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Strategies to enhance substance abuse treatment for parents involved with child welfare[1]

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This information sheet describes child welfare concerns associated with parental substance abuse and examines some of the initiatives that have been implemented in the United States to improve the delivery of treatment services to parents whose children have been removed from their care due to substance abuse-related concerns.

Relationship between parental substance abuse and child welfare

Parental substance abuse increases risk for child maltreatment. Children who have a parent who abuses alcohol and/or drugs are approximately three to four times more likely to be abused and/or neglected than children whose parents do not abuse these substances.[2,3]

How does substance abuse increase the risk of child maltreatment?

Substance abuse can interfere with adequate parenting in a variety of ways. The impact of substance abuse on parenting varies according to the substance abused (e.g., alcohol, marijuana, or heroin) and the severity of the problem (abuse vs. dependence). In general, abuse of alcohol and/or drugs can leave parents physically and emotionally unavailable for their children and influence the ways that parents react to their children and respond to their children's needs.

Parental substance abuse can:

- induce or increase negative feelings such as depression, anxiety, or irritability;
- interfere with the amount of control that the parent has over his or her emotional reactions;
- impair a parent's mental functioning, problem solving and judgment;
- interfere with parents' capacity to provide adequate care and supervision (e.g., limited family resources may be spent on alcohol or drugs rather than food or clothes);
- be associated with lifestyles that are harmful for children. Parents may engage in unlawful or high-risk behaviours to obtain substances, and may expose children to criminal activities that compromise their safety and welfare, and
- increase family stress in ways that tax a parent's abilities to cope effectively with child rearing challenges (e.g., contribute to economic and housing instability and domestic violence).

Research indicates that substance abuse affects a substantial proportion of the families involved with child welfare. Studies from the United States indicate that between one-quarter and two-thirds of the families involved with child welfare have substance abuse identified as a factor that contributed to child abuse and/or neglect.[4,5,6] Estimates at

the higher end tend to be reported for samples of children who have been placed in foster care. In examining parent risk factors associated with substantiated child maltreatment, the 2003 Canadian Incidence Study of Reported Child Abuse and Neglect found that alcohol abuse was identified as a functioning concern for almost one-third of male and one-fifth of female caregivers.[7] Drug or solvent abuse was identified as a concern for 17% of male and 14% of female caregivers. In addition, the Quebec Incidence Study of Reported Child Abuse, Neglect, Abandonment, and Serious Behavioural Problems found that almost one-half of all cases of child neglect involved excessive use of alcohol or illegal drugs.[8]

Parental substance abuse and foster care

Parental substance abuse increases the likelihood that a child will be removed from the family home and placed in foster care.[9] Because of concern for their safety and welfare, many children are placed in foster care as a temporary arrangement while their parents address their substance abuse issues. When parental substance abuse contributes to the decision to place a child in foster care, the court must decide whether and under what conditions that child can return to live with his or her parents. Reunification often depends upon parents' progress in treatment. The court may pursue other options to provide children with safe and stable homes (e.g., adoption or legal guardianship) if parents are unwilling to participate in substance abuse treatment or are unsuccessful in their treatment attempts.

Children in foster care who have a parent with a substance abuse problem tend to spend more time in care than children placed in care for other reasons.[10,11] Temporary arrangements are often extended and children may spend years in foster care waiting for their parents' substance abuse issues to be resolved. For example, one study found that children placed in care for reasons related to parental substance abuse spent almost three years in care, on average.[12] During this time children live "in limbo," uncertain about whether they will return home, remain in foster care, or be placed in a more permanent living situation. They may live in a variety of different foster homes during that time, which can disrupt the development of stable attachments to other adult caregivers. Children who have parents with substance abuse issues are also less likely to be re-united with them than maltreated children whose parents do not have substance abuse issues, and these children are more likely to re-enter care.[13,14]

Barriers to recovery

Prolonged stays in care have been attributed to:

- challenges in treating parental substance abuse, and
- problems with the delivery of substance abuse treatment services to parents involved with child welfare.

Many parents do not complete substance abuse treatment. Studies indicate that up to three-quarters of parents who start substance abuse treatment drop out before treatment is completed.[15,16] In addition, about one-half of those who complete treatment return to substance use (i.e., relapse) within one year. Low rates of treatment completion and high rates of relapse are not specific to adults involved with child welfare. Substance abuse is typically chronic and relapsing in nature. Multiple treatment attempts may be required before recovery is achieved.

