



NASW SPECIALTY PRACTICE SECTIONS  
FALL/WINTER ■ 2015

# SW&C

SOCIAL WORK & THE COURTS

SECTION  
CONNECTION



## NASW Practice & Professional Development Blog

Where can you find the latest information posting about social work practice? Visit the NASW Practice and Professional Development Blog. Designed for NASW Section members and social workers in practice, it offers trending topics, valuable resources, and professional development opportunities. Learn more at [www.socialworkblog.org/practice-and-professional-development/](http://www.socialworkblog.org/practice-and-professional-development/).

# WORKING WITH CHILDREN

## The Many Layers of Consent to Treat

CAROLYN I. POLOWY, JD • ELIZABETH FELTON, JD, MSW

©February 2014. National Association of Social Workers. All rights reserved. Re-publication of this article or portions thereof is by permission only. Re-print permission granted by NASW's Legal Defense Fund.

*The following is a condensed version of a "Legal Issue of the Month" article the complete version of which can be accessed on the Legal Defense Fund webpage.*

### PARENTAL CONSENT TO A CHILD'S TREATMENT

A child is often presented for treatment by one parent who may be separated or divorced from the other (second) parent. The second parent may or may not have legal custody (the right to make decisions) or rights to physical custody of the child. The first parent may not discuss the full family picture at the time the child is presented for treatment except, perhaps, to note that the second parent's insurance is to be billed. The first parent may want the treatment to cover issues that have evolved during the break-up of the marriage and the resulting family separation. When the second parent realizes that the child is in treatment, he/she will often demand access to the child's records, an opportunity to talk with the social worker about the treatment or the termination of treatment. That scenario provides a plethora of legal issues – some of which could be avoided if several questions were preliminarily asked and answered:

- What is the status of the child and his or her parents/family/guardians?
- What documents exist to establish the status of the family/child/guardianship?
- Will the presenting parent sign a form documenting his/her authority to consent to treatment?

Joint legal custody of children by both parents in a divorce is the rule in some states and may be required by state statute. A chart of child custody laws provided as an Appendix to the Legal Rights of Children Law Note (1), details the many variations that the states utilize to recognize or limit parental custody. For example, there is a presumption of joint custody in Alabama, California, Connecticut, District of Columbia, Florida, Idaho, Louisiana, Maine, Minnesota, Mississippi, Nevada, New Hampshire, New Mexico, Tennessee, West Virginia, and Wisconsin. At the same time these statutes may limit the presumption of joint custody by also requiring that both parents must agree to joint custody or that joint custody must be in the child's best interest and cannot be granted where there is evidence of child abuse or neglect. In most other states, the court is



National Association of Social Workers  
Specialty Practice Sections

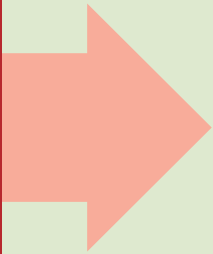
750 First Street NE, Suite 800  
Washington, DC 20002-4241

©2015 National Association of Social Workers.  
All Rights Reserved.

## IT'S A FACT:

Human trafficking has grown in part as a result of technologies which make information fast, anonymous,

# SW&C Committee Members



**Camielle Call**, MSW, LCSW, Chair  
**Ellen M. Craine**, JD, LMSW, ACSW  
**Kathryn Dixon**, MSW  
**George T. Patterson**, ACSW  
**Aaron Robb**, PhD



**NASW PRESIDENT**  
Darrell Wheeler, PhD, ACSW, MPH

**CHIEF EXECUTIVE OFFICER**  
Angelo McClain, PhD, LICSW

**NASW STAFF**  
Director, Professional and  
Workforce Development  
Raffaele Vitelli

**Specialty Practice Section Manager**  
Yvette Mulkey, MS

**Senior Practice Section Associate**  
Kamilah Omari, LMSW-Clinical  
and Macro Specialty, ACSW

**Project Coordinator**  
Rochelle Wilder

granted the authority to award joint custody taking into consideration the best interests of the child and the agreement of the parents to joint custody.

