Preventing, Identifying, and Treating Substance Use Among Youth in Foster Care

Youth in foster care often face multiple challenges that place them at increased risk of using substances, making it imperative that caseworkers understand how to prevent substance use, identify possible usage, and, if needed, support youth in their treatment and recovery. This work, however, cannot be undertaken by the child welfare field alone. It requires close collaboration with substance use treatment providers, families, the community, and others.

This bulletin provides child welfare professionals with information about the extent and effects of substance use among youth in foster care, ways to identify substance use, how to support youth in care who currently use or are at high risk for using substances, and strategies for prevention. It also addresses why and how you can collaborate with professionals in other fields.

WHAT'S INSIDE

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PREVALENCE OF SUBSTANCE USE AMONG YOUTH IN FOSTER CARE

Because of their history of maltreatment, stressful home circumstances, and other trauma, youth in foster care are at significant risk for using substances (Substance Abuse and Mental Health Services Administration [SAMHSA], 2011). Studies show that youth in foster care use substances, including alcohol, marijuana, or other drugs, at rates similar to (Braciszewski & Stout, 2012; Greeno et al., 2019; Kim et al., 2017) or higher than (Siegel et al., 2016) their peers who had not been in foster care. Furthermore, youth in foster care appear to begin substance use at an earlier age than their peers who had not been in foster care, which places them at a higher risk for developing a substance use disorder (SUD) (Braciszewski & Stout, 2012). According to data from the National Youth in Transition Database, 27 percent of 17-year-olds in foster care had been referred for substance use treatment (Administration for Children and Families, 2020).

The high risk of substance use also continues as they exit care, with youth formerly in foster care having higher lifetime use rates than their peers who were never in foster care (Greeno et al., 2019; Braciszewski & Stout, 2012). Additionally, the diagnostic rates for SUDs are much higher among youth in or formerly in foster care (Braciszewski & Stout, 2012).

UNDERSTANDING THE CAUSES AND IMPACTS OF SUBSTANCE USE DISORDERS

Repeated instances of substance use can lead to changes in the brain that cause SUDs (National Institute on Drug Abuse [NIDA], 2018b). This section describes the effects of substance use on the brain, including how it can lead to an SUD, and risk and protective factors related to youth substance use.

SUBSTANCE USE DISORDERS

The term "substance use disorders" covers a range of issues related to substance use or misuse. Clinical diagnosis of an SUD can be made by trained professionals using the criteria outlined in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). This diagnosis is different than those in previous editions of the DSM. In the DSM-5, SUD, which is measured on a continuum from mild to severe, is a combination of the DSM-IV categories of substance abuse and substance dependence (American Psychiatric Association, 2013). Although many people use the term "addiction" when referring to an individual's SUD diagnosis or situation, addiction is not a formal diagnosis in the DSM-5. However, some individuals or groups, such as NIDA, use the terms synonymously (NIDA, 2018a).

SUDs are greatly influenced by brain chemistry. The human brain is wired to make decisions and actions (e.g., eating, exercise) based on rewards. This reward system is driven by the chemical dopamine, which is released during pleasurable activities. For example, when you eat something delicious, your body may release dopamine, which makes you feel good. Your brain then associates eating this food, regardless of whether it is healthy for you or not, with pleasure and encourages you to eat it again.

When someone takes a drug, it can cause a rush of dopamine to be released. The amount of dopamine released is often much higher than that of other rewards, which creates

the "high" of taking drugs (NIDA, 2014). This can cause the person to seek out the drug to replicate the high. As the drug use continues, the brain may not achieve the same high, and so larger amounts of the drug may be required to trigger the reward system. Rather than an SUD being a character flaw, as it has historically and even presently been portrayed, it is a chemical response in the brain that can direct an individual's behaviors.

For more detailed definitions and descriptions related to substance use, refer to NIDA's The Science of Drug Use and Addiction: The Basics.