Several problems with the delivery of substance abuse treatment services have also contributed to prolonged stays in foster care. First, some studies from the U.S. estimate that only about one-third to one-half of parents involved with child welfare who are referred for substance abuse treatment receive it.[17,18] Parents who access treatment may wait several months to one year before entering treatment.[19] Access to services designed to meet the needs of women with children, and culturally appropriate services, are particularly limited. In Canada, the level of access to substance abuse treatment for parents involved with child welfare is not systematically reported; however, references to under-funding for addictions services and regional disparities in access suggest that available services are insufficient to accommodate the number of adults that need treatment.

Second, the services required to support parents' recovery may not be available. A range of ancillary services in addition to clinical treatment is needed to help parents recover from substance abuse and substance abuse-related problems and improve family circumstances.[20,21] Substance abuse can interfere with establishing healthy parent-child relationships and effective parenting skills. In addition, parents who have substance abuse issues often struggle with other challenges such as mental health issues, legal issues, lack of social support, and economic or housing insecurity.[22,23] Persistent difficulties in these other areas may contribute to parenting difficulties and hinder treatment progress.

Third, poor communication and coordination among family courts, treatment providers, and child welfare agencies have been cited as barriers to timely

decision making about children's care. Court decisions have been delayed by onerous processes that are required to obtain information from treatment providers about parents' progress.[24] In addition, treatment plans and goals of the child welfare and substance abuse systems may be incongruent. For example, the courts may require that parents abstain completely from alcohol and/or drugs, but this may conflict with approaches employed in substance abuse treatment programs (e.g., harm reduction). In addition, substance abuse treatment providers may interpret a "relapse" as a common and temporary set-back in the course of long-term recovery, but the courts and child welfare professionals may attend and respond to the risks that the relapse poses for child safety and welfare.

Strategies to enhance delivery of substance abuse treatment to child welfare clients

Concerns about children living in foster care arrangements for extended periods of time and the high costs of their care have contributed to the development of strategies to better address parental substance abuse issues. Many of the initiatives described come from the U.S., where the Adoption and Safe Families Act has accelerated the timelines to find permanent homes for children. These new policies give parents less time to address issues such as substance abuse that place their children at risk before the courts pursue more stable living arrangements such as adoption or legal guardianship. In general, these strategies aim to improve access to treatment and support timely decision making by enhancing service coordination and treatment monitoring.

Better access

To improve access, many jurisdictions give priority to treatment referrals for families involved with child welfare, and/or women with children, or allocate funds to enhance programs that target these populations (e.g., federal foster care funds). Faster access to care has two potential benefits. First, it can reduce the length of time children wait in care. Second, individuals with substance abuse problems are thought to be most receptive to change at "crisis moments," such as when a child is placed in care. Facilitating access to treatment at these times can capitalize on parents' motivation to engage in treatment. For example, one study found that mothers who entered treatment quickly were more likely to complete treatment than mothers whose participation in treatment was delayed.[25] Children whose mothers completed treatment spent less time in care and family reunification was more likely than for children whose mothers did not complete treatment.

Improved service coordination

Several approaches have been employed to improve coordination and communication among the child welfare, court, and substance abuse treatment systems. For example, by mid-2006, 43 U.S. states implemented specialized, "problem-solving" courts to address substance abuse issues that contribute to and/or place children at risk for child maltreatment. These courts are frequently referred to as Family Drug Courts or Family Treatment Drug Courts. They are similar to drug courts used in the criminal justice system in both the U.S. and Canada to deal more effectively with the factors underlying criminal behaviour, including substance abuse.

Some studies have found that parents whose substance abuse issues were addressed through Family Drug Courts were more likely to complete substance abuse treatment and had higher rates of reunification. Their children also spent less time in foster care compared to parents with substance abuse issues who received standard treatment.[26] Family Drug Courts provide an integrated, intensive and multi-disciplinary approach to addressing substance abuse. Cross-system collaboration facilitates information sharing and access to a range of services. Intensive judicial supervision is provided through case management and regular court appearances (e.g., weekly status hearings). Drug testing is mandatory and incentives and legal sanctions are applied. Sanctions, which can include a reprimand, monetary fine, or time in jail, may be imposed if non-compliance (i.e., relapse) occurs to reinforce the importance of adhering to treatment plans. Information about parents' treatment progress is used by the courts to inform decisions on where children should live.