The concept of joint custody includes both shared physical and legal (or decision-making) custody, unless limited or modified by a Court order, by state statute or by an agreement between the parents. When a parent brings a child for treatment, even if the second parent does not share physical custody of the child, he/she may have joint legal custody over the child along with the presenting parent, and it is best to presume that is the case absent information to the contrary.

An inquiry by the social worker before treatment begins about

the terms of the separation, the divorce decree and the child custody order is the first step to avoiding issues later. This point is summarized in the NASW Law Note, *The Legal Rights of Children*: "Because of the wide variation of custody arrangements that courts may impose, the question of whether both parents retain the ability to initiate or terminate mental health treatment for their minor children in joint custody determinations following divorce is of concern to social workers. Joint legal custody allows both parents to be legally responsible for their children. Unless provided otherwise in the custody decree, therefore, both parents would retain the right to make decisions about the child even if joint physical custody is not awarded." (2)

By requesting a copy of the temporary and/or final custody and divorce decree, the social worker may be able to identify the rights accorded each of the parents regarding the mental health treatment for the child. At a minimum, a review of these documents should establish whether the presenting parent has legal custody regarding the child and can make medical/mental health decisions independent of the other parent. If the documents are not clear and do not establish each parent's decision-making authority for health care decisions including mental health, requesting written consent from the two parents who each have legal custody is preferred and a better course of action prior to beginning treatment with the child. If unable to obtain a consent form signed by both parents, "...

social workers may request that the consenting parent sign a statement confirming that they have the legal right to consent to their children's treatment without the consent of any other individuals." (3) All documents related to the issue of custody and consent for treatment should be maintained in the client file.

The social worker assumes a risk of treating the child without full consent if there is no written document signed by the presenting parent that confirms her/his right to obtain mental health treatment for the child without the consent of the other parent. This has both potential ethical and legal concerns. Ethically, the *NASW Code of Ethics* in Sections 1.03(a) and (c) requires "valid informed consent" for treatment. (4) Substantiating appropriate

# result of the advances in Internet and communication technology, and easily accessible to predators and traffickers worldwide.

parental consent as a part of the initial client processing record establishes the basis for proceeding with treatment. In one case where the issue of joint consent was litigated, the Superior Court of Maine "... determined that a social worker who had obtained informed consent from only one parent before treating a child of divorce, had not violated the Maine social work licensing laws which incorporated Sections 1.03(a) and (c) of the *NASW Code of Ethics*." (5) However, there are very few published case decisions on point or applicable outside of the state of Maine. The joint written consent of both parents or a statement from the presenting parent stating that he/she has legal authority to make decisions regarding mental health treatment for the child is preferred prior to the commencement of treatment of the child to avoid disputes after treatment has begun.

## CHILDREN CONSENTING TO TREATMENT

Another issue that requires a layered analysis is whether and when a child is legally competent to consent to her/his own treatment. This is a legal question with different answers depending on

- The age of the child
- The services requested
- The State in which the child is seeking assistance
- The status of the child as emancipated, mature or being a parent

The age of majority at which an individual is deemed to be sufficiently mature to make adult decisions is 18 years of age in most of the states. Five states (Alabama, Nebraska, Colorado, Mississippi, and Pennsylvania) have statutes that increase the age to 19, 20 or 21. (6) In addition, certain

treatment requests, including for mental health treatment, can be made by minors in a number of states. (7) For example, in Maryland, a minor who is 16 years or older has the same capacity as an adult to consent to consultation, diagnosis and treatment of a mental or emotional disorder by a physician, psychologist or a clinic. Discretion is given to the health care provider concerning notice to the parent, guardian or custodian of the minor. (8) In Illinois, any minor who is twelve years or older may request and receive counseling services or psychotherapy of up to five sessions on an outpatient basis without the consent of the parent or guardian, but the parent or guardian will not be responsible for the costs of the services. (9)

