor

By working closely with a substance abuser, the counselor can break the abuse cycle. The treatment provider should become familiar with the client's family life and any parenting behaviors that might indicate possible child abuse.

Parents who abuse substances differ in experiences and parenting skills. Questions to ask clients to gain insight into their home life include

- What groups give you support? Do you have any special friends? Do you belong to a community- or faith-based organization?
- What type of social activities do you enjoy? How often do you participate in them?
- Have you been involved in the criminal justice system? When? Have you ever been on probation?
- Have you been involved with other social service agencies? With CPS agencies? Why?

- Who else lives in your home? Who else spends time there?
- What is your routine each day? On weekends?
- What do you do with your children each day? On holidays?
- Are your children receiving ongoing medical care? What is their health status?
- Does anyone care for your children besides you? What is his or her role and attitude toward the children?

If the counselor can observe how a client relates to his or her children, the counselor should consider these questions:

- How does the client react to the children's behavior?
- How does the parent respond to their emotional needs?
- Do the children make eye contact with him or her?
- How does he or she respond to the children's crying?
- How does the parent praise and discipline the children?
- Are the parent's expectations age appropriate?

In addition to the above questions, counselors treating clients who do not have custody of their children should learn about

- The CPS agency's plan, requirements, and schedule for family reunification
- The client's history of custody challenges and outcomes.

(For more information, see TIP 36, pages 79–93.)

Behavioral clues that suggest possible child abuse or neglect include

- Name calling, belittling, or negative labeling of children
- Telling stories that suggest children are living in unsafe conditions (e.g., being left alone)
- Blaming children or directing misplaced anger at them that may mask guilt or poor parenting
- Having inappropriate expectations for the children's age/developmental stage
- Giving children too many responsibilities and too much autonomy for their age
- Sexualizing a child/children
- Making negative comparisons involving the children

- Imposing inappropriate discipline or not being able to distinguish between discipline (guiding) and punishment (hurting).

(For more information, see TIP 36, pages 73–80.)

Treatment Strategies for Child Abusers

When parents lack good parenting skills, they will need help

- Recognizing the importance of appropriate parenting behaviors
- Seeking assistance in becoming better parents
- Identifying others who can support them
- Understanding how substance abuse affects responsible parenting.

Remember to reinforce clients' positive skills and praise them when they demonstrate appropriate parenting behavior.

Parents need help learning about

- Child development
- Good parenting skills
- The impact of child abuse on a person
- How to form good relationships with a partner and other adults

- Healthy personal and social development skills.

Counselors should make clear that

- They are concerned about the client both as a person with a substance abuse disorder and as a parent with responsibilities.
- The client's safety and the children's safety are both important.

LEGAL ISSUES

Recordkeeping

Instances of abuse and neglect revealed by a client must be recorded. To protect the provider, the record should state that the client reported abuse, not that the client "was abused."

Counselors should

- Record information in an organized, professional manner
- Document only the factual, observable behavior of a client and his or her statements
- Omit judgmental statements
- Respect the rules of confidentiality (42 Code of Federal Regulations [C.F.R.] Part 2).

According to Federal regulations, information may be provided to outside sources only if there is written consent from the client, a court order, or a qualified service organization agreement.

(For more information, see TIP 36, page 59 and appendix B.)

Mandated Reporting

All States require counselors to report incidents of known or suspected child abuse or neglect such as when

- A child has been injured by a parent or other adult (other than accidentally).
- A parent or other adult does not seek medical attention or fails to follow medical advice for a seriously ill or injured child.
- An adult has inappropriately touched a child (or made the child touch an adult inappropriately), sexually abused a child, or exploited a child.
- A child is not attending school, and the parent refuses to send him or her (home schooling must be documented).

Consult a supervisor before reporting suspected child abuse or neglect, unless immediate action is required (the child is in immediate danger).

Agencies should provide orientation about reporting policies and procedures to all staff.

An adult survivor of abuse usually discusses events that took place many years before, which generally are exempt from reporting requirements. However, if the person who abused or neglected the client has custody of other children, the program should seek advice about whether it has a reporting responsibility.

Provide only the basic information required by the State law: the names of the reporting counselor and of the treatment program.

The importance of the counselor–client relationship must not override the counselor's duty to report abuse. If a client has a history of violence, the counselor must also consider his or her own safety.

(For more information, see TIP 36, pages 95–104.)

CPS Agency Investigations

After receiving a report, CPS staff assess the situation and develop a service plan that details

- The conditions the clients must meet to retain or regain custody of their children
- A timetable for accomplishing each

- The resources available to help the family.

The goals of CPS agencies and the court system differ from those of the substance abuse treatment provider; they focus on children's safety.

When dealing with CPS agencies, courts, and law enforcement, counselors must

- Ask their supervisor's guidance
- Consult with their client
- Consult State law (or a lawyer familiar with State law).

(For more information, see TIP 36, pages 109–111.)

SELECTED RESOURCES

American Psychiatric Association
http://www.psych.org

American Psychological Association
http://www.apa.org

Child Welfare Information Gateway
http://www.childwelfare.gov

Institute on Violence, Abuse and Trauma
http://www.ivatcenters.org

International Society for Traumatic Stress Studies
http://www.istss.org/home.htm

Mental Health America
http://www.nmha.org

National Alliance on Mental Illness
http://www.nami.org

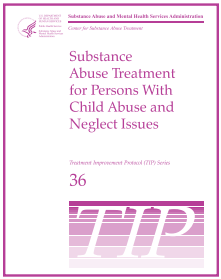
National Center for Victims of Crime
http://www.ncvc.org/ncvc/Main.aspx

National Mental Health Consumers' Self-Help Clearinghouse
http://mhselfhelp.org

Survivors of Incest Anonymous
http://www.siawso.org

Ordering Information

TIP 36 *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues*



TIP 36-Related Products

KAP Keys for Clinicians Based on TIP 36

This publication may be ordered from SAMHSA's Publications Ordering Web page at http://store.samhsa.gov. Or, please call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español). The document may be downloaded from the KAP Web site at http://kap.samhsa.gov.

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Other Treatment Improvement Protocols (TIPs) that are relevant to this Quick Guide:

TIP 25, *Substance Abuse Treatment and Domestic Violence* (1997) **(SMA) 12-4076**

TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (1998) **(SMA) 12-4215**

TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (2005) **(SMA) 08-3992**

See the inside back cover for ordering information for all TIPs and related products.

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