The need for better service coordination has also been addressed by integrating substance abuse and child welfare services. Some jurisdictions (e.g., Delaware and Maryland) have introduced multidisciplinary support teams that include child welfare workers and addictions counselors to deliver coordinated services to child welfare clients who have substance abuse issues. Situating addiction counselors in child welfare offices has also been used to improve identification of parents who have substance abuse issues and facilitate the development of coordinated service plans (e.g., New

Hampshire, New Jersey, Louisville, Kentucky). In other jurisdictions, parents are assigned specialized case managers or recovery coaches who provide support, monitor treatment progress, and coordinate and/or secure a range of supportive services to address factors that hinder treatment progress and contribute to relapse (e.g., unstable housing, problems with transportation, domestic violence, lack of child care, untreated mental health issues). Recovery coaches may also deliver outreach services to re-engage parents who drop out of treatment (e.g. Illinois). Cross-sector training and inter-agency agreements and protocols provide other methods for promoting more collaborative practice. Examples of substance abuse and child welfare initiatives are described at http://www.ncsacw.samhsa.gov/files/Virginia_Compendium.pdf.

Summary

Parental substance abuse increases the risk for child maltreatment and the likelihood that children will be placed in foster care. Before reunification is considered, courts require evidence that parents have addressed the substance abuse issues that put their children at risk. Many jurisdictions in the U.S. have modified the ways that substance abuse treatment is provided to parents involved with child welfare, to overcome difficulties accessing treatment and poor service coordination and to support expedited timelines for making permanency decisions. To improve access, some jurisdictions assign child welfare clients higher treatment priority. Others have allocated child welfare funds to enhance substance abuse treatment services. Better coordination between the courts, child welfare agencies, and substance abuse treatment services is promoted through specialized Family Drug Courts that provide intensive supervision and monitoring of parents' substance abuse treatment, specialized case managers, or recovery coaches who are assigned to facilitate and support parents' recovery, or multi-disciplinary support teams that deliver coordinated services that deal with substance abuse and child welfare issues.

More accessible, comprehensive, and coordinated approaches offer the potential for better support for parents who are recovering from substance abuse problems. They recognize both the complex needs of families involved with child welfare and the importance of child safety. Studies suggest that some of these service enhancements may improve the chances of parents completing substance abuse treatment, and treatment completion is associated with higher rates of reunification and shorter stays in foster care for children. These findings are promising but it is unclear whether or not child outcomes are improved. For example, some evaluations of Family Drug Courts found no differences in subsequent maltreatment or the likelihood that children will re-enter foster care.[27,28] In addition, although treatment completion may be enhanced by these innovative approaches, drop out rates continue to be high. To adequately prevent and address the consequences of parental substance abuse for families, more research is needed to identify ways to improve parent engagement and retention in treatment and support positive long-term outcomes.

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1 This information sheet was reviewed by experts in the field of child welfare.

2 Child Welfare League of America (CWLA). (1997). *Alcohol and other drug survey of state child welfare agencies*. Washington, DC: Author.

3 National Center on Addiction and Substance Abuse at Columbia University. (1999). *No safe haven: Children of substance abusing parents*. New York, New York: Author. Retrieved January 5, 2009 at http://www.casacolumbia.org/absolutenm/articlefiles/379-No%20Safe%20Haven.pdf.

4 U.S. Department of Health and Human Services (1999). *Blending perspectives and building common ground: A report to congress on substance abuse and child protection*. Washington, DC: Author.

5 Vanderploeg, J.J., Connell, C.M., Caron, C., Saunders, L., Katz, K.H., & Tebes, J.K. (2007). The impact of parental alcohol or drug removals on foster care placement experiences: A matched comparison group study. *Child Maltreatment*, 12 (2), 125–136.

6 Young, N.K., Gardner, S.L., Whitaker, B., Yeh, S., & Otero, C. (2005, November). *A review of alcohol and other drug issues in the states' Child and Family Services reviews and program improvement plans*. Retrieved January 5, 2009 from: http://www.ncsacw.samhsa.gov/files/SummaryofCFSRs.pdf

7 Trocmé, N., Fallon, B., MacLaurin, B., Daciuk, J., Felstiner, C., Black, T. et al. (2005). *Canadian Incidence Study of Reported Child Abuse and Neglect, CIS-2003: Major Findings Report*. Ottawa: Public Health Agency of Canada, Government of Canada. Available at http://www.phac-aspc.gc.ca/cm-vee/csca-ecve/index-eng.php

8 Mayer, M., Lavergne, C., & Baraldi, R. (2004). *Substance abuse and child neglect: Intruders in the family.* CECW Information Sheet #14E. Montreal, QC, Canada: Université de Montréal and Institut pour le développement social des jeunes. Retrieved November 29, 2008 from: http://www.cecw-cepb.ca/files/file/en/SubsAbuse14E.pdf

9 U.S. Department of Health and Human Services. (1999). *Blending perspectives and building common ground: A report to Congress on substance abuse and child protection*. Washington, DC: Author. Available at: http://aspe.hhs.gov/HSP/subabuse99/subabuse.htm

10 Choi, S., & Ryan, J.P. (2006). Completing substance abuse treatment in child welfare: The role of co-occurring problems and primary drug of choice. *Child Maltreatment*, 11(4), 313–325.

11 U.S. Department of Health and Human Services. (1999). *Op. Cit.*

12 Children's Bureau, U.S. Department of Health & Human Services. (2004). *The AFCARS Report: Preliminary FY 2002 Estimates as of March 2004*. Available at: http://www.acf.hhs.gov/programs/cb/stats_research/index.htm

13 Bronson, D.E. (2005). *Re-entry in Child Protective Services: A Rapid Evidence Assessment*. Retrieved December 13, 2008 from www.pcsao.org/PCSAOTools/_overlay/OhioReEntryReport102005.pdf

14 Frame, L, Berrick, J., and Brodowski, M.L. (2000). Understanding reentry to out of home care for reunited infants. *Child Welfare*, 79 (4): 339–369.

15 Choi, S., & Ryan, J.P. (2006). Completing substance abuse treatment in child welfare: the role of co-occurring problems and primary drug of choice. *Child Maltreatment*, 11(4), 313–325.

16 Kerwin, M.L. (2005). Collaboration between child welfare and substance-abuse fields: Combined treatment programs for mothers. *Journal of Pediatric Psychology*, 30 (7), 581–597.

17 Child Welfare League of America (CWLA). (1997). *Alcohol and other drug survey of state child welfare agencies*. Washington, DC: Author.

18 Worcel, S., Green, B., Burrus, S., & Finigan, M. (2004). *A retrospective evaluation of family treatment drug courts: Year two update*. Report submitted to the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

19 Green, B.L., Rockhill, A. & Furrer, C. (2007) Does substance abuse treatment make a difference for child welfare case outcomes? A statewide longitudinal analysis. *Children and Youth Services Review*, 29, 460–473.

20 Choi, S., & Ryan, J.P. (2006). Completing substance abuse treatment in child welfare: the role of co-occurring problems and primary drug of choice. *Child Maltreatment*, 11(4), 313–325.

21 Semidei, J., Radel, L. F., & Nolan, C. (2001). Substance abuse and child welfare: Clear linkages and promising responses. *Child Welfare*, 80, 109–128.

22 Kerwin, M.L. (2005). Collaboration between child welfare and substance-abuse fields: Combined treatment programs for mothers. *Journal of Pediatric Psychology*, 30 (7), 581–597.

23 Semidei, J., Radel, L. F., & Nolan, C. (2001). Substance abuse and child welfare: Clear linkages and promising responses. *Child Welfare*, 80, 109–128.

24 Milliken, J.R., & Rippel, G. (2004). Effective management of parental substance abuse in dependency cases. *Journal of the Center for Families, Children & the Courts*, 5, 95–107. Retrieved January 5, 2009 from: http://www.courtinfo.ca.gov/programs/cfcc/pdffiles/JVol5-Milliken.pdf

25 Green, B.L., Rockhill, A. & Furrer, C. (2007). Does substance abuse treatment make a difference for child welfare case outcomes? A statewide longitudinal analysis. *Children and Youth Services Review*. 29, 460–473.

26 Worcel, S., Green, B., Burrus, S., & Finigan, M. (2007). *Family Treatment Drug Court Evaluation: Final Report*. Report submitted to the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. Retrieved January 5, 2009 from http://www.npcresearch.com/Files/FTDC_Evaluation_Final_Report.pdf.

27 Boles, S.M., Young, N.K., Moore, T., & DiPirro-Beard, S. (2007). The Sacramento Dependency Drug Court: Development and outcomes. *Child Maltreatment*,12 (2), 161–171.

28 Worcel, S., Green, B., Burrus, S., & Finigan, M. (2007). *Op. Cit.*

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