## REQUESTS FOR CHILD'S RECORDS

Responding to a request by the noncustodial parent for the child's treatment records which should be presented in writing can also pose problems for the social worker. Absent a child custody or divorce decree that confirms the right of access to health records by the requesting parent, it is prudent to establish a proper basis for access before providing the information. The analysis can begin at the federal level with HIPAA (10) and guidance is provided in a question and answer document issued by the Department of Health & Human Services in February, 2014, (11) found at [www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html), addressing "Health Information Privacy" and information related to Mental Health treatment. As to minor children, the HIPAA guidance provides: "With respect to general treatment situations, a parent, guardian, or other person

acting in loco parentis usually is the personal representative of the minor child and a health care provider is permitted to share patient information with a patient's personal representative under the Privacy Rule. However, section 164.502(g) of the Privacy Rule contains several important exceptions to this general rule. A parent is not treated as a minor child's personal representative when: (1) State or other law does not require the consent of a parent or other person before a minor can obtain a particular health care service, the minor consents to the health care service, and the minor child has not requested the parent be treated as a personal representative; (2) someone other than the parent is authorized by law to consent to the provision of a particular health service to a minor and provides such consent; or (3) a parent agrees to a confidential relationship between the minor and a health care provider with respect to the health care service. For example, if State law provides an adolescent the right to obtain mental health treatment without parental consent and the adolescent consents to such treatment, the parent would not be the personal representative of the adolescent with respect to that mental health treatment information." [www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html). 2/25/14 (12).

Thus, it is necessary to turn to State law for confirmation of the child's independent rights to maintain the confidentiality of his or her therapy and mental health treatment records and to confirm whether the parents are barred from access without the consent of the minor. As noted above, the states vary regarding the age of consent and the type of treatment that the child can request without parental

consent. The many variations are summarized in the chart linked below (13). In a 2005 case, *In the Matter of Berg*, the Supreme Court of New Hampshire determined that it is within the trial court's discretion to determine if it is in the best interests of children to have confidential and privileged therapy records revealed to parents. The Court also concluded that parents do not have the exclusive right to exercise or waive the privilege and the effect on the continuation of the therapeutic relationship had to be considered. (14)

If the social worker denies access to the parent's request and receives a subpoena for a child's records, professional liability insurance, such as NASW's program offered through NASW Assurance Services, Inc. (15), may offer coverage for legal representation to assist in responding to the subpoena. An inquiry to the carrier regarding coverage should be initiated by the social worker as soon as a subpoena is received to assure sufficient time for consultation with an attorney designated by the insurer.

## PARENTAL RESPONSIBILITY FOR PAYMENT

Another issue that comes up when working with children is determining who has the responsibility to pay for the treatment that will be provided. It is not uncommon for one parent to want the child to participate in therapy while the other parent, whose insurance is presented for coverage, will disagree and refuse to authorize the treatment. This creates a dilemma for the clinician, especially when the child would benefit from mental health services.

In divorce cases, a parent's obligation to pay a child's

medical expenses, which include physical and mental health services, is usually established as part of the divorce proceedings and memorialized in the divorce decree or custody order. The court may require one of the parents to have financial responsibility for providing health insurance for the child or the parents may enter into an agreement as to who will cover medical/mental health treatment. This is another reason why it is beneficial for the therapist to have a copy of the divorce decree and custody order.

If the parents are not married or are separated/divorced without a court decree indicating who has responsibility for the child's health care expenses, the designated responsible payer recommended by an insurance industry model regulations is:

- custodial parent;
- spouse of the custodial parent;
- non-custodial parent; and
- spouse of the non-custodial parent(16)

These recommendations would have to be followed or adopted by a state's insurance code or the court to have application in any particular case, but may provide a useful reference if a dispute arises.

In certain situations where the minor is legally able to authorize his/her own treatment, the parent or guardian may not be legally responsible for paying for it. It also becomes a privacy issue for the minor who may not want a parent to know about the services they are receiving. (17) Since it can be difficult to determine who is responsible for the payment of mental health services provided to a minor, it is suggested that in addition to appropriate consent forms, clinicians require parents to sign a financial responsibility

agreement before providing services to the child.