IMPACT OF SUBSTANCE USE ON YOUTH

Substance use can have myriad effects on an individual's health and can lead to other negative outcomes due to changes in behavior and decision-making. Short-term health effects of substance use include changes in appetite, wakefulness, heart rate, blood pressure, and mood as well as heart attacks, stroke, psychosis, overdose, or even death (NIDA, 2017). Long-term health effects of substance use include heart or lung disease, cancer, mental illness, hepatitis, and other health problems. Other effects of substance use include increased impulsivity and poor judgement, troubled relationships, risky sexual behaviors, early pregnancy, difficulty obtaining housing and employment, stress, and criminality as well as decreased education levels and memory (NIDA, 2017, 2018b; Kim et al., 2017).

RISK AND PROTECTIVE FACTORS FOR YOUTH SUBSTANCE USE

Although anyone who uses drugs is at risk of developing an SUD or even becoming addicted, not everyone does. Just as there is no single risk factor for child maltreatment, there is no single risk factor for an SUD. Factors affecting an individual's likelihood for developing an SUD include biology or genetics (e.g., presence of a mental health issue) and their environment (e.g., peer pressure, family circumstances, exposure to stress) (NIDA, 2018b). This includes experiencing adverse childhood experiences, which can lead to substance use among youth, including earlier initiation of use (Duke, 2018).

Although not an exhaustive list, the following are risk factors for substance use by youth in the general population (Centers for Disease Control and Prevention [CDC], 2019):

- Family history of substance use, including parental substance use
- Positive parental attitudes toward substance use
- Limited parental supervision
- Family rejection of sexual orientation or gender identity
- Association with peers who use substances or have a history of delinquent behaviors
- Lack of connection to school
- Low academic performance
- Childhood sexual abuse
- Mental health challenges

Additionally, exposure to any potentially traumatic event as a child—including experiencing or witnessing maltreatment or other interpersonal violence, having a serious accident or illness, and others—can increase the risk an adolescent will use substances (Carliner et al., 2016).

Co-Occurrence of Substance Use Disorders and Mental Health Problems

SUDs and mental health problems frequently co-occur, with national surveys showing that approximately half of all individuals experiencing one will also experience the other (NIDA, 2020). Symptoms of an SUD can be similar to those of a mental health disorder, and vice versa (Child Mind Institute & Center on Addiction, 2019). Additionally, the disorders may have developed at the same time, or one disorder may have contributed to the other. For example, a youth may self-medicate to reduce their overwhelming feelings of anxiety. Since selecting the proper treatment is dependent on a correct diagnosis, it is critical to refer youth exhibiting symptoms of either disorder for a comprehensive assessment with a trained professional.

For additional information, refer to *Common Comorbidities With Substance Use Disorders Research Report* by NIDA and *Substance Use + Mental Health in Teens and Young Adults: Your Guide to Recognizing and Addressing Co-Occurring Disorders* by the Child Mind Institute and the Center on Addiction.

Unfortunately, many of the same circumstances that are risk factors for youth substance use are the same circumstances faced by youth in or at risk of entering foster care (Brook et al., 2015). Of particular note is that youth who have been maltreated, when compared to their nonmaltreated peers, are more likely to use substances earlier, use more types of substances, and have more severe usage (Gabrielli et al., 2016).

Additionally, adolescents' brains are wired for engaging in risk-taking behaviors and new experiences, and using substances may fulfill that drive in an unhealthy way (NIDA, 2014). Furthermore, the adolescent brain is still maturing and is malleable, including in areas responsible for evaluating situations, making decisions, and regulating emotions and impulses.

Protective factors can help prevent youth from using substances or help them cope if substance use has already begun. For youth, examples of protective factors for substance use include social, emotional, behavioral, cognitive, and ethical competence; self-efficacy; parent or family engagement; spirituality; resiliency; family support and stability; parental disapproval of substance use; parental supervision; and connectedness to school and community or faith-based groups (Office of the Surgeon General, 2016; SAMHSA, 2011; CDC, 2019). For additional information about protective factors, read Child Welfare Information Gateway's *Protective Factors Approaches in Child Welfare*.