### CONCLUSIONS

Working with children requires an understanding of when parental consent is required and whether both parents and, in some cases, the child, should be consenting to treatment. Being familiar with the consent laws of the state in which the social worker practices is key to avoiding issues. Requesting the written consent of both parents to the child's treatment also helps to avoid complaints and problems. At a minimum, the presenting parent should provide written assurance that he/she has the legal right to seek treatment for the child. One of the parents should also confirm financial responsibility for the treatment. Disposing of these important issues and questions at the beginning of treatment can greatly limit friction going forward and should be a part of preliminary parent/client discussions.

To read this article in its entirety, visit [www.socialworkers.org/ldf/legal\\_issue/2014/working-with-children.asp?print=1&](http://www.socialworkers.org/ldf/legal_issue/2014/working-with-children.asp?print=1&)

For more information about NASW's Legal Defense Fund, visit [www.socialworkers.org/ldf/about.asp](http://www.socialworkers.org/ldf/about.asp)

### REFERENCES/RESOURCES

1. Polowy, C. and Morgan, S., et al., Legal Rights of Children, Appendix A, pp.81-85, NASW Law Note, NASW Press, 2012.
2. Ibid., p.26
3. Id., p.27
4. NASW Code of Ethics, NASW Press, 2008.
5. Legal Rights of Children, at p.27; Andrews v. Board of

Social Work Licensure, 20005 WL, (Me. Super. Ct. 2005).

6. Legal Rights of Children, at p.3; see also, Appendix A: Alabama and Nebraska – Age 19; Colorado, Mississippi, and Pennsylvania – age 21.
7. "Also, 23 jurisdictions allow minors in need of mental health services to agree independently to such services without parental knowledge or consent, the age of consent for such services varies." Legal Rights of Children at p.5; See also Appendix A: Minors' Ability To Make Medical Decisions, pp.41-53.
8. See, Md. Code Ann., Health –Gen. II Sec20-104(a); and a summary in "Maryland Minor Consent Laws," American Academy of Pediatrics, Adolescent Provider Toolkit, Maryland\_minor\_consent\_la ws\_10.26.12 docx.
9. See, Consent by Minors to Medical Procedures Act, 410 ILC 210/1, et seq.; and "Consent By Minors For Medical Treatment," issued by Illinois Hospital Association, last updated August 10, 2010.
10. Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Sec. 164.502.
11. HIPAA Privacy Rule and Sharing Information Related to Mental Health, Health Information Privacy, U.S. Dept. of Health and Human Services, found at: [www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html).
12. Ibid.
13. See, Legal Rights of Children, Appendix A, Minors' Ability To Make Medical Decisions, pp.41-53.
14. In Matter of Berg, 886 A. 2d 980 (N.H. 2005); see also, "The Berg Case: Parents right to access medical records

v. Child's right to privacy" at: [www.nhfamilylawblog.com/2010/07/articles/parenting-rights-responsibilit-the-berg-case-parents-right-to-access-medical-records-v-childs-right-to-privacy/](http://www.nhfamilylawblog.com/2010/07/articles/parenting-rights-responsibilit-the-berg-case-parents-right-to-access-medical-records-v-childs-right-to-privacy/)

15. See. Assurance Services, Inc., at: [www.naswassurance.org/malpractice/malpractice-tips/responding-subpoena/](http://www.naswassurance.org/malpractice/malpractice-tips/responding-subpoena/)
16. National Association of Insurance Commissioners; Coordination of Benefits Model Regulation; Model Regulation Service - October 2013, Section 6 (D)(2)(b)(iv), pp. 120-7 to 120-9.
17. For example, in Maryland, a minor who is 16 years old or older has the same capacity as an adult to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a physician, psychologist, or a clinic but the parent, guardian, custodian, or spouse of a parent is not responsible for the costs of that treatment unless they consented to the care. Md. Code Ann., Health-Gen. § 20-104(a)(1)(c).

*The information contained in this website is provided as a service to members and the social work community for educational and information purposes only and does not constitute legal advice. We provide timely information, but we make no claims, promises or guarantees about the accuracy, completeness, or adequacy of the information contained in or linked to this Web site and its associated sites. Transmission of the information is not intended to create, and receipt does not constitute, a lawyer-client relationship between NASW, LDF, or the author(s) and you. NASW members and online readers should not act based on the information provided in the LDF Web site. Laws and court interpretations change frequently. Legal advice must be tailored to the specific facts and circumstances of a particular case. **Nothing reported herein should be used as a substitute for the advice of competent counsel.***

# SUPPORTING FAMILY & CHILDREN of Law Enforcement Officers

SARAH BUEHNER, MSW, LCSW

The 2014 events in Ferguson, Missouri, have been a catalyst for our country to closely examine the relationship between law enforcement and the communities they serve, and as with any significant event, emotions have run high—throughout our nation—as we all struggle with how to move forward. A lot of work must be done to ensure that minorities and people of color are not systematically discriminated against in our law enforcement and criminal justice systems; it may even take a long time for minorities and people of color to build trust in law enforcement. Throughout the United States, many people are angry at law enforcement, and officers have at times become the targets of this anger.

As the wife of a law enforcement officer and as a social worker, I am also keenly aware of the toll that Ferguson and recent related events have taken on police families. The daily life of a police family is constantly hectic, stressful, and unpredictable, as officers often work long, erratic hours and come home stressed and exhausted. As with other first responders, police officers are frequently exposed to potentially life-threatening and

traumatic situations; as social workers, we are well aware of the effects that trauma can have on families and children. For police officers, even a minor traffic stop triggers a limbic fight-or-flight response, as that officer has no idea if the person they pulled over is angry, hostile, or carrying a weapon. According to the National Law Enforcement Officers Memorial Fund, ([www.nleomf.org](http://www.nleomf.org)) between 2008 and 2014, close to 1,000 law enforcement officers have lost their lives while on duty in the United States.

When my husband leaves for work, the thought crosses my mind that he might not come home.

Life post-Ferguson has exacerbated this stress for police families. Even more than before, officers are on “high alert,” a condition that impacts the daily life and stress levels of police families and children. Children of law enforcement have also become targets of anger and bullying by peers at school, or they may be acting out as a result of absorbing trauma and stress from the family system. Spouses and family members may also feel angry, anxious, and afraid that



their loved one will not make it home from work. Police spouses often feel overburdened with home responsibilities and child rearing, as the schedule of a police officer is often erratic and unpredictable. Add all of these factors together with stress and trauma, and it is no wonder that police families have such a high divorce rate. As police officers and other law enforcement officials are a part of every community we serve, we, as social workers, undoubtedly will interact with police officers, their children, spouses, or other loved ones. From my experience as a clinical social worker and police wife, I have a few suggestions for how social workers can help these children and family members as they deal with the stress, trauma, and other effects of being part of a police family.

## BACK TO BASICS:

- **Active Listening 101:** Listen, validate, reflect. Modeling active listening can also teach police families healthy ways to communicate.
- **Empathy:** A lot of criticism is being directed at police and law enforcement right now

(and in many cases, rightly so), and it can be harder to empathize and humanize with others who are in the hot seat. Along with the criticism and challenges, police and law enforcement are still exposed to high levels of trauma and stress, and police families still feel the effects. Empathy is such a healing force—there is so much power in feeling heard and understood.

## FOR SPOUSES AND ADULT FAMILY MEMBERS:

- Teach the importance of self-care, and help the family member find a way to prioritize it as well as balance it with other responsibilities. Self-care is an investment in the family—by taking care of ourselves, we are better able to care for others.
- Educate about trauma, stress, and the limbic response, and how to manage these symptoms through self-care and healthy lifestyle choices.
- Educate about the ways kids and family members may be affected by their officer's trauma and stress, and how the family member can help the family cope through

positive communication and prioritizing quality time as a family.