The Role of Peers in Substance Use

Peer relationships play a key role in decision-making and behaviors among youth. Peer approval of substance use can increase the risk for substance use, but conversely, peer disapproval can decrease that risk (Mason et al., 2014). A large study of youth in foster care found that they considered characteristics of their peer group to be the strongest risk and protective factor for substance use (Brook et al., 2015). Family factors are still important to youth substance use, but agencies and professionals should keep in mind the importance of peer influence as they develop prevention and treatment programs.

IDENTIFYING SUBSTANCE USE AMONG YOUTH IN FOSTER CARE

Due to their close contact with youth and their families and intimate knowledge of their histories, child welfare caseworkers can play a key role in identifying youth in foster care who may be using substances. By identifying these youth as soon as possible after they come into contact with the child welfare system, caseworkers can help them access services and supports that can assist them in ending the use and stemming the possible short- and long-term effects.

Two key components of identification are screening and assessment. Screening for a possible SUD is a way to determine if a problem may be present, while assessments are more comprehensive and allow a professional to determine more conclusively if a problem is present and develop a plan to address it. Even if a screen identifies the possibility of a substance use issue, that does not mean the youth has been diagnosed as such. An assessment by a trained professional is required to make that diagnosis. Screening and assessments may be conducted as part of regular practice, or they may be used when others notice signs of possible substance use. (See the "Signs of Substance Use in Youth" box in this section for more information.) Since conducting assessments requires a level of experience and training beyond that of most caseworkers, this section focuses on the basics of conducting substance use screening.

The American Academy of Child and Adolescent Psychiatry and the Child Welfare League of America (2003) recommend that all children be screened for substance use, as well as mental health needs, within 24 hours of being placed in out-of-home care. Agencies also may want to screen or assess youth whose families have child welfare involvement but have not been removed from care (SAMHSA, 2011). Additional screening should also be provided on a regular basis, particularly after significant transitions and when there is a change in the youth's psychosocial functioning, as usage could begin or worsen during a youth's involvement with the child welfare system.

Caseworkers will need to determine who will provide the information for the screen: the youth or a parent or other caregiver. Although research has shown that parents and caregivers tend to provide more accurate information than adolescents for substance use screening, the unique situations of youth in foster care present challenges to collecting information from parents or caregivers (SAMHSA, 2011). Parents may not be available or able to provide accurate information, perhaps due to their own substance use or wanting to give responses that may expedite reunification, and caregivers may not have had enough contact with the youth to differentiate their normal behaviors from behaviors that may indicate substance use. Screening can still be conducted with the parents, caregivers, or youth, but you should interpret the results with these issues in mind. If you believe the situation is high risk, you may want to send the youth directly to a qualified professional for assessment.

Caseworkers should only use scientifically validated screening instruments that are recommended for use by their agencies. Screening instruments are developed for particular populations, so you should make sure the screen is appropriate for the person being screened and the person taking the screen, if different. For example, the screen should be appropriate for person's age, language, culture, and reading level.

You will also need to be aware of how the child's custody status affects who, if anyone, needs to provide consent for the screen (or assessment). If the youth is in the care of the State (i.e., has been removed from home and placed in out-of-home care), the agency will likely have decision-making authority about whether a youth should be screened or assessed. The results should be shared with the caregivers to help them better understand the youth's situation and needs, as allowed by State and Federal regulations regarding the disclosure of confidential substance use information. For youth still in their parents' custody, the parents may need to provide consent for the screenings or assessments, but the age at which youth can consent for those may vary by State.

Staff involved in screening should be trained about how to administer and interpret the results as well as what steps should be taken after the screening is completed (e.g., referring youth for services). When you administer a screen, it is crucial to read it to the informant exactly as written. Deviating from the wording at all can affect the informant's response and, therefore, the results. After the screen has been completed, caseworkers should seek the assistance of a substance use, medical, or other relevant professional to interpret the screen and determine what services or supports may be needed by the youth and their family (SAMHSA, 2011).

For additional information, refer to SAMHSA's *Identifying Mental Health and Substance Use Problems of Children and Adolescents: A Guide for Child-Serving Organizations*, which also features a section focused on child welfare settings. Chapter 2 features tables that provide detailed information about screening tools for youth substance use. Another useful resource is NIDA's Screening Tools for Adolescent Substance Use webpage.

Signs of Substance Use in Youth

The following are possible signs of a youth's substance use and warrant adults in the child's life taking steps to address any issues (NIDA, 2014):

- Changes in behavior for no apparent reason (e.g., withdrawal, frequent exhaustion or depression, hostility)
- Changes in peer groups
- Carelessness with grooming
- Decreased academic performance
- Skipping classes
- Loss of interest in preferred activities
- Adjustments in eating or sleeping habits
- Declining relationships with family and friends

The presence of these signs, however, is not proof that a youth is using substances, and they may also indicate other factors affecting the youth (e.g., normal developmental stages, mental health issues).

SUPPORTING TREATMENT AND PREVENTION FOR YOUTH IN FOSTER CARE

SUDs can be treated, but similarly to other chronic diseases such as diabetes or heart disease, there is not necessarily a cure (NIDA, 2018b). This section describes the availability and usage of treatments by youth and describes some of the evidence-based and promising treatments designed specifically for them. It also describes strategies for preventing the use of substances by youth.

TREATMENT AVAILABILITY AND USAGE

According to the 2018 National Survey on Drug Use and Health, only 11 percent of youth ages 12 to 17 in the general population who needed substance use treatment received any treatment at a specialty facility (i.e., hospital [inpatient], drug or alcohol rehabilitation facility, or a mental health center) (SAMHSA, 2019b). Of the youth in the general population who needed treatment but did not receive it at a specialty facility, nearly all (98 percent) did not perceive they had a need for treatment. Given that youth in foster care generally have less access to services and supports, this gap between service need and access may even be larger for them compared with the general population (Braciszewski, Tzilos Wernette, Moore, Tran, et al., 2018).

One critical barrier to obtaining treatment is the lack of facilities that offer programs tailored for youth. Results from the 2018 National Survey of Substance Abuse Treatment Services (N-SSATS) found that only 25 percent of facilities offered such programs (SAMHSA, 2019a), and the 2012 N-SSATS showed that only 48 percent of facilities even accepted youth clients (SAMHSA, 2014a). Programs geared toward youth are crucial to positive treatment outcomes because the treatment needs of youth and adults are different. For example, youth tend to use different substances than adults (e.g., many more youth receive treatment for marijuana use than alcohol, but it is the opposite for adults), and youth are less likely to experience withdrawal symptoms (NIDA,

2014). Additionally, some schools may offer substance use treatment services, as well as screening or prevention programs, for youth (Ladegard et al., 2017).

Even when programs may be available, youth in foster care still face barriers to receiving treatment. Compared to their peers not in foster care, youth in care are less likely to view substance use as harmful or have negative opinions of other substance users (Siegel et al., 2016). Additionally, youth in care also may fear the consequences of seeking help for substance use (e.g., being expelled from a program), have difficulty bonding or trusting individuals or institutions, and experience a lack of continuity or coordination of their care (Braciszewski, Tzilos Wernette, Moore, Tran, et al., 2018). They may also confront challenges common to all youth. Youth in general may have difficulty believing treatment is necessary or seeing their own behavior patterns or consequences (NIDA, 2014). They also may not know where to find help or fear the stigma of being labeled with a substance use problem.