- Help the family member understand the importance of having a support system and how seeking support from family, peers, or the local Police Wives' Association can help.
- Help the family member build a support system, if desired.
- Educate about counseling—as with the military, there is a stigma associated with counseling in the law enforcement community. Focus on destigmatizing counseling, and show how helpful it can be for individuals, families, and couples.
- Not in front of the kids! Encourage family members to set boundaries with what children/teens are exposed to. Law enforcement officers may “vent” about their day to family or a partner, but often kids (even teens) are not able to process some of the traumatic events that the officer has experienced. Limiting this exposure may also limit the child’s acting-out behaviors or anxieties.
- Limit exposure to “triggers,” like the news or violent TV shows.
- If an adult is harassed for

being related to law enforcement, coach him or her on how to de-escalate a situation. Encourage him or her to focus on safety, not defending their family member. Help him or her understand that verbal or physical arguments rarely solve a conflict.

- If someone harasses or bullies a child, coach the family member on healthy ways to talk with the child/teen to process the situation, and remind the child of the importance of safety. Validate for the child/teen that many people are angry and frustrated currently, and they aren’t sure how to process or respond to these feelings. Emphasize that fighting verbally or physically will not solve the problem; it only increases the conflict.
- If a child is acting out, educate the parent or caregiver on how children respond to family stress and/or trauma. Reframe this “acting out” as an opportunity to help the child, as children who act out often lack the skills to manage their emotions. Encourage the parent/caregiver to seek ongoing counseling or support for helping the child to learn healthier ways to cope.

#### FOR CHILDREN AND TEENS:

- Remember to be age appropriate. What you say to a 3-year-old will be very different than what you say to a 12-year-old—and even more different than what you say to a 16-year-old. A lot of people try to “shield” their children from talking about Ferguson or police-related topics, but this rarely works. Even my 3-year-old hears about police officers at school or from adults she is around, and when the riots in Ferguson happened, she was asking about “daddy helping with the fires.” Be age appropriate but give children a safe space to talk, share their perspectives, and ask questions.
- Middle or high school students are old enough to learn about trauma, stress, and the limbic response. Help them learn about how their body and mind react to these things and what they can do about it.
- Kids need support, too. You can help a child/teen learn about the importance of support.
- Teach about SELF-CARE!!! Kids need positive activities to manage their emotions and stress as well.

- Talk with kids about any bullying or harassment they may have experienced for having a police parent. Process with that child how they responded, and coach him or her on conflict resolution and staying safe.
- Assess for hobbies/extracurricular activities to help the child manage stress and have an outlet where they don’t have to worry about mom, dad, or any stresses at home.
- Teach kids about asking for help, and destigmatize counseling in order to minimize barriers to asking for help later, if needed.

**Sarah Buehner earned her MSW from the Brown School of Social Work at Washington University and holds her LCSW in the state of Missouri. She works for Lutheran Family and Children’s Services of Missouri, where she provides school-based counseling services to teens in St. Louis. She can be contacted at SarahB@lfc.org.**

## UPCOMING WEBINARS REGISTER NOW

TUESDAY, NOVEMBER 17, 2015

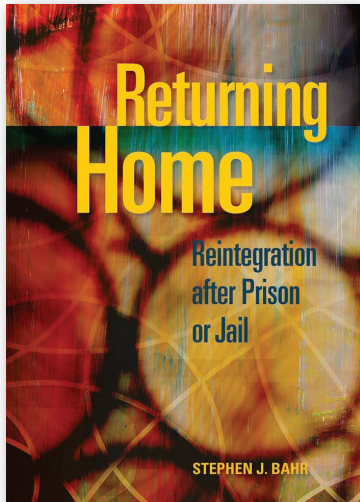
Politicizing Social Work: Developing Effective Advocacy in Your Social Work Practice

THURSDAY, DECEMBER 3, 2015

Harm Reductive Methods for High Risk Substance Abusing Adolescence

For more details visit: [socialworkers.org/sections](http://socialworkers.org/sections)

# BOOK REVIEW: AN OVERVIEW



## Returning Home: Reintegration after Prison or Jail

Authored by Stephen J. Bahr

Stephen J. Bahr provides insight on incarceration in the United States, whose rates are noted to be the highest in the world. Bahr introduces readers to the contemporary public discourse, advocacy and legislative efforts on prison reform and the reintegration process. He uses quantitative (Serious and Violent Offender Reentry Initiative [SVORI]) and qualitative (interviews) data sets to examine housing, employment, family and friends influence on the reintegration process.

### PREPARATION AND PROCESS

#### Chapter 2: Preparation for Reintegration and Chapter 3: The Reintegration Process

Readers are introduced to the four stages of reintegration: pre-prison period, prison experiences, post-release transition, post release integration (Bahr, 2015). A profile of the characteristics of prisoners in the US and categories of crimes committed is discussed. Demographics of persons released from prison in US, specifically gender, age, race or ethnicity, education level; daily rates of persons

released from prison, and yearly rates of persons released from prison is provided. The author uses SVORI and qualitative interview data to explore first day out experiences, parole agreements, supervision, friends and family connections and roles, work, housing, transportation, and attitudes at release.

### HOUSING AND EMPLOYMENT

#### Chapter 4: Living Arrangements: The Impact of where and with whom you live and Chapter 5: Training and Employment: Preparing for Self-Support

The author explores housing arrangements, policies and programs and the role of housing arrangements on reintegration and its influence on recidivism. Chapter 5 also examines employment experiences, training and education throughout the four phases of reintegration of parolees using analysis of SVORI data. Readers can gain insight on how critical the role of stable, affordable housing and adequate employment are in successful reintegration into the community.

### FAMILY AND FRIENDS

#### Chapter 6: Family Relationships: How Family Bonds Can Support or Interfere with Success and Chapter 7: Friends and Frenemies: How Peers Can Help or Hinder Success

The role of family support, the quality of family relationships and friendships and their association with reintegration success and recidivism through the four phases of reintegration is discussed in this section. The author reviews theoretical perspectives on learning about, engaging in and desisting from criminal behavior. He uses qualitative interviews to illuminate perspectives on friendships and SVORI data to examine association between types of friendships and influence reintegration and recidivism.

### SUBSTANCE ABUSE AND MENTAL HEALTH

#### Chapter 8: Overcoming Substance Abuse and Dependency: A Key to Success Chapter 9: Mental Health Challenges: Stacking the Odds against Success

Chapter 8 discusses proportions of the prison population with drug offenses and drug dependency issues and the association between drug use and crime. It also examines drug use among parolees pre-prison and post-release and drug education and treatment during periods of incarceration. Chapter 9 discusses the prevalence of serious mental illness amongst inmates. It examines data on mental health treatment in prisons and the association between SMI and recidivism. Readers are also

introduced to a discussion on mental health courts.

### MACRO CONSIDERATIONS AND REFLECTION

#### Chapter 10: Social Context: Neighborhood and Community Influences Chapter 11: Programs and Policies Chapter 12: A Look Back and a Look Forward

This text concludes with an examination of macro level factors with an influences reintegration and recidivism such as neighborhoods, gender, and race. A series of treatment programs, transitional programs, community reentry initiatives and policies are highlighted.

### REFERENCES

Bahr, S.J. (2015). *Returning Home: Reintegration after Prison or Jail*. Washington, DC: NASW Press.

For more details on this and other NASW Press titles visit: [naswpress.org](http://naswpress.org).

# Call for Social Work Practitioner Submissions

NASW invites current social work practitioners to submit brief articles for our specialty practice publications. Topics must be relevant to one or more of the following specialized areas:

- Administration/Supervision
- Aging
- Alcohol, Tobacco, and Other Drugs
- Child Welfare
- Children, Adolescents, and Young Adults
- Health
- Mental Health
- Private Practice
- School Social Work
- Social and Economic Justice & Peace
- Social Work and the Courts

For submission details and author guidelines, go to [SocialWorkers.org/Sections](http://SocialWorkers.org/Sections). If you need more information, email [sections@naswdc.org](mailto:sections@naswdc.org).



## *Did You Know?*

Research shows that the shock waves from victimization touch not only the victims, but also the victim's immediate family and relatives, neighbors, and acquaintances.

**For more information, visit  
[SocialWorkers.org/Sections](http://SocialWorkers.org/Sections)**



 **NASW** | SPS  
National Association of Social Workers  
Specialty Practice Sections

750 FIRST STREET NE, SUITE 800  
WASHINGTON, DC 20002-4241