TREATMENT CONSIDERATIONS

When youth in foster care require treatment for an SUD, caseworkers can help ensure they receive treatment that meets their specific needs, which can help optimize outcomes. Caseworkers can help find service providers that have programs that focus on youth treatment in general, and they can also ensure providers are familiar with the specific needs of youth in foster care. They can also support youth during and after treatment. Since youth generally have less access to services after they transition out of care, it is important to ensure they receive services for any substance use issues before that occurs.

Adolescent Community Reinforcement Approach (A-CRA)

A-CRA is an intervention that seeks to support youth in recovery by increasing family, social, and educational/vocational reinforcement. Sessions are conducted with the youth alone, the caregiver alone, and the youth and caregiver together. The therapist reviews the youth's needs and self-assessment and chooses from among 17 A-CRA procedures that address areas such as coping skills, problem-solving, and social activities in order to help eliminate substance use. A-CRA is designated as being evidence supported or based by NIDA, the Alcohol & Drug Abuse Institute, and the California Evidence-Based Clearinghouse for Child Welfare.

NIDA (2014) provides guidance for treating SUDs in youth, including the following:

- Treatment should be tailored to the unique needs of each youth and address their overall needs (e.g., physical health, housing, school, transportation).
- Behavioral therapies have been shown to be effective in treating youth SUDs. They can strengthen their motivation to change, offer incentives, build skills to resist or refuse substances, help the youth replace substance use with other activities, and promote positive relationships.
- Youth with SUDs also frequently have mental health conditions, and so it is critical that any co-occurring conditions are identified and treated as well.

- Since any use by youth is cause for concern, even youth without a diagnosed SUD may benefit from some type of intervention.
- Youth should remain in treatment for an adequate period of time and receive appropriate follow-up care. (This is further addressed later in this section.)
- Although addiction medications have been shown to be effective and are commonly prescribed for adults, they are not generally approved for youth by the Food and Drug Administration.
- Legal interventions and sanctions or family pressure may be an important factor in entering or completing treatment, especially given that youth with an SUD often do not see the need for treatment. In publicly funded substance use facilities, the juvenile justice system is the top referral source.

The University of Washington Alcohol and Drug Abuse Institute (2016) lists six treatment interventions for youth as being evidence based:

- Adolescent community reinforcement approach (see text box)
- Brief intervention/motivational interviewing
- Cognitive behavioral therapy
- Functional family therapy
- Motivational enhancement therapy and cognitive behavioral therapy
- Multidimensional family therapy

Culturally Appropriate Interventions

When referring youth to treatment, caseworkers should make sure the proposed treatment, as well as the provider itself, are culturally appropriate for that individual. Treatments that are tailored for a particular culture can help with client engagement and attendance and promote improved provider-client relationships (Gainsbury, 2016). For additional information about culturally appropriate substance use treatment, refer to the Georgetown University National Center for Cultural Competence, the University of Washington Alcohol and Drug Abuse Institute, and the National Network to Eliminate Disparities in Behavioral Health.

Treatment Resources

For a more complete review of treating SUDs in youth, including descriptions of evidence-based programs, refer to NIDA's *Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide*.

The following resources offer additional information about substance use treatment approaches for youth:

- *Treating Youth Substance Use: Evidence Based Practices & Their Clinical Significance* (University of Washington Alcohol and Drug Abuse Institute)
- Behavioral Health Treatment Services Locator (U.S. Department of Health and Human Services [HHS], SAMHSA)
- Program Search (Blueprints for Healthy Youth Development)

RECOVERY SUPPORT

Relapse (i.e., resuming substance use after an attempt to stop) is common and does not mean the treatment is not or will not be successful (NIDA, 2014). Multiple rounds of treatment may be necessary, and additional supports will be necessary even after the treatment has been completed. During and after treatment, caseworkers should help monitor youth for continued substance use or potential triggers for use, such as high levels of stress or contacts with peers who have previously promoted substance use. They can also follow-up with other caring adults in the youth's life, such as their current caregivers, other family members, teachers, and coaches, to see if they have observed any risk factors and help determine how they can promote continued abstinence from substances. During a series of focus groups, youth reported the following five major reasons for relapse: feeling unable to cope with negative emotions without substances, stress relief, cognitive factors (e.g., poor motivation, urges to use substances, low confidence), social issues (e.g., peer pressure), and environmental issues (e.g., access or availability of substances) (Gonzales et al., 2012b).

Access to recovery supports is a key factor to averting future substance use. Components of recovery support may include aftercare (e.g., support groups), relationships with peers and family, and substance-free activities (e.g., work, school, hobbies) (Acri et al., 2012). Although an SUD is a chronic disease, many youth do not view it that way (Gonzalez et al., 2012a). Rather, they view substance use as being about lifestyle or individual choice, something they can stop at any time, and not putting them at risk for negative outcomes. Therefore, caseworkers and others supporting youth in recovery may want to focus on strategies that mesh with youth views of substance use. For example, youth views about substance use and recovery do not necessarily align with 12-step programs, which are a commonly referred aftercare support (Gonzalez, 2012a). Rather, they may want to highlight activities that support lifestyle improvement (e.g., improved decision-making, employment, education, new positive activities).

Mobile Interventions to Treat Substance Use

Mobile interventions have become more popular and shown promise in multiple fields, including treatment for physical and mental health problems (Braciszewski, Tzilos Wernette, Moore, Tran, et al., 2018). Advantages of mobile interventions include increasing the likelihood of honest responses, the prevalence of mobile devices among youth, and youth preferring computerized or paper forms to face-to-face interactions (Braciszewski, Tzilos Wernette, Moore, Tran, et al., 2018; Pilowsky & Wu, 2013). iHelp (Interactive Healthy Lifestyle Preparation) is a mobile intervention designed for youth exiting foster care. It includes a computer-based intervention that utilizes motivational interviewing principles and is individualized based on user responses. Youth then receive daily text messages tailored to their readiness for change, with themes changing over time based on participants' responses to poll questions. In a pilot study, iHelp showed positive scores for youth satisfaction, engagement, and retention and moderate effects on use of marijuana, which was the substance the pilot focused on (Braciszewski, Tzilos Wernette, Moore, Bock, et al., 2018).

PREVENTION

Although youth in foster care often have a host of risk factors for substance use, it can be prevented. Substance use prevention efforts can be applied at three levels, similar to maltreatment prevention interventions: universal interventions aimed at all members of a given population; selective efforts aimed at a subgroup at high-risk for substance use; and indicated interventions targeted to individuals already using substances but who have not developed an SUD (Office of the Surgeon General, 2016). Communities will need to determine the mix of strategies that works best for them.

Results from NIDA-funded research show that programs involving families, schools, communities, and the media are effective for preventing substance use in youth (NIDA, 2018b). Outreach and education are critical in these efforts, particularly when they demonstrate the harmful effects of substance use. Examples of evidence-based prevention programs that have shown positive results for decreasing substance use in youth include LifeSkills Training and Project Towards No Drug Abuse, two school-based programs, and Strengthening Families Program: For Parents and Youth 10–14, a family-focused program (Office of the Surgeon General, 2016).

Not all evidence-based prevention programs have been tested for effectiveness on foster care populations, and agencies and communities may need to make adjustments to fit their needs. For example, many prevention programs take place in

school and family settings, but given the transitional nature of the lives of many youth in foster care, this could pose a barrier to full participation. Additionally, many programs highlight parent training and family management, but for youth in foster care, family may represent increased risk for use (Brook et al., 2015). Youth in foster care are also less likely to talk with parents or guardians about substance use issues than those living with their biological or adoptive parents (SAMHSA, 2014b). Since parent or family engagement is a protective factor, though, programs that help develop the caregiver-youth relationship may be a valuable means of preventing substance use.

Prevention efforts can begin well before children reach adolescence. However, few substance use prevention programs for children under age 10 have been evaluated for their effect on usage, in part because that requires expensive long-term follow-up on use that may not begin until years or decades later (Office of the Surgeon General, 2016).

Agencies and communities will need to assess the needs of their children, youth, and families—as well as seek their input—to determine the prevention strategy and programs that will best serve them. For additional information about best practices in substance use prevention, refer to chapter 3 of *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* as well as NIDA's "Lessons From Prevention Research."

Preventing Substance Use in Foster Care by Improving the Caregiver Environment

KEEP SAFE is a prevention program designed to address problem behaviors, including substance use, in youth in foster care by improving the caregiving environment and improving the youth-caregiver relationship. Foster parents and kinship caregivers attend 16 weekly 90-minute group support sessions in which they learn parenting techniques (e.g., positive reinforcement, increased supervision) and are given an opportunity to practice the acquired skills (Buchanan et al., 2019). A randomized controlled trial showed that youth in foster care participating in the program had significantly less substance use than those in the group receiving standard services (Kim et al., 2017).

Use of Psychotropic Medications

Children in foster care are much more likely than children in the general population to use psychotropic medications, which are prescribed to address emotional and behavioral problems (Stambaugh et al., 2012). According to data from the National Survey of Child and Adolescent Well-Being II, between 27 and 47 percent of youth in foster care ages 11 to 17 use psychotropic medications, with the rate increasing the longer the child has been in care (Fernandes-Alcantara et al., 2017). Even if a medication is prescribed for a youth, caseworkers should ensure that the medication is being used as prescribed, and it is best practice for agencies to have medical providers review prescribed medications to determine if they are still required or if the dosages or number prescribed are appropriate. Caseworkers should also see if nonmedication interventions, such as therapy, are available and appropriate for the youth. For additional information, refer to Information Gateway's Understanding Psychotropic Medications web section as well as two Children's Bureau publications: *Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care* and *Supporting Youth in Foster Care in Making Healthy Choices: A Guide for Caregivers and Caseworkers on Trauma, Treatment, and Psychotropic Medications*.

COLLABORATION TO SUPPORT YOUTH

To best prevent, identify, or treat substance use among youth in foster care, it is critical for the community to come together as one. No single individual or agency can provide the support youth need to thrive and avoid the inappropriate use of substances. Child welfare agencies should seek out opportunities to work with substance use treatment providers, educators, mental health professionals, juvenile justice professionals, court staff, and others who work with youth in foster care. By working together, they can develop a comprehensive and consistent message to support youth at risk of or already using substances. For example, agencies can institute an adolescent-focused framework to help all parties better agree on who the client is and what the goals are; develop joint accountability and outcomes that link the services together; establish data and information-sharing measures; and provide training for staff beyond child welfare, such as substance use treatment, education, and mental health (Traube, 2019). They can also work together to support youth in engaging in prosocial activities that may help reduce the risk of substance use. Additionally, agencies should work in partnership with parents and other caregivers as well as the youth themselves. They can provide valuable information about youths' needs and help shape programs.

CONCLUSION

Youth in foster care are at a heightened risk for substance use. Since they may not recognize their own problems with substances, it is critical for adults in their lives, including child welfare professionals, to help them identify any substance use problems and seek assistance from treatment professionals. It is also incumbent upon the child welfare field to work with other systems touching the lives of these youth to develop and implement evidence-based prevention strategies.

ADDITIONAL RESOURCES

- *Substance Use Disorders and Addictions Series* (American Psychological Association)
- "Tutorials for Child Welfare Professionals" (National Center on Substance Abuse and Child Welfare)
- Substance Use and Adolescent Development (HHS, Office of Population Affairs)
- Screening and Assessment Tools Chart (HHS, NIH, NIDA)
- *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* (HHS, Office of the Surgeon General)

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SUGGESTED CITATIONS:

Child Welfare Information Gateway. (2020). *Preventing, identifying, and treating substance use among youth in foster care.* U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau