No Safe Haven:

Children of Substance-Abusing Parents

January 1999

Funded by:
The Edna McConnell Clark Foundation
PRIMERICA Financial Services, Inc.
Samuel M. Soref and Helene K. Soref Foundation

Board of Directors

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Foreword and Accompanying Statement By Joseph A. Califano, Jr. Chairman and President

A devastating tornado of substance abuse and addiction is tearing through the nation's child welfare and family court systems leaving in its path a wreckage of abused and neglected children, turning social welfare agencies and courts on their heads and uprooting the traditional disposition to keep children with their natural parents.

There is no safe haven for these abused and neglected children of drug- and alcohol-abusing parents. They are the most vulnerable and endangered individuals in America.

That is the grim finding of The National Center on Addiction and Substance Abuse at Columbia University (CASA) two-year exhaustive analysis of the available data on child abuse and neglect; an unprecedented CASA national survey of 915 professionals working in the field of child welfare; a review of more than 800 professional articles, books and reports; six case studies of innovations in the field and numerous in-depth interviews with judges, child welfare officials and social workers on the frontlines.

From 1986 to 1997, the number of abused and neglected children in America has jumped from 1.4 million to some 3 million, a stunning rise more than eight times faster than the increase in the children's population (114.3 percent compared to 13.9 percent). The number of *reported* abused and neglected children that have been killed has climbed from 798 in 1985 to 1,185 in 1996; the U.S. Advisory Board on Child Abuse and Neglect sets the actual number higher, at 2,000, a rate of more than five deaths a day.

Alcohol, crack cocaine, methamphetamine, heroin and marijuana are fueling this population explosion of battered and neglected children.

Children whose parents abuse drugs and alcohol are almost three times (2.7) likelier to be physically or sexually assaulted and more than four times (4.2) likelier to be neglected than children of parents who are not substance abusers. With 28 million children of alcoholics and several million children of drug addicts and abusers, the number of children and adults in America who, during their lives, have been neglected and/or physically and sexually assaulted by substance-abusing parents is a significant portion of our population.

Parental neglect of children is a consequence of substance abuse and addiction and such neglect often leads to sexual or physical abuse by others. While three-fourths (77.8 percent) of abuse perpetrators are birth parents, 10.1 percent are other relatives and 12.1 percent are unrelated adults.

In 1998, CASA conducted the first survey about substance abuse and addiction ever undertaken of frontline professionals in child welfare agencies and family courts. The responding 915 professionals hail from every state, and from inner city, suburban and rural areas. This survey reveals a corps of professionals sounding the alarm and crying out for help. The picture of child abuse and neglect in America that they paint is colored with alcohol and drug abuse and addiction. Eight of 10 professionals surveyed (81.6 percent) cite alcohol in combination with other drugs as the leading substance of abuse in child abuse and neglect; another 7.7 percent cite alcohol alone; 45.8 percent cite crack cocaine as the leading illegal substance of abuse; 20.5 percent, marijuana. For these child welfare workers confronting parental maltreatment of children, marijuana can hardly be considered a benign substance.

Eighty percent (79.8) of the professionals said that substance abuse causes or exacerbates most cases of child abuse and neglect that they face; 40 percent (39.7) reported that it causes or exacerbates 75 to 100 percent of their cases. So pervasive has drug and alcohol abuse been among parents receiving services of the Department of Health and Human Services in Sacramento County, California (notably including alcohol and methamphetamine use by child-abusing parents), that the department's former director Robert Caulk required every employee to receive intensive training in substance abuse and addiction.

Although estimates vary, CASA's analysis, survey and interviews lead to the finding that parental substance abuse and addiction is the chief culprit in at least 70 percent--and perhaps 90 percent--of all child welfare spending. Using the more conservative 70 percent assessment, in 1998 substance abuse and addiction accounted for some $10 billion in federal, state and local government spending simply to maintain child welfare systems.

This $10 billion does not include the costs of providing healthcare to abused and neglected children, operating law enforcement and judicial systems consumed with this problem, treating developmental problems these children suffer, providing special education for them or lost productivity. Nor does it include the costs attributable to child abuse and neglect that are privately incurred. It has been impossible to calculate those costs with precision, but CASA estimates that they easily add an additional $10 billion to the price our nation and its people pay for child abuse and neglect.

The human costs are incalculable: broken families; children who are malnourished; babies who are neglected, beaten and sometimes killed by alcohol- and crack-addicted parents; eight-year-olds sent out to steal or buy drugs for addicted parents; sick children wallowing in unsanitary conditions; child victims of sodomy, rape and incest; children in such agony and despair that they themselves resort to drugs and alcohol for relief. For some of these children it may be possible to cauterize the bleeding, but the scars of drug- and alcohol-spawned parental abuse and neglect are likely to be permanent.

Parental substance abuse does not fester in a cocoon. It is usually found among a cluster of daunting conditions--poverty, a history of having been physically or sexually abused, depression, other mental illness, unemployment, discrimination and social isolation. The impact

of poverty is profound: children from families with incomes below $15,000 are 25 times likelier to be abused and neglected than children from families with incomes above $30,000, and parents of poor children are less likely to have access to treatment. The parent who abuses drugs and alcohol is often a child who was abused by alcohol- and drug-abusing parents. Most parents involved with child welfare systems are women since so many men have walked out on their parental responsibilities.

This violent storm of parental drug and alcohol abuse and addiction has overwhelmed the dedicated army of more than 200,000 caseworkers, judges, lawyers and child advocates in the nation's 1,000 state, county and private child welfare agencies, 1,200 family courts and thousands of foster care and adoption agencies.

By 1997, in some states and cities caseworkers were responsible for 50 cases of child maltreatment at any one time and judges were handling as many as 50 cases a day. At that pace, in less than 10 minutes a judge must assess the circumstances and credibility of the mother and/or father, child, caseworker, siblings, law enforcement officer and any other witnesses and make a decision that may determine a child's future--and that assumes the judge is working on the substance of these cases for more than eight non-stop hours a day!

Few caseworkers and judges who decide for these children have been tutored in substance abuse and addiction. While most child welfare officials say they have received some training, usually it involves brief, one-shot seminars that last as little as two hours. For judges, training tends to be on-the-job. Such training is woefully inadequate for the profound decisions that these officials are called upon to make for these vulnerable children.

Despite the sharp rise in cases of child abuse and neglect involving alcohol and drugs, the number of families receiving in-home services from caseworkers has dropped 58 percent, from 1.2 million in 1977 to 500,000 in 1994. In 1997, child welfare workers were able to investigate only a third (33 percent) of cases of child abuse and neglect, a decline from 1986 when they investigated half (51 percent) of such cases.

There are no national estimates of the gap between those parents who need treatment and those who receive it, but CASA's research concerning women and a study of 11 states indicates that most of those who need treatment don't receive it. Drug and alcohol addiction is a chronic disease so without treatment and aftercare, these parents have little hope of recovery.

Substance abuse and addiction has shaken the foundations of the nation's child welfare systems and fundamentally changed the nature of the tasks required of the professionals involved. Physical and sexual abuse and neglect are striking younger and younger children and a growing number of babies. As the role of substance abuse has increased, the age of the victimized children has gone down. Many fetuses are exposed to alcohol, illegal drugs and tobacco during pregnancy: between 1991 and 1995, alcohol use during pregnancy rose more than 30 percent (from 12.4 to 16.3 percent of pregnant women). Each year, some 20,000 infants are abandoned at birth or are kept at hospitals to protect them from substance-abusing parents. The proportion of children that caseworkers place in foster care at birth jumped 44 percent from the 1983-86 period (16 percent) to the 1990-94 period (23 percent). Today most cases of abuse and neglect by substance-abusing parents involve children under five.

Generations ago, child welfare workers were able to concentrate on care of the children; for them, reconstituting the natural family was a happy result and it was often just a matter of getting an unemployed parent a job or helping husband and wife deal with an intense but passing personal crisis. Alcohol and drugs have blown away the topsoil of family life and reshaped the landscape of child abuse and neglect. Parents addicted to drugs and alcohol are clever at hiding their addiction and often more concerned about losing their access to drugs and being punished than losing custody of their children. As a result, child welfare agencies have been forced to allocate more time

to investigations, gathering evidence of neglect and abuse of children by alcohol and drug involved parents that increasingly leads to criminal prosecution. This shift in focus has changed the way parents and children see caseworkers and the way these workers view themselves, immeasurably complicating their task of protecting children and either putting the birth family back together again or placing the child with another set of parents. This shift also threatens to criminalize a process that should be driven by treatment, healthcare and compassion for both child and parent.

Drug and alcohol abuse has thrown into doubt a fundamental tenet of child welfare: the commitment to keep the child with his or her natural parents. Child welfare workers have long viewed terminating parental rights as a failure. But alcohol, crack cocaine and other drug abuse has shattered this time-honored precept. Where drug- and alcohol-abusing and addicted parents are concerned, the failure often rests in perpetuating such rights at the expense of the child's development.

There is an irreconcilable clash between the rapidly ticking clock of cognitive and physical development for the abused and neglected child and the slow motion clock of recovery for the parent addicted to alcohol or drugs. In the earliest years, the clock of child development runs at supersonic speed--intellectually, physically, emotionally and spiritually. For the cognitive development of young children, weeks are windows of early life that can never be reopened. For the parent, recovery from drug or alcohol addiction takes time--certainly months and often years--and relapse, especially during initial periods of recovery, is common. Quick fixes and cold turkey turnarounds are the rare exception for alcohol and drug addicts and abusers. Bluntly put, the time that parents need to conquer their substance abuse and addiction can pose a serious threat to their children who may suffer permanent damage during this phase of rapid development. Little children cannot wait; they need safe and stable homes and nurturing adults *now* in order to set the stage for a healthy and productive life.

For some parents, concern about their children can provide a primary motivation to seek treatment for alcohol and drug abuse and addiction. But for many, the most insidious and horrifying aspect of substance abuse and addiction is its power to overwhelm and even destroy the inherent natural instinct of parents to love and care and sacrifice for their children. Whether the abuse involves alcohol, crack cocaine or some other drug, its most savage manifestation is the destruction of the motivation of parents to seek help for their addiction so that they can care for their children. Eighty-six (85.8) percent of survey respondents named lack of motivation as the number one barrier to getting parents into substance abuse treatment.

The cruelest dimension of the tragedy for children abused by parents using drugs and alcohol is this: even if parental rights are timely terminated for such parents who refuse to enter treatment or who fail to recover, there is no assurance of a safe haven for the children. There are not nearly enough adoptive homes for these children. Some 107,000 children were either legally free or destined for adoption at the end of 1995; only 27,115 children--one in four--were adopted that year. Foster care, while far better than being abused, rarely offers the lasting and secure nurturing for full cognitive development--and appropriate foster care is also in short supply.

Child welfare professionals struggle with this problem. More than eight of 10 (82.4 percent) believe that repeated abuse should prompt termination of parental rights and three fourths (75.1 percent) believe that severe abuse requires such termination. Yet these professionals admit that in current practice, far fewer such cases result in termination.

Parental alcohol and drug abuse and addiction have thrown the nation's system of child welfare beyond crisis, into chaos and calamity. It is the children who pay the exorbitant price. They are beaten by mothers and fathers high on alcohol or cocaine. They are left to suffer malnutrition and disease because they lack food and heat. Children of substance-abusing parents suffer low self-esteem, depression, self-mutilation, suicide,

panic attacks, truancy and sexual promiscuity, and in later life mimic the drug and alcohol abuse problems that they witness in their parents. For most of these children, we offer no safe port from the storm of parental drug and alcohol abuse and addiction that has engulfed their lives. We spend more on cosmetic surgery, hairpieces and make-up *for men* than we do on child welfare services for children of substance-abusing parents. In this nation, we take better care of endangered condors than of children of substance-abusing parents.

The best hope of a safe haven for these children is to prevent alcohol and drug abuse by their parents.

Child welfare systems and practices need a complete overhaul. Some leaders in the field have moved to reshape systems under their control. The former Director of the Sacramento County Department of Health and Human Services required all employees to be intensively trained in substance abuse and addiction. Officials in Connecticut and New Jersey have enlisted specialists in drug and alcohol addiction to screen and assess parents, place them with treatment providers and monitor their progress. Judges in Reno, Nevada, Pensacola, Florida, and Suffolk County, New York, have used their family courts to coerce parents into treatment and follow their progress closely, an innovation that is being replicated in other parts of the country.

Social service providers, from agency directors to frontline child welfare workers, judges, court clerks, masters, lawyers, and health and social service staffs need intensive training in the nature and detection of substance abuse, and what to do when they spot it. States should require as a condition of certification that child welfare workers be thoroughly trained in substance abuse and addiction and require these workers to undergo continuing education on the subject. In all investigations of child abuse or neglect, parents should be screened and assessed for substance abuse: those who need help should be offered comprehensive treatment. Caseworkers and judges should use the carrots and sticks at their disposal to get parents who need it into treatment and should prevent and plan for relapse. They should move rapidly to place children for adoption when parents refuse treatment or fail to respond to it.

This CASA report underscores the need for substantial increases in funding for treatment and healthcare for substance-abusing parents and their children. Comprehensive treatment that is timely and appropriate for parents is the linchpin of strategies to prevent further child abuse and neglect by substance-abusing parents. Just as the substance abuse does not occur in isolation, so the treatment cannot be provided in isolation. It must be part of a concentrated course of mental health services and physical healthcare; literacy, job and parenting skills training; socialization, employment and drug-free housing, and it must be attentive to the fact that most of these parents are women. Where the only hope of reconstituting the natural family for the abused child rests in comprehensive treatment for the parent, it is an inexcusable and cruel Catch-22 not to make such treatment available to the parent.

Most importantly, this report suggests these guiding principles to help those who devote their lives to the welfare of children:

1) Every child has a right to have his or her substance-abusing parents get a fair shot at recovery with timely and comprehensive treatment.

2) Every child has a right to be free of drug- and alcohol-abusing parents who are abusing or neglecting their children and who refuse to enter treatment or despite treatment are unable to conquer their abuse and addiction.

3) Every child has a right to have precious and urgent developmental needs take precedence over the timing of parental recovery.

4) The goal of the child welfare systems is to form and support safe, nurturing families for children--where possible within the biological family and where not possible with an adoptive family.

The need for this two-year effort to examine and expose the impact of substance abuse and addiction on child abuse and neglect became evident to CASA as a result of research for our reports, *Substance Abuse and The American Woman* and *Substance Abuse and Urban America: Its Impact on an American City, New York*. The report on women, released in 1996, described how the illness, death and violence that substance abuse spawns undermine a woman's health, the health of her fetus and her ability to be a nurturing parent. The New York study revealed that 77 percent of that city's 1994 foster care budget ($595 million of $775 million) was due to parental drug and alcohol abuse and addiction.

We are grateful to the American Bar Association, American Public Human Services Association, Child Welfare League of America, National Association of Counsel for Children, National Association of Court-Appointed Special Advocates and National Council of Juvenile and Family Court Judges for their help in providing access to professionals in the child welfare field for our national survey. Child welfare agencies in Los Angeles, California, New York, New York, Pensacola, Florida, and Wichita, Kansas, collaborated with CASA to survey their frontline workers who work with the children of substance-abusing parents every day. The Connecticut Department of Children and Families, New Jersey Division of Youth and Family Services, and Sacramento County Department of Health and Human Services allowed CASA to research and observe their innovative approaches to changing child welfare practices. We appreciate the time and access to their courts granted to CASA by Judge Charles McGee of Reno, Nevada, Judge Nicolette Pach of Central Islip, New York and Judge John Parnham of Pensacola, Florida. We are grateful to the parents who shared with us their experiences with substance abuse and public child welfare systems. Dewey Ballantine, CASA's counsel, was most helpful in analyzing the legal issues.

Finally, for the financial support which made this unprecedented undertaking possible, we extend our thanks to the Edna McConnell Clark and Samuel M. Soref and Helene K. Soref foundations and the Personal Financial Analysts of PRIMERICA Financial Services, Inc., a member of Citigroup Inc., our partners and supporters in so many efforts. All share a strong commitment to the safety and welfare of the nation's children. I remember discussing this project with Mrs. Helene Soref in Florida in 1996 and I regret that she did not live to see this product of her generosity and concern for children.

Jeanne Reid, M.P.A., a distinguished CASA senior research associate, was the principal investigator for this effort and she has done a typically brilliant and thoughtful job. Throughout the effort, she was most ably assisted by Peggy Macchetto, J.D. David Man, Ph.D., CASA's librarian, and library assistant Amy Milligan were a big help. Marcia Lee, M.P.P., my Special Assistant, edited the manuscript. Herbert Kleber, M.D., Executive Vice President and Medical Director, William Foster, Ph.D., Senior Vice President and Chief Operating Officer, Susan Foster, M.S.W., Vice President and Director of Policy Research and Analysis, Patrick Johnson, Ph.D., Deputy Director of Medical Research and Practice Policy, Lawrence Murray, M.S.W., Senior Program Associate, and I reviewed the report. Jane Carlson, as usual, handled the administrative chores with efficiency and good spirit.

The Advisory Board, a distinguished group of experts, were invaluable in guiding this effort and reviewed a draft of this report. But responsibility for the analysis and findings sits with CASA.

I. Introduction and Executive Summary

The number of children in America who are abused or neglected has more than doubled from 1.4 million in 1986 to about 3.0 million in 1997.[1] As child welfare officials have responded by focusing on investigating a flood of new cases, chronic child abuse and neglect has surged and the number of children dying while under the watch of the nation's child welfare system has risen. Without a concerted effort to assess and treat substance abuse, the tragic consequences for the nation's children will continue to accumulate.

This report is a comprehensive analysis of the deep and complex connection between substance abuse and child maltreatment.* It exposes how child welfare agencies and family court† systems struggle to handle the critical decision of child custody when a parent is a drug or alcohol abuser, and it recommends substantial changes in practice to safeguard our nation's children. The most significant findings of our two-year analysis are:

- Substance abuse and addiction severely compromise or destroy the ability of parents to provide a safe and nurturing home for a child.

- Substance abuse and addiction confound the child welfare system's ability to protect children.

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* In this report, "maltreatment" means abuse and/or neglect of a child. Abuse includes both physical and sexual abuse unless otherwise stated. Neglect includes abandonment, expulsion, delay or refusal of healthcare, inadequate supervision, inadequate nutrition (starvation), emotional neglect (such as witness to chronic/extreme spouse abuse) and other omissions of proper care.

† In this report, "family court" includes any court that hears cases involving child abuse and/or neglect. In some states or counties, these courts are referred to as juvenile courts or dependency courts.

- Timely and comprehensive treatment can work for substance-abusing parents, and such treatment is cost effective.

- Only a major overhaul of the child welfare system and dramatic changes in child welfare practice can make real progress against this formidable problem.

As part of this two-year analysis, CASA conducted a targeted, national survey of professionals who work in child welfare agencies or family courts to learn their perceptions of the extent of the substance abuse problem, how they decide who will care for the children in cases involving substance abuse and the changes that they believe would benefit the nation's children.* The key findings:

> *"It's scary. It's scary to not have your mom there, to have to worry where you're gonna get your next meal and who's gonna change your diaper, who's gonna feed you and who's gonna put you to bed at night. Dad tried to stab himself when he was drinking and high on drugs. It was right in front of me. I was scared."*[2]
>
> -- Melissa, age 14

- Three of four (71.6 percent) cite substance abuse as one of the top three causes for the dramatic rise in child maltreatment since 1986, followed by better reporting of child maltreatment (35.4 percent) and poverty (31.8 percent).

- Most survey respondents (79.6 percent) report that substance abuse causes or contributes to at least half of all cases of child maltreatment; 39.7 percent say it is a factor in over 75 percent of the cases.

- Almost all survey respondents (81.6 percent) say that parents who abuse or neglect their children most commonly abuse a combination of alcohol and drugs; 7.7 percent cite alcohol alone.

- Overall, 89.3 percent of all respondents recognize alcohol as a leading substance of abuse among parents.

- 45.8 percent of all respondents say that cases of illegal drugs involve crack. One in five (20.5 percent) respondents say that cases of illegal drugs involve marijuana.

- Three of four survey respondents (75.7 percent) say that children of substance-abusing parents are likelier to enter foster care, and 73.0 percent say that children of substance-abusing parents stay longer in foster care than do other children.

- Almost half (42 percent) of all case workers say either they are not required to record the presence of substance abuse when investigating child maltreatment or do not know whether they are required to do so.

- 61.3 percent of respondents say that what treatment is "available" determines what treatment is "appropriate" for the parent.

- Only 5.8 percent of survey respondents say that there is no wait for parents who need residential substance abuse treatment. Only 26.0 percent say that there is no wait for outpatient treatment.

- Respondents overwhelmingly (85.8 percent) name lack of motivation as the number one barrier to getting parents into substance abuse treatment, followed by lack of residential treatment (53.0 percent), lack of insurance coverage for treatment (50.7 percent), lack of outpatient treatment (35.4 percent) and lack of child care (28.5 percent). It is not possible to determine from the survey how much the perceived lack of motivation is influenced by these other barriers.

* A copy of the questionnaire and a description of the survey methodology appear in Appendices A and B. A total of 3,486 surveys were distributed; 915 responses were recorded. The overall response rate is 26.4 percent.

In addition to the survey, CASA reviewed more than 800 technical articles, books and reports covering medical, social science, legal and substance abuse literature relevant to child maltreatment when parents are abusing alcohol and drugs. We interviewed numerous caseworkers, judges and other professionals. We conducted six case studies to identify promising innovations in the field to address substance abuse among parents who abuse or neglect their children and reviewed numerous other innovations.[*] Together, the CASA survey, literature review and case studies provide the foundation for the following key findings.

Substance abuse and addiction are the primary causes of the dramatic rise in child abuse and neglect and an immeasurable increase in the complexity of cases since the mid-1980s.

In both CASA's survey and other research, child welfare and family court officials report that substance abuse--alcohol, crack cocaine and other drug use--is responsible for the dramatic rise in cases. Children whose parents abuse drugs and alcohol are almost three times (2.7) likelier to be abused and more than four times (4.2) likelier to be neglected than children of parents who are not substance abusers.[4] Substance abuse and addiction is almost guaranteed to lead to neglect of children.[5] Further fueling the number of cases, the rate of repeated abuse or neglect appears to be increasingly driven by alcohol and drug addiction.[6]

> *It's awful in the long run… When you grow up you have to deal with a lot more problems, 'cause when you're little you don't realize everything that's happening, and you try to understand and you don't. And then when you get older, it's so hard to think that your mom would do that to you. I mean she'll tell you that she loves you and that she'll help you in any way she can -- but she doesn't. She tries, but she can't; the drugs just take over. And, I don't know, it's just hard. It's really hard.*[3]
>
> -- Brandy, age 16

Crack cocaine was responsible for at least the initial spike in the caseload. While new crack use appears to have subsided nationally in the 1990s, the child welfare caseload has held steady. In some areas, child welfare officials report no decline in crack use by parents.[7] A judge in Washington, D.C. reported that, "The crack epidemic spawned a four-fold increase in child welfare cases here beginning in the mid-1980s, and crack continues to sustain it."[8] In other areas, the reasons for the continuing high caseloads are more complex.

Improved recognition and reporting of child maltreatment may be uncovering cases involving substance abuse that before went unrecognized. In particular, greater attention to the consequences of alcohol, crack and other drug use generates a torrent of cases that is unlikely to recede dramatically as crack alone recedes. A dramatic increase in the complexity of cases is a factor as well. Parents landing in the child welfare system, predominately female addicts, are more deeply troubled than their counterparts 20 years ago.[9] Their substance abuse most frequently occurs as one of a cluster of serious problems including physical and sexual abuse, stress, social isolation, financial crisis, unemployment, depression and family histories of these problems. Few child welfare agencies are prepared to address this panoply of problems.

Another factor may be the steadily declining age of first use of alcohol and all addictive substances and the resulting damage to social skills and emotional maturity--necessary prerequisites to parenting.[10] These parents need "habilitation" not "rehabilitation," and their cases tend to linger in the child welfare system for years, further sustaining the high number of cases.[11]

[*] A description of the case study methodology appears in Appendix C.

Finally, CASA's survey of child welfare professionals found that most commonly, cases of abuse and neglect by substance-abusing parents involve alcohol in combination with other drugs such as crack cocaine, methamphetamine, heroin and marijuana.

CASA estimates that substance abuse causes or contributes to seven of 10 cases of child maltreatment and accounts for some $10 billion in federal, state and local government spending on child welfare systems.

Estimates vary, but across the country, substance abuse and addiction causes or contributes to at least 50 percent of all child welfare cases and in some areas it plays a role in 90 percent of all cases.[12] CASA estimates--based on other research, our survey of professional perceptions in the field and our case studies--that on average in seven of 10 cases, substance abuse or addiction causes or contributes directly to child maltreatment.

While a handful of innovators in child welfare agencies and family courts are changing child welfare practice to address substance abuse and addiction, these efforts are rare. The result is that substance abuse and addiction account for some $10 billion in federal, state and local government spending (70 percent of the $14.4 billion in total child welfare spending).[*] Approximately 44 percent flows from federal coffers, 44 percent from state coffers and the balance (12 percent) from local (usually county) governments.[13]

This $10 billion does not include costs of healthcare, operating judicial systems, law enforcement, special education and lost productivity; nor does it include privately incurred costs. It has not been possible to calculate these costs with precision, but CASA estimates that they total some $10 billion. This is a common sense estimate. There are 28 million children of alcoholics, 21 million of them adults. The lost productivity of those who were neglected or abused as children is significant. The lost productivity for Fetal Alcohol Syndrome adults alone is about $1 billion annually. These numbers do not include the lost productivity attributable to children of drug-abusing and addicted parents. Healthcare costs and related services just for children and surviving adults who suffer Fetal Alcohol Syndrome amount to $2 billion; hospital costs for newborns whose mothers abused illegal drugs amount to $360 million.

Treatment can prevent chronic maltreatment and reduce costs.

Many of these costs could be avoided through the provision of treatment. National treatment outcome studies and specifically studies of women receiving federally funded treatment clearly show that treatment can be effective and significant costs can be avoided as a result.[14]

By providing treatment to substance-abusing parents, we will be able to take advantage of the opportunity to treat a problem that results in costs not only to the child welfare system, but also to our family and criminal courts, our Medicaid and welfare programs, special education programs for children, and other health services. Many of the families involved with the child welfare system reappear in other health, social service and justice system agencies. By treating the addiction, the public sector will realize savings in other areas and avoid the consequences of untreated addiction that are visited on our families, communities and public sector budgets.

Child welfare practice has shifted away from providing services aimed at preventing further maltreatment toward investigation, child removal and custody decisions.

Overwhelmed by the onslaught of cases, child welfare agencies are devoting more of their resources solely to investigation, foster care and permanent custody decisions while the provision of services to

[*] A description of the cost methodology appears in Appendix D.

prevent the recurrence of child maltreatment has become a lower budget priority.[15] This shift has occurred in the face of increasing evidence of repeated maltreatment linked to substance abuse, more abuse and neglect of infants and young children and increasing instances of child deaths.

The crack epidemic caused the caseload of a caseworker to jump to 50 or more in some areas. Some family court judges saw their own caseloads jump to 40 or 50 a day.[16] This level of caseload requires that they assess the credibility of the mother or father, the caseworker and other witnesses and possibly make a profound decision for a child in as little as 10 minutes. At the same time, the number of families receiving in-home services through a child welfare agency has dropped 58 percent from 1.2 million in 1977 to 500,000 in 1994.[17] Even when child welfare agencies do provide services, the typical array of services they offer--parent education and housekeeping help, for example--is unlikely to match the needs of multi-problem families struggling with addiction.[18]

More than 40 percent of all child welfare caseworkers either aren't looking for the problem or aren't aware of any policies instructing them to do so. Despite the predominance of substance abuse in the child welfare caseload, 42 percent of the respondents to CASA's survey say either they are not required to record the presence of substance abuse when investigating charges of child maltreatment or do not know if they are required to do so. One public official explained, "'Don't ask, don't tell' is a policy that protects the system from collapse."[19]

Lack of training prevents the recognition, assessment and appropriate treatment of substance abuse problems in parents who abuse or neglect their children. The child welfare system is a disparate array of more than 200,000 caseworkers, judges, lawyers and child advocates in the nation's 1,000 state, county and private child welfare agencies, 1,200 family courts and thousands of foster care and adoption agencies.

In the CASA survey and other research, most professionals in this system say they have been trained in substance abuse and addiction. But in practice, this training is grossly inadequate. Usually it involves brief, one-time only seminars that may last as little as two hours. That they receive inadequate training comes through loud and clear in their response to the problem.

The shortage of appropriate substance abuse treatment for women sabotages the efforts of child welfare officials and judges who try to intervene with substance-abusing parents. Substance-abusing parents usually experience multiple problems that few child welfare agencies and substance abuse treatment programs are prepared to address. There are no national estimates of the gap between parents who need treatment and those who receive it. However, a 1997 survey of state child welfare agencies found that while 67 percent of all parents involved with their agencies and 35 percent of those who are pregnant need substance abuse services,[20] they can provide relevant services to only 31 percent of all parents with substance abuse problems and 20 percent of pregnant women with substance abuse problems.[21] Many parents in need are not getting appropriate treatment. CASA's survey finds that when treatment is available, the type of treatment provided to parents through the child welfare system is determined almost exclusively by what is available at the moment, rather than a careful assessment of need.

Even when treatment is available, the difficulty of motivating parents to enter and complete treatment is the biggest challenge for child welfare officials who seek to preserve and/or reunify families. Denial and dishonesty are part of the disorder of

addiction.[22] The belief that one does not have a problem with alcohol and drugs is a major barrier to getting a parent into treatment. Denial also hinders the ability of outsiders to assess the severity of the substance abuse problem. Addicts become masters of manipulation and dissembling in order to hide their problems, further complicating entry into treatment.

Child welfare officials return children to their families without preparing for the common event of relapse. Upon completing substance abuse treatment, aftercare in the form of self-help groups and support services can prevent or minimize relapses, but child welfare agencies devote few if any resources to connecting families to these services.[23] Nor do they monitor cases closely for a period of time after treatment to watch for and respond to relapse. In the CASA survey, when asked what percentage of parents who complete substance abuse treatment participates in aftercare programs, one of three (36.6 percent) said that less than half of parents attend such programs, and another third (30.0 percent) did not know.

Few child welfare professionals agree on how to safeguard children in substance-abusing families. Survey respondents do not show any consensus on how to remedy the crushing problems created or exacerbated by substance abuse and addiction. The greatest area of consensus involved only 18.9 percent of respondents who stated that substance abuse treatment should be more available.

This is a significant barrier to leaders in the field who recognize the pressing need to deal with substance abuse among parents. To complicate matters, they face structural and cultural barriers within child welfare agencies and courts: the lack of substance abuse training both on the frontlines and in the judicial system; concerns about confidentiality that prevent child welfare officials from getting important information about parents in treatment for substance abuse; the need to change the insular culture of the child welfare system and forge a more integrated approach across agencies that can address the multiple problems afflicting substance-abusing parents; and the need to redefine success so that removing children from homes and even severing parental rights is not always seen as a sign of failure.

The child welfare and family court system must answer hard questions while satisfying demands from two clocks fundamentally out of sync. Child welfare and family court officials struggle to decide when it is safe to return a child to an addicted parent, how many chances at recovery a parent should be given and how much the system is obligated to offer a parent with an addiction problem. They do all this while different clocks are ticking away,[24] most importantly: 1) The Clock of Child Development: Children cannot wait. Children urgently need safe and stable homes and nurturing relationships to develop a foundation for a healthy and productive life. 2) The Clock of Recovery: Alcohol and drug abusers need time to conquer their addiction. It can take several attempts before treatment works and relapse is common.

The consequences inevitably fall on the children. Although children demonstrate amazing resiliency in the face of adversity, many children who survive abuse or neglect are angry, antisocial, physically aggressive and even violent.[25] They may perform poorly in school and engage in delinquent or criminal behavior.[26] For some, the consequences include low self-esteem, depression, hopelessness, suicide attempts and self-mutilation.[27] They may behave compulsively, suffer panic attacks, be highly distrustful of others, tend towards dangerous play and sexual promiscuity.[28] These children are also at high risk of developing their own substance abuse problems, as both a history of childhood maltreatment and parental substance abuse increase the odds that individuals will abuse alcohol and drugs.[29] And they may repeat the cycle of abuse and neglect that has plagued them in their childhood.[30]

Six critical weaknesses hobble the efforts of child welfare officials to protect children in families with substance problems. CASA's analysis reveals that the child welfare system, in attempting to deal with substance-abusing parents, faces major problems in six critical areas: 1) lack of effective substance abuse screening and assessment practices; 2) lack of timely access to appropriate substance abuse treatment and related services; 3) lack of strategies to motivate addicted parents; 4) lack of criteria or knowledge to inform decisions on when to return children to their families; 5) few efforts to prevent or prepare for relapse; and 6) the difficulty of determining when "reasonable efforts" have been made for substance-abusing parents and adoption proceedings should begin.

> *I wish that I hadn't done the drug[s] and stuff…I was the one who put my daughter in the system. I wish that at that time I had the mind that I have now. What can I do now? But to pray and do the program right. This is only way to help me get my baby back from my mother. I just wish people wake up on time before they go through what I'm going through, because our children are more important than the drugs and alcohol and the street.*[31]
>
> --Amalia
> Participant in treatment program

Enterprising leaders in child welfare agencies are beginning to produce positive results. Federal and state laws set few guidelines regarding how to respond to substance abuse and child maltreatment, leaving most of the key policy decisions to child welfare agency directors and family court judges. Within this general framework, a handful of agency directors and judges are trying new strategies to meet the challenge of substance abuse and child maltreatment, and despite formidable barriers some are producing positive results. The most significant of these results are a function of dramatic changes in practice and availability of effective treatment.

Although there are others that CASA did not have the resources to review, CASA found three promising examples of efforts to address substance abuse that originated in child welfare agencies and provide important lessons for the field: the Alcohol and Other Drug Training Initiative in the Sacramento County Department of Health and Human Services, a department-wide training program to improve the ability of Department workers to handle cases involving substance abuse; an initiative by the New Jersey Division of Youth and Family Services in which certified alcohol and drug counselors, who are professionals with expertise in substance abuse, and home visitors, who are paraprofessionals in recovery from addiction, work in tandem with caseworkers handling cases involving substance-abusing parents; and Project SAFE, an experiment by the Connecticut Department of Children and Families with a managed care model of service delivery.

Each of the three case studies demonstrates an attempt to overcome substantial structural and cultural barriers to improve child welfare practice regarding substance abuse and child maltreatment. These systems are beginning to address critical areas of practice that hinder child welfare efforts with substance-abusing parents: improved screening and assessment, timely access to appropriate treatment and related services, strategies to motivate addicted parents and knowledge to inform decisions on if and when to return children home. They also illustrate the problems child welfare agencies encounter when trying to implement change.

Family drug courts are an innovative grass-roots movement to motivate parents and make informed, timely decisions regarding children. CASA identified three family drug courts, the seeds of a grass-roots movement to capitalize on the success of the criminal drug court model by applying it in family courts to substance-abusing parents who have maltreated their children: the Family Drug

Court in Reno, Nevada; the Parent Drug Court in the First Judicial Circuit in Pensacola, Florida; and the Family Drug Treatment Court in Suffolk County, New York.

Each of these case studies demonstrates both the promise and peril of applying the drug court model in a family court. The strategy produces significant results in many critical areas of practice: improved screening and assessment, timely access to appropriate treatment and related services, strategies to motivate addicted parents and knowledge to inform decisions on if and when to return children home. Family drug courts are an effort by judges to impose accountability not only on substance-abusing parents, but also on a social welfare system that is fragmented, uncoordinated and generally ill-prepared for the multiple, intertwined problems of families with substance abuse problems.

Family drug courts must also take careful steps to assure that they respect the principles of due process, confidentiality and fairness. Concerns about family drug courts also center on the value of coerced treatment and whether such efforts come too close to turning the disease of addiction into a crime worthy of punishment. Yet many who work in the field of addiction argue that serious consequences are sometimes necessary to get the serious attention of addicts who do not want to address their problem. The child welfare system, which must attend to the urgent developmental needs of children, cannot have the patience with the recovery process that should be accorded to addicts in public health arenas.

The nation's inability to protect children whose parents are substance abusers springs from the lack of practice guidelines to achieve federal and state policy objectives; and the lack of federal and state support for prevention, substance abuse treatment, training, research and evaluation.

All of CASA's research points to one fact: the nation cannot protect our children from harm unless it faces head on substance abuse and addiction. Recent changes in the federal law notwithstanding,[*] the solution does not appear to rest entirely with aggressive federal or even state legislative authority. Rather, the problem lies in establishing and implementing effective practice guidelines to fulfill the law's objectives.

This report calls for new practice guidelines for child welfare agencies, a concerted effort to integrate them into the daily routines of child welfare and family court professionals and substantial increases in federal and state funding for prevention, treatment and training. It is also vital to devote resources to research and evaluation within the field. With an analysis of lessons learned in the field, the results of CASA's national survey and CASA's review of the most recent literature, this report offers an agenda for action.

Recommendations

To respond to the reality and consequences of a caseload now dominated by substance-abusing parents, CASA suggests the following guiding principles:

1) Every child has a right to have his or her substance-abusing parents get a fair shot at recovery with timely and comprehensive treatment.

2) Every child also has a right to be free of drug- and alcohol-abusing parents who are abusing or neglecting their children and who refuse to enter treatment or despite treatment are unable to conquer their abuse and addiction.

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[*] The Adoption and Safe Families Act of 1997 (P.L. 105-89) guides child welfare practice to push state and local child welfare agencies to resolve cases more quickly and reduce the time that children spend in foster care, but makes little note of the predominant problem of substance abuse.

3) Every child has a right to have precious and urgent developmental needs take precedence over the timing of parental recovery.

4) The goal of the child welfare systems is to form and support safe, nurturing families for children--where possible within the biological family and where not possible with an adoptive family.

With these guiding principles in mind, CASA recommends urgent action on five recommendations:

1) Start with prevention. Preventing substance abuse in general should be the top priority. Secondly, for those parents who become involved with substances, preventing child maltreatment within their families is essential. The problem is too big and too devastating in human and economic terms to justify remediation only. Social service providers, health professionals and treatment providers should capitalize on pregnancy as an opportunity to prevent child maltreatment among these parents by offering comprehensive and appropriate treatment to substance-abusing pregnant women. Home visits before and after birth by a nurse or qualified paraprofessional can greatly reduce the incidence of maltreatment.

2) Dramatically reform child welfare practice. Child welfare officials and family court judges must change the way the system does business. They must employ critical components of practice to respond effectively to substance abuse: protocols to screen and assess for parental substance abuse in every investigation of child abuse and neglect; timely and appropriate treatment for parents; strategies to motivate parents; prevention of and planning for relapse; and facilitating adoption for children when parents fail to engage in treatment by establishing and fulfilling criteria for "reasonable efforts" to preserve or reunify families torn by substance abuse.

3) Fund comprehensive treatment. Comprehensive treatment that is timely and appropriate for parents is the linchpin of strategies to prevent further maltreatment by substance-abusing parents. The supply of treatment must be greatly increased to meet the demand. Comprehensive treatment should also include interventions targeting the children of parents in treatment in order to break the cycle of maltreatment and addiction.

4) Provide substance abuse training to all child welfare, court, social and health service professionals. Social service providers, from agency directors to frontline child welfare workers; judicial officials, from judges to lawyers; and health and social service professionals who serve these families need training in the nature and detection of substance abuse and addiction, and what to do when they spot it. Substance abuse training should be a required element in certification and licensing requirements for child welfare professionals.

5) Evaluate outcomes, increase research and improve data systems. Child welfare officials and family court judges need to collect better data and evaluate the outcomes of their efforts in cases when substance-abusing parents maltreat their children. We also need to invest in research to better understand the causes of substance abuse and addiction and improve treatment outcomes.

Child welfare directors and family court judges who initiate these changes will face formidable structural and cultural barriers. They must help child welfare agencies and family courts abandon the insular culture that deters them from working with other agencies that are also struggling to prevent and remedy the consequences of a parent's substance abuse and addiction. To implement innovations in practice, these leaders must also prepare to enlist the cooperation and support of their respective staffs--sometimes one person at a time. Deep-seeded skepticism and resistance to change in child welfare agencies and courts should not be

underestimated by those seeking sweeping innovations.

Providing safe homes for children in the face of the tight connection between substance abuse and child maltreatment is a daunting task. But inaction in the face of children who are suffering abuse and neglect is an option no one supports. The recommendations outlined in this report are an agenda for action that can make a difference for thousands of children. As a nation and as members of our communities, we need to reshape the public response to the calamity and chaos in our child welfare systems. We can do this by facing up to the role that alcohol and drug abuse play in maltreatment, taking steps outlined in this report to protect children who suffer at the hands of parents who abuse alcohol and illegal drugs, and investing in treatment to secure and support one of America's most valuable resources--our families.

II. No Safe Haven for Children

Since the advent of the crack epidemic in 1985, substance abuse and addiction has fundamentally altered the challenge of protecting the nation's children and turned the child welfare system on its head. The result has been a flood of new cases of child abuse and neglect, a climbing rate of chronic maltreatment and more children dying while under the watch of the child welfare system.

Since the mid-1980s, the number of cases reported to the child welfare system increased by 43 percent while the complexity of each case increased.

Some child welfare caseworkers started juggling as many as 50 cases at a time. Efforts to offer social services to families in their own homes dwindled as child welfare agencies poured resources into investigating charges and removing children from their families. Some family court judges saw their caseloads jump to 40 or 50 a day, forcing them to make profound judgments regarding the rights of parents and the future of children in as little as 10 minutes.

Deciding when to return children to their parents is a complicated matter, particularly when substance abuse is involved. Mothers can show devotion to their children and then disappear on drug and alcohol binges for days, even weeks. Parents may successfully complete the arduous process of substance abuse treatment and then relapse the night before regaining custody of their children. The powerful lure of addiction competes with parents' bonds to their children, and can sap their motivation to meet the demands of child welfare officials and to regain their children despite an abiding love for them.

The rise in cases involving substance abuse and addiction has increased the number of infants and toddlers in the system. Forty percent of all cases are now under the age of five.[1] The urgent developmental needs of young children and their vulnerability to maltreatment has narrowed the

allowable margin of error for child welfare officials and family court judges making delicate decisions about child custody. At the same time, confidence in the safety and adequacy of foster care homes has declined as a shortage of them led some child welfare agencies to loosen standards. Kinship care--usually by grandmothers or aunts--is complicated by the fact that substance abuse that afflicts parents often burns through the ties that bind their families, leaving what had been a network of caring relatives in ashes. When children do enter kinship care, some mothers continue their alcohol and drug abuse and visit the child at their convenience--with little incentive to take up the responsibilities of parenting.[2]

Top Causes of the Rise in Child Maltreatment

By percent of survey responses (Percentages add to more than 100 because respondents gave more than one answer to the question.)

1. *Substance abuse and addiction (71.6 percent)*
2. *Better reporting (35.4 percent)*
3. *Poverty (31.8 percent)*

Source: CASA Survey of Child Welfare Professionals 1997-1998

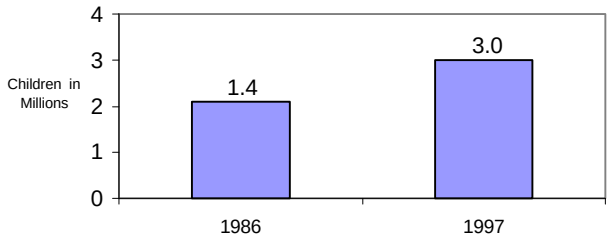
At the center of this national catastrophe are millions of children suffering unthinkable acts of abuse and neglect at the hands of parents with heavy burdens themselves and in the grip of alcohol and drugs. Some of these children suffer developmental delays and behavioral problems related to prenatal and postnatal exposure to drugs and alcohol, increasing their need for a nurturing home and social and healthcare services. For them, the child welfare system has not proved to be a safe haven, but rather a revolving door that shuttles them in and out of foster care as the chronic disease of substance abuse and addiction--and the child maltreatment that it triggers--recurs.

Overwhelmed by a problem that they do not know how to address, child welfare officials are no longer confident that the majority of children they are "protecting" are in fact safe. The urgent need to rebuild this system requires an understanding of: 1) how substance abuse has created a flood of new and chronic cases in the child welfare system, 2) how substance abuse dramatically increases the complexity of each case; and 3) the consequences for parents and children.

New and Chronic Cases

The number of children in America who are abused or neglected more than doubled from 1.4 million in 1986 to about 3.0 million in 1997, a 114.3 percent rise that occurred while the total population of children under age 18 grew only 13.1 percent.[3] Some 42 of every 1,000 children in the United States were abused or neglected in 1997, up from 22 of every 1,000 in 1986.[4]

Number of Abused and Neglected Children



Source: CASA analysis of data provided by The Third National Incidence Study of Child Abuse and Neglect (NIS-3), The National Center on Child Abuse and Neglect and The National Committee to Prevent Child Abuse.

In the fall of 1997, CASA conducted a survey of 915 professionals working in the child welfare system nationwide (judges, attorneys, court-appointed special advocates for children, child welfare agency directors and frontline child welfare workers).* The CASA survey found that today when children in America are abused or neglected, their parents are very likely to be drunk from alcohol, high on drugs like cocaine or marijuana, or suffering the hangovers and withdrawal symptoms that come after a binge.

* A copy of the questionnaire and a description of the survey methodology appear in Appendices A and B.

Almost three of four (71.6 percent) of the child welfare professionals in the survey cited substance abuse and addiction as one of the top three causes for the dramatic rise in child maltreatment since 1985, more than twice the number who named better reporting of child maltreatment (35.4 percent) and the number who cited poverty (31.8 percent).* Other research has similarly found that substance abuse and addiction is far and away the leading culprit.[5]

Most survey respondents (79.6 percent) report that substance abuse now causes or contributes to at least half of all cases of child maltreatment. Approximately 40 percent (39.9 percent) say it affects between 50 and 75 percent of their cases. For many, this understates the problem. Another 40 percent (39.7 percent) say that it affects between 75 and 100 percent of their cases. These findings are consistent with other research showing that substance abuse is a factor in at least 50 percent and up to 90 percent of all child welfare cases.[6] CASA estimates that substance abuse is a causal or contributing factor in at least 70 percent of all reported cases of child maltreatment.[7]

The CASA survey suggests that the role of substance abuse in child maltreatment varies little by type of area--urban, suburban or rural. Of those working in major urban areas, 42.8 percent said that at least 75 percent of their cases involve a substance-abusing parent, compared to 40.3 percent of those working in suburban areas, 38.4 percent of those in small cities and 49.4 percent of those in rural areas.†

While the crack epidemic grabs the headlines, the CASA survey found that the substance most frequently used by parents who have maltreated their children is alcohol, usually in combination with other drugs.[8] Overall, 89.3 percent of all respondents cite alcohol as a leading factor in child maltreatment. Almost all survey respondents (81.4 percent) said that parents who abuse or neglect their children most commonly abuse a combination of alcohol and illegal drugs. Another 7.7 percent said that alcohol alone is the most common culprit and 0.2 percent cited alcohol in combination with prescription drugs; 4.3 percent named solely illegal drugs; 3.4 percent responded prescription drugs or "other"; and 3.0 percent did not know.

When Parents in Child Abuse and/or Neglect Cases are Substance Abusers, What Kind of Substance Do Parents Most Commonly Abuse?

By percent of survey responses

- *Combination of alcohol and illegal drugs (81.4 percent)*
- *Alcohol alone (7.7 percent)*
- *Illegal drugs alone (4.3 percent)*
- *Prescription or other drugs alone (3.4 percent)*
- *Combination of alcohol and prescription drugs (0.2 percent)*
- *Don't know (3.0 percent)*

Source: CASA Survey of Child Welfare Professionals 1997-1998

* Child welfare agencies have no standard definition of substance abuse and addiction. In this report, "substance abuse" is used to mean the abuse of illicit drugs or alcohol that causes health, social, legal or economic problems. Addiction is used to mean the abuse of illicit drugs or alcohol that causes health, social, legal or economic problems in conjunction with tolerance, withdrawal or compulsive drug taking behavior.

† Those in "suburban areas" include those who describe themselves as working in both urban and suburban areas.

Almost half of all respondents (45.8 percent) say that cases of illegal drugs involve crack. One in five (20.5 percent) respondents say that cases of illegal drugs involve marijuana.

When Parents Who Maltreat Their Children Use Illegal Drugs, What Drug Do They Most Commonly Use?

By percent of survey responses

- *Crack cocaine (45.8 percent)*
- *Marijuana (20.5 percent)*
- *Methamphetamine (14.2 percent)*
- *Powder cocaine (2.2 percent)*
- *Heroin (1.9 percent)*
- *Other (1.6 percent)*
- *Do not know what drugs parents use. (13.8 percent)*

Source: CASA Survey of Child Welfare Professionals 1997-1998

What's the Connection?

Research has found a strong connection between substance abuse and child maltreatment.[9] In a study that controlled for income, family size, degree of social support, parental depression and anti-social personality, children whose parents were abusing substances were almost three times (2.7) likelier to be abused and more than four times (4.2) likelier to be neglected than children whose parents were not substance abusers.[10]

Alcohol and Illegal Drugs March in Step

Few parents use only alcohol or illegal drugs; they usually use a volatile mix of the two. In CASA's survey, more than four of five respondents (81.4 percent) report that parents who maltreat their children most commonly abuse a combination of alcohol and illegal drugs.

Source: CASA Survey of Child Welfare Professionals 1997-1998

Usually parents who abuse alcohol and drugs and maltreat their children suffer many problems at once.[11] They tend to be socially isolated, to live chaotic lives, to suffer from depression and other chronic health problems, to be struggling with drained financial resources and to be unemployed.[12] While child maltreatment cuts across all social and economic classes, children from families with incomes below $15,000 are 25 times more likely to suffer abuse or neglect than are children in families with incomes over $30,000.[13] The common companions of poverty --high and frequent stress, lack of child care and other social supports--can be a recipe for child maltreatment.[14] When substance abuse is added to the mix, neglect is almost inevitable.

Parents may use alcohol and drugs with the belief that they will help them cope with the stress of parenting or financial problems, but alcohol and drug abuse only adds to it and may in turn cause or contribute to neglect or violent behavior toward children.[15] Neglect can range from momentary lapses in supervision, such as leaving a child unattended in a bathtub, to chronic neglect, such as malnutrition and even starvation.[16] Since 1986, largely due to substance abuse, the overall incidence of neglect has risen, particularly among children below age three.[17] A study of children in foster care found that those whose parents had substance abuse problems were more likely to have suffered neglect, such as malnourishment, poor hygiene, having physical needs unmet, having been unattended or unsupervised, and having parents who had left the household with an uncertain return, than children whose parents did not have substance abuse problems (60.6 percent vs. 29.3 percent).[18]

Abuse of young children generally coincides with "triggers" such as an infant's inconsolable crying, feeding difficulties, failed toilet training and exaggerated parental perceptions regarding a child's ability to control his or her behaviors and intent to "disobey" a parent.[19]

Alcohol and violence. The connection between alcohol and violent behavior is strong, but complex.[20] Almost half of all violent crime is connected with concurrent alcohol abuse.[21] Alcohol affects individuals differently, based on

their physiology, psychology, experience, gender and immediate situations.[22] Individuals may believe that being drunk provides a justification for normally proscribed behaviors.[23] Alcohol abuse may lead to child abuse by lowering inhibitions; sharpening aggressive feelings; decreasing frontal lobe functioning, which affects one's ability to handle unexpected situations; and disrupting neurochemical systems that mediate aggressive behavior.[24]

Alcohol and Incest

Between 30 and 40 percent of all reported incest cases involve an alcoholic parent.[25]

Illegal drugs and violence. Abuse of illegal drugs like powder or crack cocaine can also cause or contribute to violent behavior.[26] In 1993, 60 percent of adults arrested across the country for violent crime tested positive for drugs, 37 percent for cocaine and six percent for heroin and other opiates.[27] Use of certain illegal drugs can lead to child abuse when they produce excitability, irritability and paranoia, sparking assaults and reducing inhibitions in individuals prone to violent behavior.[28] Cocaine, methamphetamine, LSD (lysergic acid diethylamide) and PCP (phencyclidine) are the illegal drugs most likely to be implicated in such violence.[29]

Alcohol, illegal drugs and neglect. Substance abuse and addiction is likely to lead to neglect of children, especially when the substance-abusing parent does not have access to services or alternate caregivers for their children.[30] The search for drugs or alcohol; the use of precious resources to pay for drugs and alcohol; the time spent raising money to pay for drugs or alcohol--often via theft or prostitution; the time spent binging; and the time spent recovering from hangovers or withdrawal symptoms--all are the preoccupations of drug and alcohol abusers that leave little time to care for the basic physical and emotional needs of children.[31]

Many alcoholics and addicts neglect their children because they can think of only one goal: getting their next high. Addicts develop a "relationship" with alcohol and illegal drugs and their energy and resources focus on maintaining that relationship.[32] Crack addicts who are in recovery report that when they wanted to get high, they could think of nothing else and would stop at nothing, including selling their bodies or their children's, in order to get the drug and use it.[33] Commonly, children end up "parenting" their own parents, taking care of them and running the household.[34]

"Children who stay in homes with addicts are at risk of abuse not only by parents but by friends of parents."

--Caseworker in Commerce, CA

Source: CASA Survey of Child Welfare Professionals 1997-1998

Parents may leave their infants or children unattended when they pursue their drug and alcohol habits. Sometimes children are molested simply because parents are not around to protect them from attackers.[35] Although three of four (77.8 percent) of the perpetrators of child maltreatment are birth-parents, 10.1 percent are other relatives of the victim and 12.1 percent are unrelated adults.[36]

Children can also be endangered when parents bring them along on drug and alcohol pursuits. Violence and danger are intrinsic to the activities of drug dealing, including fights over drug turf, retribution for selling "bad" drugs, violence to enforce rules within drug-dealing organizations and fighting among users over drugs or drug paraphernalia.[37]

Mom didn't want us around. She'd say she was goin' to the store and either stay gone for hours or sometimes she'd stay gone for a couple of days. . . . If she was there, she wasn't there for us emotionally. She was always off doin' her own thing. She wasn't even really a mom.[38]

--LaTasha, age 18

Chronic Maltreatment on the Rise

Substance abuse is responsible not only for a rush of new cases into the child welfare system, but for a surge in the number of cases that must be re-opened because child maltreatment recurs. In about 30 percent of all cases that have been closed by child welfare officials (monitoring by child welfare authorities has been discontinued), child abuse and neglect recurs.[39] This rate of repeated abuse or neglect has been increasing and the leading reason is substance abuse.[40]

"It is very common for [substance] abusing parents to get clean, relapse, get clean [and] relapse, and so permanency decisions can take longer."

--Caseworker in Wichita, KS

Source: CASA Survey of Child Welfare Professionals 1997-1998

A 1993 national study of families whose parents were abusing alcohol found they were almost twice as likely to have a history of allegations of child maltreatment (58.8 percent had more than one allegation on record) as families without alcohol problems (34.3 percent had multiple allegations).[41] A 1988 study in Illinois found that after an initial finding of child abuse or neglect, 92 percent of substance-abusing parents who did not participate in treatment and support services maltreated their children again.[42] And a 1988 study in New Jersey found that among 132 cases of child maltreatment involving substance-abusing parents, 39.3 percent were reported for abuse or neglect again within two years.[43]

Parents with alcohol and drug problems were more than twice as likely to abuse or neglect again, compared to families with no apparent substance abuse problem (57.6 percent vs. 25.2 percent).[44]

CASA's survey found that recurrent abuse and neglect is common in cases involving substance abuse. Almost half of all respondents (45.8 percent) say that repeated abuse or neglect occurs in at least half of all cases involving a substance-abusing parent. Some respondents believe that the presence of substance abuse almost guarantees that child maltreatment will continue. One of five respondents (21.4 percent) said that at least 75 percent of substance-abusing parents chronically neglect or abuse their children.

More than one-third of respondents (35.7 percent) do not know how many parents with substance abuse problems continue to neglect or abuse their children; this likely reflects a system that returns children to their homes, closes the case and tries not to look back. The result is a vicious cycle of cases that close and re-open, close and re-open, creating an endless drain on child welfare resources and a tragedy for the children.[45]

The Rising Number of Child Deaths

In an increasing number of cases, this maltreatment is leading to death. Public records indicate that in 1996, about 1,185 children were reported to have died from abuse and neglect, up from 798 in 1985.[46] While some of this increase may be due to better reporting, these numbers are still widely believed to be underestimates. The U.S. Advisory Board on Child Abuse and Neglect estimates that actually 2,000 children die each year from abuse or neglect--more than five a day--and that child maltreatment is the leading cause of trauma-related death for children under age five.[47]

As many as two-thirds of these deaths may occur at the hands of parents under the influence of illegal drugs and/or alcohol.[48] Half of the children who died (51 percent) were victims of abuse; 44 percent died from neglect; and five percent died from multiple forms of maltreatment.[49] Very young children are most likely to be killed.[50] Four of five (78 percent) of the children who die from

maltreatment are under age five and 38 percent are under age one.[51] Many deaths involve children who had been born with signs that the mother had used drugs during pregnancy.[52] For example, in New York City, more than one quarter of child fatalities attributed to abuse and neglect involve children prenatally exposed to alcohol and/or drugs.[53] In 40 percent of the deaths, the child welfare system knew the child was in danger.[54]

Amoret Powell told investigators she had been clean for about two years but began using heroin again after her daughter, Eve, was born in May. Now Eve is dead, and Ms. Powell is in jail, accused of first-degree murder because of the drugs the baby consumed through breast milk. The police said that the heroin Ms. Powell injected into her leg, coupled with the methadone she was taking to help curb her addiction, made her breast milk into a deadly drug cocktail that they say led to Eve's death a few weeks later.[55]

--New York Times, August 3, 1997

The Complexity of Substance Abuse

While the nation's child welfare system has been struggling to bear the weight of new cases triggered by alcohol and drug abuse, it has largely failed to respond to how substance abuse has fundamentally altered the nature of these cases. Substance abuse and addiction adds unique complexity and persistent danger to cases of child maltreatment that few child welfare professionals know how to address.[56]

More Infants and Young Children

As the role of substance abuse in child maltreatment has grown, the average age of the victims has declined.[57] This may be due in part to increased reporting of babies testing positive for drugs at birth. Most cases of child maltreatment by substance-abusing parents now involve children under age five.[58] Infants in particular are the fastest growing population in foster care.[59] One in four of the children in foster care (23 percent) had been admitted at birth from 1990 to 1994, compared to one in six (16 percent) from 1983 to 1986.[60] Babies tend to stay in foster care for longer periods of time than older children.[61]

"Our policies clearly and absolutely cause more pain for children than they prevent."

--Child Welfare Agency Director
in Western Region

Source: CASA Survey of Child Welfare Professionals 1997-1998

Many of these children have been exposed to illegal drugs during pregnancy.[62] From 1986 to 1991, in New York, California and Pennsylvania, the percentage of those in foster care, age three or younger, who suffered prenatal drug exposure doubled from 29 percent to 62 percent.[63] Documented prenatal cocaine exposure tripled from 17 percent to 55 percent.[64] Nationwide some 500,000 babies are born each year having been exposed to cocaine or other illicit drugs during the woman's pregnancy; most of them have also been exposed to alcohol and tobacco, both of which can cause serious harm to the fetus.[65]

Alcohol use during pregnancy is on the rise nationally. In 1995, 16.3 percent of pregnant women reported drinking during the previous month, a 31.4 percent rise from 1991 when 12.4 percent of pregnant women reported such drinking.[66] The rate of frequent or binge drinking rose even more dramatically; 3.5 percent of pregnant women reported frequent or binge drinking, compared to only 0.8 percent in 1991.[*] [67] These increases followed steady declines in alcohol consumption among pregnant women in the 1980s. With about 3.9 million women giving birth each year, this means that at least 636,000 women drink during pregnancy and 137,000 are drinking frequently or heavily.[68]

[*] "Frequent drinking" is drinking at least seven drinks a week; "binge drinking" is drinking five or more drinks at one sitting at least once during the past month.

"When I was five, my mom would put me to bed at night; she'd tuck me in and say she loved me and she'd see me in the morning. And I'd wake up in the middle of the night and call for Mommy or Daddy 'cause I had a scary dream, and I'd go looking around the house. All the lights would be turned out and nobody would be there. And that's how I'd feel all the time: I'd feel alone. Now that I'm older, I realize that drugs were more important than me, that I didn't come first in my mother's life. She wasn't worried about if I ate or where I slept--she was more worried about drugs." [69]

--Felicia, age 17

In the late 1980s, newborns who had been prenatally exposed to alcohol, drugs and often tobacco crowded neonatal intensive care units and "boarder babies" languished in hospitals for months because addicted parents were unable or unwilling to care for their children and child welfare agencies could not decide what to do with the child.[70] Today some 20,000 infants each year are either abandoned at the time of birth or remain in the hospital because foster or adoptive homes are not available; in most cases, the mothers of these babies are addicted to alcohol and drugs.[71]

In infancy and early childhood, physical, social and cognitive developmental needs are most urgent, increasing the pressure on child welfare agencies to resolve such cases as quickly as possible. While the physical effects of maltreatment are most obvious in children, recent discoveries in the development of the brain's physiology during the first years of life suggest that maltreatment at this time could have serious, lifelong consequences.[72] Research has found, for example, that as infants are stimulated by experience and learn skills, pathways in the brain are being created that children will use their entire lives.[73] The creation of these pathways--or lack of them--appears to affect profoundly a child's social and cognitive abilities.[74]

At these early stages, children are most defenseless against abuse and neglect, narrowing the margin of error that child welfare agencies have when making the decision to leave a child in a home or return a child to a home where maltreatment has occurred.

Children who have been exposed to alcohol and drugs during pregnancy tend to be medically fragile, having been born at low birth weight or prematurely, and requiring intensive care and stable, nurturing environments. Trembling, high-pitched cries and inconsolability are the markers of a baby exposed to crack cocaine before birth.[76] For those whose mothers drank alcohol heavily during pregnancy, the signs of mental retardation emerge more slowly.[77] Because the rate of HIV infection among female addicts is higher than among other women, children of substance-abusing mothers are at high risk of contracting the AIDS virus before they are born.[78] Between 1978 and 1996, 16,017 infants were born with the HIV virus in the U.S.[79]

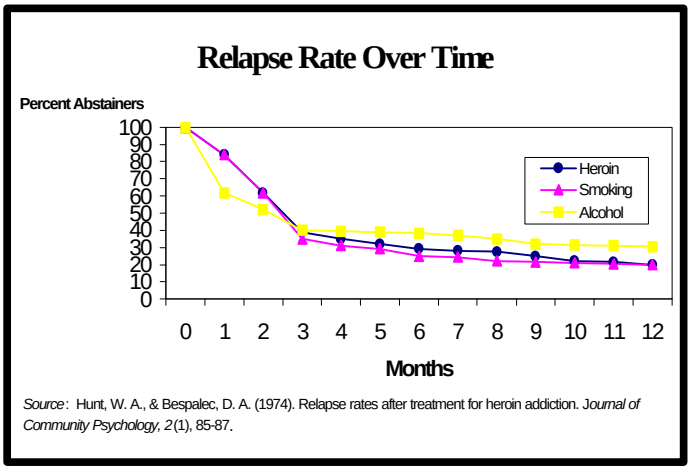
"I was using cocaine and stopped for a little while and then I continued the use and my baby was born positive. . . . I can say that during the three months without my kid I felt that I wanted to use cocaine, but I persevered and I would not allow myself to use any drugs. Alianza Dominicana's [substance abuse treatment] program was giving me, day by day, the skill, knowledge and love that I need to see the world with different eyes." [75]

--Luz Maria, parent

The challenge of caring for infants exposed to alcohol and drugs during pregnancy is by itself a risk factor for child abuse and neglect.[80] Sadly, children with health problems, whose physical and emotional demands may be high, are more likely than those without health problems to suffer repeated abuse or neglect.[81] The chance that they will suffer maltreatment also rises because a woman who abuses alcohol and drugs during pregnancy is likely to continue doing so after birth; without treatment, substance abuse during pregnancy is rarely an isolated event.[82]

Children who have been exposed prenatally to illicit drugs are two to three times more likely to be abused or neglected than are children in similar social and economic circumstances, but whose mothers did not use drugs prenatally.[83] In one study of 513 babies identified at birth as having been prenatally exposed to illicit drugs, 30.2 percent of the children were reported as abused or neglected within six years, twice the rate among all children living in the area.[84] This rate may, in fact, be low due to problems of under-reporting of maltreatment among children below school age.[85] In almost three of four cases (72.6 percent), children had been neglected.[86] Three children died of neglect before the age of four months.[87]

For those who survive, abuse and neglect are likely to recur. A California study found that infants are more likely than older children to suffer chronic abuse or neglect;[88] one of four (23 percent) return to foster care after reunification with their families, compared to one in five children (19 percent) overall.[89] The rising toll of child deaths is another grim result of this recurring pattern of abuse.



Source: Hunt, W. A., & Bespalec, D. A. (1974). Relapse rates after treatment for heroin addiction. J*ournal of Community Psychology, 2*(1), 85-87.

A Chronic Disease

Rising rates of chronic child maltreatment are driven largely by the fact that substance abuse and addiction is a chronic disease. Relapse is a common event in the lifelong process of recovery from addiction.[90] Often it takes several treatment episodes before treatment produces sustained abstinence, and many clients will "lapse" (having a drink or taking a drug), which frequently turns into an all-out relapse (resumption of chronic or heavy drinking or drug-taking).[91] In CASA's survey of child welfare professionals, the great majority of respondents (84.9 percent) said that parents with substance abuse problems sometimes or always relapse. Relapse usually occurs during the first three to six months after treatment.[92] About two-thirds of alcoholics relapse within a year after treatment.[93]

In the absence of appropriate treatment and aftercare to prevent or minimize relapses, child maltreatment related to the substance abuse is very likely to recur. Child welfare officials witness the consequences of such relapses as children are abused or neglected again, cases are re-opened and the system pours precious resources into repeated investigations and attempts to stabilize the same families over and over. Caseworkers and judges need to understand how relapse, when recognized and addressed, can be a phase in the recovery process, rather than a sign that attempts toward recovery are futile.

The Multiple, Intertwined Problems of Addicts

Parents who are addicts tend to suffer multiple, intertwined problems that traditional child welfare services do not address. They tend to need assistance from many types of social welfare agencies and are likely to appear at these agencies concurrently and repeatedly over time.[94] As Robert Caulk, former Director of the Sacramento County Department of Health and Human Services, concluded, "Alcohol and drug abuse is driving the major public systems."[95]

> *Infants need lots of time, attention and patience, three things that an alcoholic or drug addict is likely to lack.*

While 61.9 percent of the parents who are reported to child welfare officials are women,[96] the percentage of parents under supervision in the child welfare system who are women is much higher.[97] Many of these women, struggling with substance abuse and addiction, are raising their

children single-handedly because the fathers of their children have left their families.

Child welfare officials and treatment providers report that most of the female addicts they see today are much more deeply troubled than their counterparts of just 20 years ago, that they require "habilitation," not "rehabilitation" because the development of their social skills and emotional maturity has been arrested so early or damaged so severely by substance abuse and addiction.[98] Some require help with basic tasks, such as making and keeping appointments, completing forms and proving identity, let alone the challenges of raising children.[99]

Substance-abusing women are often second and third generation alcoholics and drug addicts, users of more than one kind of drug, never married and involved in troubled relationships with men who encourage drug use.[100] One study found that women who are alcoholics are more than five times more likely to have spouses with alcohol problems than a sample of women randomly selected from the general population (55 percent vs. 10 percent).[101] In the child welfare system, many of the women with substance abuse problems have little education and were born into poverty.[102] Some have been infected with the AIDS virus, have engaged in prostitution or property crimes to finance their addiction and have been incarcerated as a result.[103]

They frequently suffer mental health problems such as depression and post-traumatic stress disorder.[104] Female addicts are more likely than male addicts to have suffered maltreatment--often sexual abuse and incest--when they were children.[105] The prevalence of sexual abuse histories among substance abusers is two to four times higher than in the general population, and most pronounced among women.[106] One study found that almost half of women seeking treatment for alcoholism (46.0 percent) said they had been abused physically or sexually by a parent.[107]

These problems make child welfare cases involving these women far more time-consuming and demanding than others, and require a range of specialized services that are foreign to most child welfare workers.[108] Moreover, few substance abuse treatment providers have tailored their services to women, let alone women with the intensive needs of those who land in the net of child welfare agencies.

Past and Present Violence

Violence permeates the lives--past and present--of addicted women.[109] In addition to childhood experiences of abuse, many women who are abusing alcohol and illegal drugs may become involved in violent relationships with men who are also substance abusers.[110] For example, alcoholic women are likelier to have been threatened or beaten by a spouse than other women. In one study, 60 percent of female alcoholics had been "pushed or grabbed" by a spouse (vs. 13 percent of the other women); 24 percent of female alcoholics had been beaten up (vs. five percent); 20 percent of female alcoholics had been threatened with a knife or gun (vs. five percent); and 50 percent of female alcoholics had been threatened with abandonment (vs. 13 percent).[111]

The persistent strain of violence in the lives of addicted women adds to the challenge of providing treatment and services that will help them become responsible parents. Their continuing experience as victims of violence may be closely connected to their substance abuse, may hamper their ability to engage in treatment and may diminish their capacity to protect and nurture their children.

Denial, Dishonesty and the Difference Between Use, Abuse and Addiction

The belief that she does not have a problem with alcohol or drugs is a major barrier to getting a woman into treatment.[112] Denial also hinders the ability of outsiders to assess the severity of her substance abuse. Addicts become masters of manipulation and dissembling in order to hide their problem. Simply asking addicts whether they have a problem is unlikely to elicit candid answers. Moreover, the type and severity of substance abuse varies widely, from occasional binges to full-fledged addiction. While both extremes can cause significant harm to children,

the response and treatment for each might be quite different.

In short, cases involving substance abuse are the hardest to assess and impervious to short-term fixes. Detecting the problem in an individual who wants to conceal it and discerning the nuances of use, abuse and addiction requires expertise that most caseworkers lack.[113] In a field where assessing risk to a child is the cornerstone of effective practice by caseworkers, cases involving substance abuse often stump the best of them.

The Consequences for Parents and Children

More than most other problems that cause or contribute to child maltreatment--stress, social isolation, financial crises, unemployment, depression--substance abuse can strip a parent of her ability to protect and nurture her child. High, drunk, hungover, anxious, irritable, depressed, preoccupied with the demands of the addiction or physically absent, parents who are addicted have a consuming passion for alcohol and drugs that competes with their passion for their children.

Women who are addicted to alcohol and drugs tend to live chaotic lives that preclude the stability children need to develop cognitively and emotionally.[114] The poor parenting skills of some substance-abusing parents may further hamper the development of children.[115] Parents with substance abuse problems, many of whom also suffer mental disorders such as depression, can be emotionally disengaged from their children, behave inconsistently and vacillate between non-supervision and strict command-oriented discipline.[116] They tend to have low self-esteem and feelings of helplessness.[117] Without counseling and support, difficulties of bonding with their children can reinforce such feelings, reducing the likelihood that they will become nurturing, responsible parents and increasing the chance that they will maltreat their children.[118]

What Happens to the Child?

Children who are abused or neglected, and survive, tend to be angry, antisocial, physically aggressive and even violent.[119] They frequently perform poorly in school and engage in delinquent or criminal behavior.[120] For some, the consequences include low self-esteem, depression, hopelessness, suicide attempts and self-mutilation.[121] They may behave compulsively, suffer panic attacks, be highly distrustful of others, tend towards dangerous play and sexual promiscuity.[122]

> *Every day I've got to look to the side of me, see my child, and that's what keeps me going. That's the only thing. Because if I didn't have my children with me and it was just me, any given time I think I might just pick up [and use drugs]. If I didn't think about my kids, who I love dearly, my four-year-old, I would pick up any day.*
>
> --Parent in treatment
> CASA Focus Group, June 13, 1997

These children are also at high risk of developing their own substance abuse problems, as both a history of childhood maltreatment and parental substance abuse increase the odds that an individual will abuse alcohol and drugs.[123] The nature of the link between childhood victimization and later substance abuse is unclear.[124] Individuals who have suffered maltreatment may use alcohol or drugs as a way to cope with depression, low self-esteem and other internal troubles; their maltreatment may lead to external behaviors such as aggression, delinquency and antisocial behavior that are themselves risk factors for substance abuse; and they may suffer post-traumatic stress disorder (related to being victims of violence and sexual abuse), which by itself is correlated with substance abuse.[125]

Abuse or neglect may inhibit a child's formation of a secure attachment to his or her parent in early childhood, which may have long-term consequences for the child.[126] Some research indicates that the formation of secure attachments during early childhood is an important foundation of a child's social and cognitive development.[127] Without such attachments, children may not develop a sense of their own competence and the ability to trust others, and may be at higher risk of depression later in life.[128] Children without this foundation tend to score poorly on developmental tests and to have troubled relationships.[129]

Despite the fact that maltreatment hinders the formation of attachments, some maltreated children nevertheless become strongly attached to one or both parents. The trauma of separating these children from their parents can be severe, a factor that complicates the task of child welfare officials and family court judges who must determine what is best for the child.[130] In addition, the decision to remove children from their biological parents in the first days or months of life may jeopardize opportunities for the child to become attached to any adult because foster care arrangements are usually temporary and children frequently move from one home to another over the course of their stay in foster care.[131] These factors add complexity to the already delicate custody decisions that face child welfare agencies and family court judges.

The Legacy of Alcohol and Drug Abuse During Pregnancy

Children who have been exposed prenatally to alcohol and drugs (and usually tobacco as well) are more likely to be born prematurely, to suffer the consequent medical problems such as trouble breathing and eating, to have a low weight at birth and to have contracted the AIDS virus.[132] They may suffer withdrawal symptoms after birth such as trembling, trouble sleeping and eating, irritability and inconsolable crying.[133] The average hospital bills of children born with cocaine in their blood are 10 times higher than those born without cocaine ($13,222 vs. $1,297), largely due to the medical problems that arise from premature birth.[134]

Long-term studies that follow children of alcoholic mothers into adolescence have found that are they are likely to be mentally retarded or to suffer a range of neuropsychological problems with visual perceptions, spatial relations, language and motor skills, attention and short-term memory.[135] These problems, collectively known as Fetal Alcohol Syndrome, or Fetal Alcohol Effects if less severe, persist through adolescence.[136]

Similar long-term studies of children whose mothers used cocaine during pregnancy have not yet been completed. Cocaine-exposed children under age three score in average ranges on developmental tests, although overall, their average score is lower than children who have not been drug-exposed.[137] Some children of women who used cocaine (and usually alcohol and tobacco as well) during pregnancy suffer significant developmental impairments; they tend to be irritable, have difficulty switching from being asleep to being alert, find it hard to focus their attention, have motor delays and experience problems organizing their play and structuring their relationships.[138] Preliminary results from studies beyond age three are mixed, but suggest that some of the behavioral problems may persist.[139] Other studies have found that after accounting for socioeconomic status--a proxy for the disadvantages facing parents and children who live in poverty--many of the developmental problems found in children who have been prenatally exposed to drugs are no longer apparent.[140]

Research strongly indicates that a stable, nurturing environment after birth can ameliorate prenatal damage to the child from substance abuse, although significantly less so for children suffering from exposure to alcohol.[141] In addition to their particular physical needs, these children may need special attention to their mental health. They require consistent and reliable care from individuals who have time and patience to help them make transitions from activity to activity, learn how to solve problems effectively and focus on the task at hand.[142] Also, children whose families receive support services that are focused on the needs of parents with substance abuse-affected children do better developmentally than

those who do not receive such services.[143] It is a cruel reality that these children who most need special care are born to parents who may be least prepared to provide it for them and rarely get the support services and treatment that could help them do so.[144]

Intergenerational Repetition

> *In one study of child abuse and neglect cases reported by a California hospital, 69 percent of the parents had a history of alcoholism or alcohol abuse; 41 percent of the parents had themselves been maltreated as children; and 92 percent of the parents who had been maltreated as children had been maltreated by an alcoholic or alcohol-abusing parent.*[145]

Substance abuse can ignite a vicious intergenerational cycle of child maltreatment and substance abuse. Substance abuse by parents can lead to abuse or neglect of their children. The children who suffer this maltreatment are likelier as adults to maltreat their own children,[146] and to develop their own substance abuse problem.[147] Aside of past history of maltreatment, having a substance-abusing parent also increases their chances of developing their own substance abuse problem,[148] which in turn further increases the chance that they will maltreat their children. These phenomena may combine to create a devastating pattern of child maltreatment and substance abuse that can repeat from one generation to the next.

The Financial Costs

The human tragedies that result are incalculable. The financial costs are staggering. CASA estimates that the substance abuse-related costs to solely the nation's public child welfare systems are $10 billion a year, or 70 percent of such spending.* This is equal to more than four times the amount spent on the prevention of pediatric AIDS, infant mortality, low birth weight, sudden infant death syndrome and other pediatric diseases.[149]

This $10 billion does not include the costs of providing healthcare to abused and neglected children, operating law enforcement and judicial systems consumed with this problem, treating developmental problems these children suffer, providing special education for them or lost productivity. Nor does it include the costs attributable to child abuse and neglect that are privately incurred. It has been impossible to calculate those costs with precision, but CASA estimates that they total some $10 billion. This is a common sense estimate. There are 28 million children of alcoholics, 21 million of them adults. The lost productivity of those who were neglected or abused as children is significant. The lost productivity for Fetal Alcohol Syndrome adults alone is about $1 billion annually. These numbers do not include the lost productivity attributable to children of drug-abusing and addicted parents. Healthcare costs and related services just for children and surviving adults who suffer Fetal Alcohol Syndrome amount to $2 billion; hospital costs for newborns whose mothers abused illegal drugs amount to $360 million.[150]

Nor does it include millions of children who are living in families torn by substance abuse and addiction but whose cases have not reached the child welfare system. Of the 75 million children and adolescents under age 18, 8.3 million are living with a parent who is either dependent on alcohol or needs treatment for illicit drug abuse; by comparison, only about two million children of substance abusers are currently involved with the child welfare system.[151] Because the immediate consequences of having a substance-abusing parent so often go unrecognized and the long-term consequences have yet to unfold, these costs are probably immeasurable, but surely immense.

This is not to say that the $10 billion are all avoidable costs if the substance abuse problems could be addressed. Some parents would still neglect and abuse their children even in the absence of substance abuse. Rather, this estimate provides a starting point for understanding the magnitude of costs associated with substance abuse.

* A description of the cost methodology appears in Appendix D.

The Benefits of Treatment

It is essential that we provide treatment for substance-abusing parents for four reasons: to give children the chance to reunite safely with their biological parents; to protect future children; to minimize costs in child welfare agencies and health, education and social service programs; and because there simply aren't enough foster and adoptive homes.

National treatment outcome studies show that treatment can be effective.[152] The National Treatment Improvement Evaluation Study (NTIES), sponsored by the federal Center for Substance Abuse Treatment (CSAT), found that one year after treatment 52 percent of women in federally funded treatment were still drug free; only 12 percent had been arrested (compared to 37 percent a year before treatment); and 45 percent were employed (compared to 36 percent a year before treatment).[153]

Studies have also demonstrated that treatment can be cost effective.[154] A study of the costs and benefits of treatment in California found that the benefits of treatment outweighed the costs for the taxpayer over a two-year time frame by an average factor of seven to one.[155]

III. Who Decides Who Will Care for the Child?

The rise in substance abuse has fundamentally altered the challenge of protecting children, and yet most child welfare agencies are still trying to conduct business as usual. Struggling simply to investigate and process a sharply increased caseload, few child welfare officials have stepped back to examine how substance abuse is driving the caseload and leading to chronic child maltreatment that will continue in the absence of a thoughtful, concerted response.

The nation's child welfare "system" is really a collection of 50 state-run systems (51 including Washington, D.C.) that vary in their definition of child maltreatment and their response to it. These systems will spend a total of at least $14.4 billion in 1998 to fund the work of more than 200,000 caseworkers, judges, lawyers and child advocates in the nation's 1,000 state, county and private child welfare agencies, 1,200 family courts and thousands of foster care and adoption agencies.[1]

The Definition of Child Abuse and Neglect

The state laws that define child abuse and neglect vary. The National Council of Juvenile and Family Court Judges defines child abuse as "to hurt or injure a child by maltreatment. As defined by statutes in the majority of states, [child abuse is] generally limited to maltreatment that causes or threatens to cause lasting harm to the child." [2] *The Council defines neglect as "to fail to give proper attention to a child; to deprive a child; to allow a lapse in care and supervision that causes or threatens to cause lasting harm to the child."* [3]

Our child welfare systems grew out of the mid-nineteenth century mission of child protection agencies to "rescue" children from abusive or neglectful parents by enforcing laws against child maltreatment, removing children from their homes and placing them in institutions, such as orphanages (also known as almshouses) or foster homes.[4] During the 20th century, this mission changed to include not only rescuing children through law enforcement, but also preserving families through the provision of social services for an array of family problems.[5]

Efforts now exerted through this system to protect children begin with reports of alleged maltreatment to child welfare agencies, which then investigate and decide whether it is safe to leave the child in the home or whether they should place the child in foster or institutional care. If a child welfare agency decides to remove the child (standards vary by state, by agency and by worker) and the parent contests, the child welfare agency must get the approval of a family court judge.* The family court judge then oversees disposition of the case while the child is in state custody. Approval can be obtained after the fact if the child is in imminent danger. In each case, child welfare agencies decide whether to offer services to families and, if so, what kind of services to offer, such as counseling or parenting classes. If a child is removed from the home, usually parents' participation in these services becomes a condition of regaining custody of their children. In many cases, decisions regarding the services offered and progression of the case are made by the child welfare agency. With input from child welfare agency representatives and other court-appointed officials, such as advocates for children and consulting psychiatrists, family court judges monitor progress of the case and decide if and when children will return to their families or whether to terminate parental rights upon the agency's recommendation.

State and county child welfare systems vary in how quickly they remove children and how quickly they terminate parental rights. All of them, however, operate under the framework of federal law that authorizes unlimited funding to a state for foster care, as long as that state matches the federal funds. This program skews child welfare practice toward foster care and away from more home-based services. Even so, since 1980, the law has decreed that family preservation is the preferred outcome of public interventions in families where children have been maltreated, a premise that has since come under heated dispute.

Family Preservation and Crack Cocaine: A Head-On Collision

In the late 1970s, support for the goal of preserving families gained momentum amidst concerns that children were "drifting" for years in foster care.[6] Child welfare cases nationally totaled 1.7 million; more than 500,000 children were in foster care. Concerns about this situation led to federal legislation that encouraged child welfare workers to be "home builders " rather than "home breakers."[7] In 1980, the federal government enacted the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272), which created a legal framework for child welfare practice based on the belief that children should be separated from their families only as a last resort and that removal of children from their families was usually considered a sign of failure.[8] Several premises provided the philosophical foundation for the law: children grow best in their own families; parents have a right to raise their own children; most children can be protected in their own homes; most children want to live with their parents if they can be safe; the state is not a good parent; and most families, given enough support, can be preserved.[9]

A pivotal part of the 1980 law was the mandate that child welfare agencies make "reasonable efforts" to preserve or reunify families.[10] Parental rights can be terminated only when a judge has decided that child welfare agencies have intervened in ways sufficient to be deemed "reasonable efforts."[11] However, neither the statute nor subsequent modifying legislation defines "reasonable efforts." According to the

* If a parent voluntarily gives up custody of the child, no approval from a judge is necessary.

National Council of Juvenile and Family Court Judges, "These efforts may consist of the provision of direct services, financial or in-kind benefits or counseling assistance."[12] In addition to the "reasonable efforts" requirements, the 1980 law requires courts to make a determination regarding a permanent plan for the child within 18 months of any out of home placement of the child.

> *On Sunday night, the police said, Brenda Melendez was roaming the streets to feed her drug habit when a fire broke out in her family's run down home. Because of her history of drug use and a string of related problems with the law, Ms. Melendez had lost legal custody of the children earlier this year. But the police said she had persuaded her grandmother, who was the children's legal guardian, to let her keep the children for the weekend. Just before midnight on Sunday, after what the police said was an evening of using heroin and crack cocaine, Ms. Melendez left her three children upstairs and went out, while an unidentified adult friend slept down stairs on the couch. Upon realizing the house had caught fire, the man ran from the house and the children remained where they died trapped upstairs. According to police, she left them there with a sleeping intoxicated male who did not even know she was gone. Ms. Melendez was later charged with reckless endangerment.*[13]
>
> --New York Times, May 6, 1997

Determining whether "reasonable efforts" have been exerted is practically and often emotionally very difficult.[14] Parents almost always oppose efforts to terminate rights to their children.[15] Child welfare officials, many of them trained in social work and focused on "helping families," are generally reluctant to recommend breaking up families.[16] With an uncoordinated and often inconsistent delivery of services from various agencies and providers to assist families, family court judges often find defining "reasonable efforts" an elusive goal,[17] especially since substance abuse is a factor in most cases and most child welfare workers and family court judges have little or no understanding of the nature of substance abuse and addiction, or the process of treatment and recovery.

These weaknesses in the ability of the child welfare system to implement the law became dramatically apparent when the crack epidemic struck. Indeed, the well-intentioned effort to prevent children from lingering in foster care by preserving or reunifying families had a head-on collision with the crack epidemic, and the child welfare system has been limping along ever since, trying to protect children with strategies that provide a meager defense against the havoc created by substance abuse.

Early Success and Then Calamity

At first, the 1980 federal law appeared to be a success. By 1983, the number of children in foster care had dropped from its high of over half a million in 1977 to less than 250,000.[18] The average length of time in foster care declined from 47 months in 1977 to 35 months in 1983.[19]

The foremost model of family preservation strategy, known as "intensive family preservation services," was widely celebrated as a cornerstone of this success, although many children who returned home during this time did not receive family preservation services.[20] This strategy focused on families who were in crisis and at imminent risk of losing custody of their children.[21] Families were allowed to keep custody of their children while a caseworker provided and coordinated an intensive and sometimes round-the-clock array of short-term services, such as housekeeping services and child care, to keep the family together.[22] The intervention usually lasted for no more than four to six weeks.[23]

Early returns from the model were promising; evaluations suggested that intensive family preservation services prevented out-of-home placements.[24] However, the validity of these evaluations was uncertain because some followed families for only a year and excluded families with substance abuse problems.[25] Researchers and practitioners in the field began to accumulate evidence that intensive family

preservation programs failed to protect children of substance-abusing parents.[26]

The model of brief, intensive family preservation services had not been designed for families with complex and long-term impairments including mental and physical disorders such as substance abuse.[28] As crack and its companions of alcohol and other drugs began to savage American families, even the founders of Homebuilders, the first model of intensive family preservation services, began to question its effectiveness when a family is in the grip of drugs and alcohol.[29]

The wisdom of family preservation efforts is in hot dispute.[36] *A 1994 survey of state child welfare administrators found sharp divisions in whether the central goal of child welfare agencies should be to preserve families or protect children.*[37]

As crack use spread across the nation in the mid-1980s, the positive trends in foster care reversed.[30] The number of children in care rose; more very young children entered foster care; and tragically, re-entry rates rose, which meant that children who returned to their families were being neglected and abused again and then returning to foster care.[31] The revolving door to the child welfare system was spinning and confidence in family preservation* strategies began to wane.[32]

Changing Laws and Policies

Disillusioned with family preservation efforts, some legislators and child welfare officials moved to change the laws and policies that govern child welfare practice to encourage or mandate the more rapid removal of children from their homes and action to sever parental rights.[33] In 1997, the federal government enacted the Adoption and Safe Families Act of 1997 (P.L. 105-89), which tried to clarify the "reasonable efforts" requirement by asserting that "the child's safety and health shall be the paramount concern."[34] The law shortened the time allowed for child welfare officials to decide the fate of a child in foster care from 18 months to 12 months. In an attempt to appease both supporters and critics of family preservation efforts, federal law sustained the "reasonable efforts" requirement as a condition of a state receiving matching funds, but permitted exceptions, such as when the parent committed murder, involuntary manslaughter or felony assault that resulted in serious harm to the child or another child of the parent.[35] At the beginning of 1999, most states are still deciding how to implement the law.

Impatient with the pace of federal policymaking, some state and local public officials and legislatures have begun to mandate that child welfare officials more rapidly remove children from homes where parents are abusing drugs and alcohol and sever parental rights.[38] When the county board in Sacramento County, California mandated a zero tolerance policy--that children be removed from any home with substance-abusing parents--the caseload doubled in four months and the system ground to a virtual standstill.[39]

After 13 years of experience, the only group we are reluctant to serve are parents who are so addicted to hard drugs that their entire lives are focused on obtaining them and in surviving in very dangerous drug cultures. We feel it is too dangerous to leave children in situations where addicts are climbing up fire escapes, breaking into each others' apartments, selling each others' food and threatening each other with butcher knives…. [27]

--Proponents of the Homebuilders model of intensive family preservation services, 1990

Other states have focused on mandating that physicians report signs of drug use by pregnant women or that physicians and other health authorities report signs of drug exposure in newborns.[40] In some states, a positive drug test

* Unless specified as "intensive family preservation services," the term "family preservation" is used to describe a variety of strategies to preserve or reunify families rather than to represent any one specific model of intervention.

of an infant at birth is enough to trigger placement of the child in foster care; in others, to lead to criminal or civil action against the mother.[41] Since 1985, at least 200 women in 30 states have been prosecuted for using illegal drugs during pregnancy.[42]

> *"If treatment is ordered and not complied with, a contempt finding is appropriate. It tends to convince the parents to cooperate."*
>
> --Family Court Judge in Marietta, GA
>
> Source: CASA Survey of Child Welfare Professionals 1997-1998

Courts have generally been unwilling to uphold convictions in these cases, concluding that state laws regarding child abuse and neglect were not intended to apply to the fetus.[43] However, the South Carolina Supreme Court has held that its law against child abuse and endangerment makes prenatal use of illicit drugs a crime.[44] In 1996, that Court upheld the convictions of two South Carolina women for violating the law by using drugs while they were pregnant.[45] In May 1998, the U.S. Supreme Court declined to review the case.[46] One of the women had been sent to prison for eight years after using cocaine while pregnant; the other had been placed on probation because her son had tested positive for cocaine at birth.[47]

Some judges have begun to use civil commitment in cases of drug use during pregnancy, mandating women into treatment, and, if they refuse, confining them in hospitals or institutions. In 1997, legislation was introduced in 12 states to permit civil commitment of pregnant women; so far, Wisconsin and South Dakota have enacted such laws.[48] In Minnesota, physicians who suspect that a pregnant woman is using illegal drugs must test her for drugs, and if the test is positive, report her to the child welfare agency.[49] If child welfare agencies offer her treatment and she refuses, then the state can begin a civil commitment proceeding.[50]

Critics of criminal prosecution or civil commitment, including the American Bar Association, the American Medical Association, the American Psychological Association and the National Association of Public Child Welfare Administrators, generally argue that such measures inappropriately treat addiction as a crime rather than a disease and that the presence of substance abuse is not by itself evidence of child abuse or neglect.[51] Because enforcement has generally focused on cocaine use, some critics contend that it discriminates against black women, who have been hit particularly hard by the crack epidemic.[52] They also warn that legal sanctions against drug use during pregnancy may deter women from seeking prenatal care and substance abuse treatment because they fear losing their children.[53] Some critics caution that similar efforts to protect the fetus could logically apply to other behaviors such as cigarette smoking.[54] Critics of these measures favor voluntary treatment and education for women with substance abuse problems.[55]

But supporters of criminal prosecution and/or civil commitment say that because the life and health of a child is at stake, stronger interventions are warranted.[56] Encouraged by evidence that individuals who are mandated into treatment are as likely and possibly even *more* likely to complete treatment than those who enter treatment voluntarily, they believe that using the force of law will increase participation in treatment.[57] In one study, 27.7 percent of women who were ordered into treatment completed it, compared to 16.2 percent of women who were not ordered into treatment.[58]

Hard Questions

Drug and alcohol abuse and addiction have prompted a common desperation among professionals seeking to protect children of substance-abusing parents. While child welfare officials and public advocates in the field frequently disagree, they all are struggling to answer difficult, even profound questions that the destructive partnership between substance abuse and child maltreatment raises:

- When is it safe to return a child to an addicted parent?
- How best can the child welfare system help families with substance abuse problems?
- How many relapses should addicted parents who enter treatment be permitted before they permanently lose rights to their children?
- How do answers to these questions change when parents say they love their children and children express love for their parents and a desire to stay with them?

The Two Clocks

Two clocks tick as child welfare officials make tough decisions:

1) ***The Clock of Child Development.*** *Children cannot wait. Children urgently need safe and stable homes and nurturing relationships to develop a foundation for a healthy and productive life.*

2) ***The Clock of Recovery.*** *Alcohol and drug abusers need time to conquer their addiction. It can take several attempts, over months and years, before treatment works, and relapse is common. The process of recovery is life-long.*

The main actors in the child welfare system--frontline workers, agency directors, advocates for children, attorneys and judges--must tackle these questions while satisfying the competing clocks of children's development and recovery from addiction.[59] Moreover, federal laws and policies encourage child welfare agencies to resolve cases within one year of finding maltreatment, and the 1996 federal welfare reform law limits the time that parents can receive benefits to five years. Some states have further curtailed eligibility for benefits to two years. Cases of child maltreatment that hit this two-year limit will face new threats to the safety of children. The immense challenge of balancing these different clocks requires a thoughtful assessment of the child welfare system's current response to child maltreatment in families with substance abuse problems.

In assessing current practices, CASA identified six critical weaknesses: 1) lack of training, 2) lack of treatment and related services for parents, 3) lack of strategies to motivate parents, 4) no standard criteria for when to return children to their families, 5) lack of preparation for relapse, and 6) an inability to determine when "reasonable efforts" have been made to preserve a family and if termination of parental rights is appropriate.

Investigation and Assessment

In 1997, 3.2 million alleged incidents of abuse or neglect were reported to child welfare offices nationally.[60] To detect child maltreatment, child protective service agencies rely heavily on physicians and other healthcare professionals, school personnel, law enforcement officials and social service workers who are required by state laws to report signs of child abuse and neglect.[61] Two-thirds of all substantiated reports of child maltreatment (66 percent) come from these professional sources.[62] The remaining third come from family, friends, neighbors, anonymous sources and victims themselves.[63]

Increasingly, hospital staff and public authorities have been recognizing signs of a parent's substance abuse at the child's birth.[64] Since 1986, the number of reports to child welfare agencies from hospitals has more than tripled.[65] In some cases, women are reported to child welfare agencies for substance abuse during pregnancy, although among and even within states, laws and court cases are not consistent regarding what amount of drug or alcohol use during pregnancy should be reported to child welfare agencies.[66]

Blacks are likelier than whites to be reported to the child welfare system. While black Americans represent 13 percent of the total population, they constitute 27 percent of the children who are involved with the child welfare

system due to maltreatment.[67] This results in part from the fact that black parents are more likely than white parents to live in poverty, a condition that increases the risk of child maltreatment.[68] In 1997, the poverty rate for black families was 23.6 percent and the poverty rate for white families was 8.4 percent.[69]

Black parents may also be more frequent targets of child welfare investigations because of racial prejudices and public concerns about cocaine addiction, which has hit the black community with magnum force.[70] A study in Florida found that although pregnant white and black women were just as likely to use illegal drugs (15.4 percent of white women vs. 14.1 percent of black women), health officials were 10 times more likely to report black women to the child welfare agency.[71] In the study, black women were likelier to use cocaine while white women were likelier to use marijuana.[72] Overall, past-year use of illegal drugs by blacks and whites is roughly the same (12.1 percent vs. 11.3 percent), as is past-month use of such drugs (7.5 percent vs. 6.4 percent).[73]

As reports of maltreatment have soared, child welfare agencies have not been able to keep up.[74] In 1993, child welfare workers were able to investigate only a third (33 percent) of all cases of child maltreatment, a decline from 1986, when they were able to investigate half (51 percent) of all cases.[75] In practice, this amounts to investigation of only the most serious-sounding cases and largely ignoring other cases of children who have been abused or neglected.[76]

Looking for Substance Abuse and Assessing Its Severity

When child welfare caseworkers do investigate, they usually make home visits to interview parents and children and assess the home for signs of child abuse or neglect. Until recently, some child welfare officials considered a parent's substance abuse to be "none of their business" during these investigations, a view that is becoming harder to sustain in the face of evidence that substance abuse is driving the caseload.[77] One official contends that some individuals in the child welfare system continue to ignore substance abuse because addressing it head-on would create demand for services and treatment that child welfare agencies are not prepared to provide. He explained, "'Don't ask, don't tell' is a policy that protects the system from collapse."[78]

How Caseworkers Screen for Substance Abuse

A staff member of the child welfare agency in Sacramento County, California described the typical screening interview as: Child welfare worker: "Do you have a drug problem?" Parent: "No." Child welfare worker: "Good." [81]

This ambivalence about looking for substance abuse is reflected in child welfare practice. In the CASA survey, two of three respondents (67.0 percent) say that investigations include routine screening for substance abuse. This is consistent with other research[79] and represents a significant improvement from the early 1990s, when child welfare agencies in only 14 states routinely collected information on substance abuse.[80] However, the rigor of this screening varies widely. In the CASA survey, 42.0 percent of the caseworkers say they either are not required to record the presence of substance abuse when investigating charges of child maltreatment or do not know whether they are required to do so.

Interestingly, perceptions about how often frontline workers screen for substance abuse vary among the different players in the child welfare system. While almost all frontline workers (83.5 percent) say such screening is routine, little more than half of judges (52.6 percent) and attorneys (56.8 percent) say that frontline staff routinely screen. This suggests that even where workers screen for substance abuse, they do so superficially or the information may not be recorded or reported to the judicial system, denying judges a critical piece of information when they make decisions about child custody.

When caseworkers do look for substance abuse, typically they simply ask parents questions about their use of alcohol and illegal drugs, just as a caseworker might ask a parent about employment, housekeeping, stress and other factors related to the child's safety and care. Two of three survey respondents say that child welfare workers screen parents in this way. One of eight (12.0 percent) say that child welfare workers use advanced screening tools designed to detect substance abuse, such as the CAGE or SASSI.[82]

To address the problem appropriately, screening is followed by an assessment process, usually conducted by a caseworker, to determine the severity of the problem and appropriate course of treatment. In the CASA survey, more than two of three respondents (68.6 percent) claim that frontline caseworkers determine what type of substance abuse treatment is appropriate for a parent, but 61.3 percent admit that what treatment is available determines what is appropriate.

Relying on questioning parents to screen for and assess substance abuse problems only works when workers are trained to deal with the unique challenges of addiction: detecting a problem when denial and dishonesty are common symptoms; distinguishing between use, abuse and addiction; and motivating parents to seek appropriate treatment.[83] Assessing the severity of the problem, the risk to the child and the appropriate course of treatment requires expertise that most caseworkers lack and few gain by seeking help from a substance abuse professional.[84] Lack of training can create frustration and burn-out among caseworkers who do not know how to assess and address a problem that, if untreated, undermines all their efforts to help families.[85] Even when the condition is properly assessed, appropriate treatment is often not available.

As a result, substance abuse problems frequently go unrecognized, and when they are addressed, parents may not get the type of treatment they need. CASA's survey finds that the treatment provided to parents through child welfare systems is determined almost exclusively by what is available at the moment.

At a minimum, caseworkers need to understand the nature of substance abuse and how to detect it through observation and interviews with parents. Yet most child welfare workers are grossly unprepared even for this threshold task.[86] In the CASA survey, although most child welfare workers say they have received some training in substance abuse (90.3 percent of frontline staff told CASA that they had been so trained), this training is generally skimpy--brief, one-time-only seminars that may last as little as two hours. Similarly, few family court judges have any training in substance abuse and addiction and few arrange to have experts in substance abuse advise them when they make critical decisions about child custody.

Assessing the Child's Safety

It is the first job of child welfare agencies to determine which reported cases can be substantiated. Of the 3.2 million reported cases in 1997, 1.1 million were substantiated, a rate of 33 percent.[87] The substantiation rate has remained relatively stable around one-third throughout the 1990s;[88] substantiation rates prior to the 1990s were higher. The fact that fewer cases are investigated (33 percent in 1993 vs. 51 percent in 1986)[89] is in good measure responsible for this difference and reporting of baseless claims may share responsibility.[90]

CRITICAL WEAKNESS #1

Child welfare workers and family court judges lack training and expert assistance to understand the nature of substance abuse and how to detect it and assess its severity. This seriously hinders their ability to assess the safety of children.

Using the results of their investigation, child welfare workers decide whether to leave the child in the home or place the child in foster care. Placement requires the approval of a family court judge if the parent contests removal. Stung by the steady rise in child

deaths since 1985, child welfare agencies began shuttling more children into foster care rather than leaving them in homes that might be dangerous. Nationwide, the number of children in foster care increased 79 percent from 280,000 at the end of 1986 to 502,000 at the end of 1994.[91] The number of children who spent time in foster care in 1994 is much higher--at least 700,000.[92]

The strategy of preventing harm by removing more children from their homes is limited by the number of foster care families. The availability of foster parents fell from 147,000 in 1985 to 125,000 in 1992, and has since rebounded to 165,000 in 1995, largely due to the greater use of foster care provided by relatives (kinship care).[93] As the medical needs of children in foster care have increased--largely due to the consequences of prenatal exposure to alcohol, drugs and tobacco--it has become even more difficult to find qualified foster parents.[94] Some critics charge that foster care agencies have loosened their standards for new foster parents in order to bolster the ranks.[95]

The criteria caseworkers use to decide when to remove children from their homes appears to vary significantly by caseworker.[96] Efforts to develop effective scientific tools that can help caseworkers predict whether a child is at risk of further maltreatment have been disappointing, and the presence of substance abuse only complicates this challenge.[97]

Child welfare workers are more likely to decide that children with substance-abusing parents cannot safely remain in their homes than they are to decide the same for children of parents who do not have substance-abusing parents.

Three of four survey respondents (75.7 percent) agreed that children of substance-abusing parents are likelier to enter foster care. The most common explanation (named by 32.0 percent of respondents) is the parent's lack of interest in the child. One of 10 respondents (10.1 percent) said that substance abuse takes a long time to address, and another 9.4 percent said that children are removed because no attempt is made to address the substance abuse problem.

As caseloads soared in the 1980s, some child welfare workers were making this decision while juggling 50 cases or more at a time.[98] Even for the best trained professional, this is an impossible burden. CASA's survey reveals a critical mismatch between the need for screening and assessment of substance abuse problems and the current training and practice of most child welfare workers and family court judges. Most child welfare workers and family court judges base their critical decision of child custody when a parent has a substance abuse problem by relying on on-the-job experience and making their best guess.

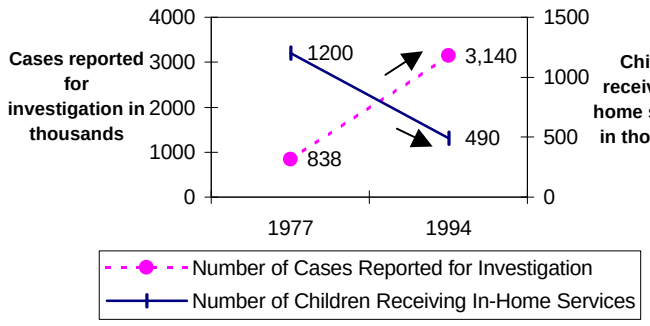
> *"As a Certified Social Worker for L.A. County, I am responsible for 50 to 65 children every month and 40 to 100 parents…. Sometimes I never see or find parents."*
>
> --Caseworker in Covina, California
>
> Source: CASA Survey of Child Welfare Professionals 1997-1998

Trying to Help: Services and Treatment

In most cases of maltreatment, the child remains in the home and the family receives short-term services such as individual or family counseling, parent education, housekeeping help and child care, which aim to stabilize the family and prevent further abuse or neglect.[99] The child welfare agency provides or arranges such services until it decides to close the case. For other cases, removal of the child from the home is necessary. The family court approves placement of the child in foster care and the child's parents receive services until child welfare agencies and/or the court find that the child will return to a safe home.[100] In still other cases, children remain in the home and receive no services.[101]

As the number of cases has soared, child welfare agencies have devoted more resources solely to investigation and foster care, while the provision of services to prevent the recurrence of child maltreatment has become a lower budget priority.[102] The number of children receiving in-home services through a child welfare agency has dropped 58.3 percent from 1.2 million in 1977 to just 500,000 in 1994.[103] This drop has occurred as the number of multi-problem families with urgent and complex needs has expanded.

As the Number of Cases for Investigation Increases, the Number of Children Receiving In-Home Services Decreases



When child welfare agencies do provide services, the typical array they offer--individual or family counseling, parent education, housekeeping help and child care, for example--is unlikely to match the multiple needs of families struggling with addiction.[104] Short on resources, authority and experience in cross-agency collaboration, caseworkers are generally unprepared to coordinate an unwieldy array of agencies and professionals (legal aid attorneys, housing officials, child care providers, substance abuse treatment providers, healthcare providers and domestic violence counselors) that might offer the services these families require.

Child welfare agencies are prepared to provide substance abuse services to only a fraction of the parents who need it. Sources of funding for substance abuse treatment for parents involved with the child welfare system varies. Parents may be eligible for treatment funded by Medicaid or other publicly funded treatment, usually outside the child welfare system. A 1997 survey of state child welfare agencies found that while 67 percent of all parents involved with their agencies and 35 percent of those who are pregnant need substance abuse services, they can provide relevant services to only 31 percent of the parents who need them and 20 percent of pregnant women who need them.[105]

The shortage of treatment for women is a national problem beyond the child welfare system.[106] On average, less than half (44 percent) of all Americans who need substance abuse treatment receive it, and treatment rates are lowest for women who are poor.[107] A 1990 survey found that only 11 percent of pregnant women who need drug treatment receive it.[108] CASA's survey indicates that this problem persists.

In practice, when caseworkers determine that a parent needs treatment, the wait for an open slot can be long. Ninety-four percent (94.2 percent) of the survey respondents say that parents who need residential substance abuse treatment must wait; only 5.8 percent said that such parents receive treatment immediately. One of three (33.3 percent) said that the wait for treatment is one to three months; and one of 10 (9.6 percent) said more than three months.

CRITICAL WEAKNESS #2

Child welfare agencies and family courts do not have timely access to substance abuse treatment and related services that are appropriate for parents.

Outpatient treatment is somewhat more available. While one of four (26.0 percent) said that there is no wait for outpatient substance abuse treatment, one of seven (13.5 percent) said that the wait is one to three months; only one of

50 (1.8 percent) said that the wait is more than three months. In another indication of how child welfare systems neglect substance abuse problems, one of four frontline workers (25.2 percent) did not know the wait for residential treatment and one of seven (15.3 percent) did not know the wait for outpatient treatment.

> *The heroin-addicted mother of 3-year-old Tamika Triggs has been sentenced to 30 days in jail on a misdemeanor charge of child endangerment. Mother and daughter were discovered in the garage of a filthy lower West Long Beach home, where authorities found crack pipes and several hypodermic needles, some of which were uncapped. Triggs said that she loves her daughter but is often so overwhelmed by her body's need for heroin and cocaine that she can think of little else.*
>
> --Los Angeles Times, 11/20/97, A1.

When substance abuse treatment is available, it is unlikely to be appropriate for pregnant or parenting women because most programs have been tailored for men.[109] Few treatment programs address the multiple problems that are frequently interwoven with a woman's drug or alcohol use: depression, past and current histories of being battered, troubled relationships, employment problems and unplanned pregnancies.[110] Women need treatment that:

- addresses the nexus of substance abuse, poverty and violence in their lives;
- provides all-female support groups to encourage candid discussions about incest, other sexual abuse and relationships with men that may contribute to their substance abuse;
- addresses their particular concerns regarding child-rearing; and,
- allows mothers to bring their children with them to treatment or offers child care so that a woman need not choose between treatment for herself and custody of her child.[111]

Monitoring Progress

> *What keeps me drug-free is my children. I look at them and I know I don't want to use.*
>
> --Parent in treatment, CASA Focus Group June 13, 1997

After the child welfare agency and the court decide whether children can safely remain with their families, caseworkers monitor a parent's progress to determine when a case can be closed. When a child has been placed in foster care, a family court judge assesses the parent's progress to determine whether and when the child can return home. In the past, the challenge for child welfare officials was to capitalize on the motivation of parents who wanted to regain custody of their children. But alcohol and drug addiction may have sapped natural parental instincts. Parents must want to regain their children *and* they must be ready to address their substance abuse problem.

Compliance with court orders to enter treatment is low.[112] A study of 84 parents who, after losing custody of their children, were ordered by a court to enter outpatient treatment found that only one of 10 parents (9.9 percent) showed up for at least two-thirds of their treatment appointments and only one of five (20.9 percent) showed up for even half of their appointments.[113]

In CASA's survey, only one of five respondents (22.5 percent) said that less than half of parents who are ordered by a court to enter treatment for substance abuse do so. An equal proportion (22.6 percent) have no idea how often parents enter treatment, an indication of how little attention on substance abuse caseworkers and judges focus on parental substance abuse. Federal law also discourages substance abuse treatment providers from sharing information about an individual's progress in treatment; these confidentiality concerns can make it difficult for

the child welfare officials to monitor a parent's progress.

Barriers to Treatment

In the CASA survey, child welfare professionals say that the biggest barrier to getting parents into treatment is lack of motivation. Respondents overwhelmingly (85.8 percent) named lack of motivation as the number one barrier to getting parents into appropriate substance abuse treatment. Next in line were lack of residential treatment (53.0 percent), lack of insurance coverage for treatment (50.7 percent), lack of outpatient treatment (35.4 percent), and finally, lack of child care (28.5 percent).

CRITICAL WEAKNESS #3

Few child welfare agencies and family courts have strategies to motivate parents to enter and complete substance abuse treatment.

In practice, these factors are likely to occur together. Individuals addicted to alcohol and drugs often do not want to enter treatment and end their drinking and drug use. The shortage of treatment--particularly for women--can mean that at the moment a parent has the motivation to seek help, no treatment slot is available.[114] Lack of child care and fear of losing custody of children also discourage women from seeking treatment.[115] If they lose custody of their children, they may also lose their eligibility for welfare benefits and housing subsidies.[116] Women who can keep their children with them when they enter treatment may have better outcomes--staying in treatment longer and completing treatment--than women who cannot.[117]

Child welfare professionals often lack training in the nature of addiction and how to encourage individuals to seek treatment.[118] This in turn may contribute to the lack of motivation of parents to seek help.

Even when parents enter treatment, child welfare agencies and family court judges are not confident that it will be successful. In CASA's survey, only 4.7 percent of respondents believe that substance abuse treatment is very effective at reducing or eliminating substance abuse by parents who enter treatment. More than half (56.1 percent) deem treatment "somewhat effective" and more than one of four (28.2 percent) say it is somewhat or very ineffective.

The most common reason given for the perceived ineffectiveness of treatment is lack of motivation in parents. When asked why treatment is generally ineffective, two of three survey respondents (66.2 percent) cited the parent's lack of motivation.

Despite this resounding consensus that parental motivation is critical, few child welfare agencies have a strategy for motivating parents other than to make regaining custody of the child dependent on the parent completing treatment. While regaining child custody is a critical element of motivation for many women, it is often not enough. Addicts are usually in deep denial about their problem and have a strong compulsion to keep using alcohol and drugs, which can sap parental instincts.[119]

"Most parents [in treatment] don't last the first week."

--Caseworker in Pensacola, FL

Source: CASA Survey of Child Welfare Professionals 1997-1998

The Limbo of Foster Care

Children of substance-abusing parents tend to linger in foster care. In the CASA survey, three of four respondents (73.0 percent) said that children whose parents have substance abuse problems stay longer in foster care than do other children. The most common explanations were the time required to address substance abuse (36.2 percent of respondents) or failure to treat substance abuse (13.5 percent of respondents).

We can't predict who is going to come off drugs or how long they remain drug-free before relapse. What in the heck is happening to these children while their parents are going through this process?" [125]

--Judy Howard, Professor of Pediatrics at the University of California, Los Angeles School of Medicine and a director of a treatment program for mothers addicted to crack cocaine

Other research also indicates that children of substance-abusing parents are most likely to have foster care placements that last for years.[120] One study found that 62.5 percent of children of substance-abusing parents were in foster care four years later, compared to 46.6 percent of the children whose parents did not abuse substances.[121] Some of these children had been placed in foster care at birth and did not even know their parents.[122] In many cases, children must move from one foster home to another.[123] Given the shortage of foster care parents, many end up in group care arrangements--what would have been called orphanages in an earlier era.[124]

Kinship Care

As demand for foster homes has outstripped supply, child welfare officials have made greater use of kinship care in which children stay with a relative rather than an independent foster family.[126] About a third (31 percent) of all children in legal custody are in kinship care.[127] In New York City and California, at least half of children in custody reside in kinship care and most of these children (77 percent in New York City) have parents who are substance abusers.[128]

"With kinship placements, the parent often seems willing to walk away from parental responsibility and just visit on occasion."

--Child Welfare Director in Western Region

Source: CASA Survey of Child Welfare Professionals 1997-1998

This alternative has obvious appeal because it can reduce the trauma of familial separation and disruption for the child, and it has created a national corps of caring grandmothers who are raising their grandchildren.[131] But the likelihood that children will either return to their biological parents or be adopted is lower for children in kinship care.[132] Social workers may believe that such care is "in the family" and thus requires less urgent action.[133] Kinship care may also reduce the incentives of a parent address her substance abuse problem because, although she has lost custody of her children, in many cases she gets to see them when she wishes and is free of the daily obligations of child care. Although parents are required to follow the restrictions on visitation imposed by the child welfare system, these rules can be more easily disregarded in a kinship care setting.

Nurturing Bonds

To nurture bonds between substance-abusing parents and their children while parents are in treatment and children are in foster care, the Family to Family Program, funded by the Annie E. Casey Foundation, encourages frequent visitation and positive interactions between biological and foster parents.[129] *The goal is to reduce the trauma of separation to the child and to strengthen the bond between parent and child, which may be a source of motivation for the parent to stay sober and drug-free.* [130]

As substance abuse has pushed child welfare agencies to the brink of collapse, kinship care has in some cases become a convenient choice rather than the result of a careful comparison of a mother's and a relative's ability to care for a child.[134] This is a particular concern for children of substance-abusing parents because substance abuse and addiction often leave families broken and bitter, with little ability to nurture a traumatized child.[135] Without careful evaluation of kinship care arrangements, child welfare officials may lock children in a dysfunctional family poisoned by substance abuse and its common companions of violence and neglect.[136]

Returning Children Home

In most cases, family court judges eventually decide to return children to the parents who abused or neglected them.[137] Only eight percent of the children in foster care are adopted; the majority (60 percent) return to their families, and the remainder (32 percent) live with other family members or graduate to independent living arrangements.[138] Despite an influx of federal funds to subsidize adoptions of children with special needs, the total number of children adopted each year has risen only six percent from 118,216 in 1987 to 125,248 children in 1992, the most recent data available.[139] Some 107,000 children were either legally free or destined for adoption at the end of 1995; only 27,115 children--one in four--were adopted that year.[140] Only 31,000 in the child welfare system were adopted in 1997.[141]

CRITICAL WEAKNESS #4

Family courts have inadequate criteria to guide determination of when to return children to their families where substance abuse is involved and often make such decisions based on insufficient information.

The complexities of family dynamics make it difficult for family courts to establish standard conditions for the return of children to their parents. CASA's survey found that judges usually return children to parents with substance abuse problems when a combination of objective and subjective criteria for reunifying families have been met: the parent completes treatment (cited by 80.2 percent of respondents as a common prerequisite); parents appear to be "ready" (cited by 81.0 percent of respondents); and the parent remains abstinent for some period of time (cited by 73.3 percent of respondents).

When is a parent ready? How long a period of abstinence is long enough? Answering these questions is more art than science. But the determination of when a parent is "ready" is only as good as the information--including a thorough substance abuse assessment--upon which it is based. The decision about how long a parent should be abstinent depends on an understanding of the nature of relapse in the process of recovery. Because of ineffective screening and assessment practices and inadequate training in substance abuse, child welfare officials and family courts frequently lack this critical information.

"I have witnessed cases in which it appears that the 'system'… negotiate[s] a compromise of long-term foster care rather than facing the adversarial issue of termination of parental rights." [144]

--Peter Digre, Director
Department of Children and Family Services
Los Angeles County, CA

The frequency with which child maltreatment recurs in families appears to be highest when parents have substance abuse problems.[142] One of four survey respondents (24.4 percent) say that abuse or neglect recurs in at least half (50.0 percent) of all cases involving a substance-abusing parent, and one in five (21.4 percent) say it recurs in at least 75.0 percent of such cases. These recidivism rates are much higher than the 30 percent average for all cases.[143]

CRITICAL WEAKNESS #5

Child welfare agencies do little to prevent or prepare for relapse, a common event for individuals addicted to alcohol and drugs. As a result, children who return to their families may be abused or neglected again, establishing a revolving door of child abuse and foster care.

Upon completing substance abuse treatment, aftercare in the form of self-help groups and support services can prevent or minimize relapses, but child welfare agencies devote few if any resources to connecting families to these services.[145] In the CASA survey, when asked what percentage of parents who complete

substance abuse treatment participates in aftercare programs, 36.6 percent said that less than half of parents attend such programs, and another 30.0 percent did not know.

With so little attention to preventing and preparing for the likely event of relapse, children either sit in foster care while judges and child welfare officials wait for a parent to stay drug-free and sober for some period of time or they return to their parents only to be abused or neglected when relapse--and the child maltreatment that so often accompanies it--occurs.

CRITICAL WEAKNESS #6

Child welfare officials and family court judges find it difficult to conclude that attempts to preserve families have been sufficient and that parental rights should be terminated. As a result, children of substance-abusing parents spend years in foster care limbo.

With preparation or support, a lapse can be managed; without them a lapse can evolve quickly into a severe relapse. Failure to understand and act on these truths keeps the door revolving as caseworkers and judges continue to be overwhelmed with cases and often fail to protect children.

Adoption: When To Cut the Ties That Bind?

When efforts to reunify families fail, at some point a family court judge must decide that enough is enough by determining that "reasonable efforts" have been made to preserve or reunite a family.[146] Since family preservation has become a primary goal, the separation of families becomes an indication of failure that few choose lightly.[147]

Trapped by the child welfare system's failure to make "reasonable efforts" for families with substance abuse problems--or the lack of certainty about what constitutes "reasonable efforts"--and its reluctance to terminate parental rights, children languish in foster care.[148]

CASA's survey respondents say that the repetition of maltreatment is the usual trigger for terminating parental rights when parents have substance abuse problems. Three of four respondents (75.7 percent) say repeated neglect, and almost two of three (63.5 percent) say repeated abuse most commonly lead to the termination of parental rights. More than half (61.1 percent) say one instance of severe neglect, and about half (51.0 percent) say one instance of severe abuse usually lead to the initiation of such proceedings.

Two-thirds of respondents (65.8 percent) say that multiple failures to complete substance abuse treatment is a common trigger for terminating parental rights. But respondents overwhelmingly report (90.5 percent) that a single failure to complete treatment does not lead to such proceedings. Similarly, three of four (77.9 percent) say that the use of drugs during a pregnancy does not lead to the loss of parental rights; less than half (41.3 percent) say that multiple births of babies who have been exposed to drugs leads to the loss of parental rights. The child welfare system seems inclined to give substance-abusing parents many chances, but those chances are hardly meaningful when needed treatment and related services are not available.[149]

"After six months, parents' rights should be terminated. I have some cases where the children have been in foster care for 2 to 3 years because parents continued to relapse. I feel if parents can't get their priorities straight in six months then they probably never will, and why make the children suffer. Haven't they suffered enough?"

--Caseworker in Wichita, KS

Source: CASA Survey of Child Welfare Professionals 1997-1998

Relatively few children are adopted, and parents who are willing to adopt children exposed to alcohol and drugs during pregnancy are in short supply. Children who do find adoptive parents usually spend three to five years in foster care before their adoption becomes final.[150] (The Adoption and Safe Families Act of 1997, a federal law, was designed to facilitate adoptions.) When adoptions do occur, they are almost always permanent. Only three to four percent of adoptions through public agencies are disrupted, with the children returned to state care.[151]

"Do not return child home until parents are demonstrably sober for an extended amount of time (i.e. one year). Initiate TPR [termination of parental rights] proceedings immediately--they can be stayed if there is progress. Give up the dream that everyone can be helped--direct or triage resources to families that show promise, TPR ones that don't."

--Child advocate in Houston, TX

Source: CASA Survey of Child Welfare Professionals 1997-1998

What To Do?

Child welfare professionals generally support current practice regarding the termination of parental rights, although they think the child welfare system should in some cases be more aggressive about it. While 63.5 percent of respondents say that repeated abuse currently leads to the termination of parental rights, 82.4 percent believe that it should. While half (51.0 percent) of respondents say that severe abuse leads to the termination of parental rights, three of four (75.5 percent) say that it should.

Child welfare professionals agree on little else with respect to substance-abusing parents. Survey respondents differ on whether evidence of substance abuse during pregnancy should trigger immediate removal of the child at birth. More than half (56.9 percent) say that infants should not go to foster care immediately in such cases and more than a third (35.7 percent) say that they should. (7.4 percent do not know.) Employers differ with their own employees on this issue. While 83.0 percent of state child welfare directors say that infants should not be removed right away, 55.4 percent of frontline child welfare workers say that they should.

"Parental rights termination depends on other factors, i.e. whether the child is adoptable."

--Judge in Los Angeles, CA

Source: CASA Survey of Child Welfare Professionals 1997-1998

When asked what changes in policy and practice would improve outcomes for children and families with substance abuse problems, the most common recommendation--made by only one of five respondents (18.9 percent)--was that treatment should be more available. One of six respondents (17.9 percent) say that the child welfare system should do a better job of specifying goals in cases that involve a substance-abusing parent. This may reflect tension between the goals of preserving families and assuring that children get into safe and

What Should Change?

The most common recommendations made by child welfare professionals in an open ended response to a survey question (By percent of respondents):

- *Make substance abuse treatment more available (18.9 percent)*
- *Specify goals in cases with substance-abusing parents (17.9 percent)*
- *Terminate parental rights more quickly (7.8 percent)*
- *Use drug-testing more often (6.8 percent)*
- *Monitor parents more closely (5.2 percent)*
- *Improve caseworker training (4.0 percent)*

Source: CASA Survey of Child Welfare Professionals 1997-1998

permanent homes as quickly as possible. One of 15 respondents (7.8 percent) say that termination of parental rights should occur more quickly. Some feel that substance-abusing parents should be watched more closely: 6.8 percent say drug testing should be used more often and 5.2 percent say closer monitoring of parents would help. Only one of 25 (4.0 percent) say that better training in substance abuse is important.

Child welfare practice is riddled with six critical weaknesses. It lacks: effective substance abuse screening and assessment practices; timely access to appropriate substance abuse treatment and related services; strategies to motivate addicted parents; criteria and knowledge to inform decisions on when to return children to their families; efforts to prevent or prepare for relapse; adequate guidelines as to when "reasonable efforts" have been exerted for substance-abusing parents and adoption proceedings should begin.

Few professionals in the child welfare system agree on how to remedy these weaknesses. This lack of consensus helps explain why legislatures and policymakers have done so little to address substance abuse head-on and why current practices continue despite such disappointing results. Child welfare systems are frequently under attack for failing to protect children, but dissent within the system poses a serious barrier to those who seek to change practices to tackle the extraordinary complexity that substance abuse brings to parental child abuse and neglect.

The findings from CASA's survey and analysis of the research literature point to other structural and cultural barriers that confront those who want to put innovative strategies into practice: the lack of substance abuse training throughout the child welfare system from frontline caseworkers to family court judges; concerns about confidentiality that prevent child welfare officials from getting important information about parents; the need to change the insular culture of the child welfare system and forge a more integrated approach across agencies that can address the multiple problems afflicting substance-abusing parents; and the need to redefine success so that removing children from homes and even severing parental rights are not always seen as a sign of failure.

The case studies in the next two chapters illustrate some of these problems.

IV. Promising Innovations: Bringing Substance Abuse Expertise to the Frontline

Federal and state laws leave the key policy decisions regarding substance-abusing parents to child welfare agency directors and family court judges. Given this freedom, a handful of agency directors and judges are putting new strategies in practice, and despite formidable barriers--some overcome, some not--they appear to be producing promising results.

Through a literature review and interviews with policymakers and practitioners in the field, CASA scanned the country for examples of innovations within child welfare agencies or family courts, including experiments with systemic changes borrowed from other public and private organizations, such as managed care, to improve outcomes for children whose parents are substance abusers.[*] After finding many candidates, CASA chose six innovations--planned, conceptual changes in policy and practice--that had some evidence of positive outcomes while illustrating the difficulties of changing practice. In this and the following chapter, we describe the nature, implementation and results of these six examples in the form of case studies. We also highlight other promising efforts to address substance abuse in text boxes that accompany the main text.

The case studies focus on three innovations that began in child welfare agencies (Chapter IV) and three that originated in family courts (Chapter V). In practice, the efforts of either child welfare agencies or family court agencies to address substance abuse require collaboration between the two--and other agencies and organizations as well. But we begin by examining their origins to provide context that can inform and offer lessons to others in the

[*] A description of the case study methodology appears in Appendix C.

field who are ready to take on substance abuse front-and-center. At the end of each case study, we assess how each addresses the six critical weaknesses identified in Chapter III.

Case Study: Department of Health and Human Services, Sacramento County, California

Over the past decade, Sacramento County experienced an alarming increase in the number of children reported for child abuse and neglect. In 1994, Sacramento had 36,985 reports of child abuse and neglect--a rate of 13.7 for every 100 children, one of the highest rates in the country.[1] During the year, 2,987 children were in foster care,[2] 2,300 children were in "long-term" foster care and 200 children were waiting to be adopted having had parental rights severed. Adoption workers were carrying caseloads of 60 each.[3]

In response to this dismal situation, Robert Caulk, Director of the Sacramento County Department of Health and Human Services at the time, compiled local statistics on substance abuse by recipients of the Department's services in 1993. He found that substance abuse was a significant factor in virtually every area of the Department's services. Most recipients of services were multi-problem families who needed assistance from more than one branch of the Department, and families with substance abuse problems were most likely to appear at various agencies concurrently and repeatedly over time. Substance abuse during pregnancy also appeared to be on the rise. A 1990 study found that 9.2 percent of women who delivered newborn children in Sacramento County tested positive for alcohol or drugs.[4] In 1992, 15.2 percent of the women who gave birth in the county tested positive for alcohol or drugs; they delivered 3,158 babies in total.[5]

Overwhelmed with the growing size and complexity of a caseload increasingly dominated by substance abuse, the Department's caseworkers were focused on immediate damage control with scant attention to the long-term problem of substance abuse. With little understanding of the nature of addiction, some caseworkers were frustrated and wondering, "Why don't these parents just quit drinking or using drugs?"[6]

Although frontline Department workers now believe that 80 to 90 percent of the parents involved with child protective services in recent years have had substance abuse problems,[7] less than one-third of the referrals made by workers in 1994 (28.5 percent) were to substance abuse treatment.[8] This gap illustrates the inability of caseworkers to correctly identify and manage cases with substance abuse problems. Few caseworkers had been trained in substance abuse, and it was not part of the Masters in Social Work (MSW) required curriculum at the local universities.[9]

Alcohol abuse was commonly overlooked. Although caseworkers say that methamphetamine and alcohol were the most prevalent drugs, one caseworker reported that few caseworkers take alcohol abuse seriously and many fail to report it.[10] Unless substance abuse was an explicit element of the initial referral, it was not addressed.[11]

Caseworkers had few skills in assessing the severity of a substance abuse problem and the appropriate course of treatment. When one supervisor asked a caseworker, "How do you determine the treatment plan for a parent with a substance abuse problem?" The reply was "Wherever there is a vacancy" in a treatment facility.[12]

When caseworkers did make referrals to treatment, other obstacles arose. Poor relations between substance abuse treatment providers and the Department's staff were the status quo. Caseworkers were unable to monitor a parent's progress in treatment because they could not get information from treatment providers. When caseworkers asked whether parents had entered treatment, providers would say they could not confirm or deny if the parent was receiving treatment because of confidentiality guarantees made to parents.

To address these failings, in 1995 Caulk launched the Alcohol and Other Drug Training Initiative (AODTI), a department-wide training program to improve the ability of Department workers to handle cases involving substance abuse and to stop the revolving door that was consuming the Department's resources and failing the families it served. The Department estimated that development, implementation and evaluation of the project would cost $3,540,300. It began work after The Annie E. Casey Foundation provided an $800,000 grant and the California Department of Alcohol and Drug Programs agreed to fund an evaluation.

Nature of the Innovation

The Department implemented a training program that would strive for better recognition and assessment of substance abuse problems, better use of substance abuse treatment and the provision of support services to motivate parents to engage in treatment. As of July 1998, there had been 75 training sessions with over 2,500 participants.[13]

The training had three components; each required four days--one day per week, for four consecutive weeks. Level One of the training provided an overview of chemical dependency and an introduction to assessment and treatment. Level Two covered advanced information on chemical dependency, assessment and treatment. Level Three covered the development of parent support groups.[14]

Recognition and assessment of substance abuse. The training program educated workers on the nature and pattern of drug and alcohol abuse, and how to use a diagnostic tool, the Substance Abuse Subtle Screening Instrument (SASSI), to assess the severity of the substance abuse problem.[15] Using the SASSI, the parent independently completes the form, which the caseworker and parent then score together. The caseworker then uses the results to determine the best treatment for parents. [16]

Provision of support services to motivate parents. Caseworkers were trained in specific motivational interviewing skills and techniques to engage parents in the assessment process and treatment, and they learned how to establish and lead support groups to encourage substance-abusing parents to confront their addiction problem and to provide support for parents.[17] Initially the groups were characterized as a possible mode of treatment, but in practice they serve as informational, educational and support groups that fall short of being a substitute for treatment.

The groups try to attract parents who are attending outpatient or low-intensity substance abuse treatment programs, who are waiting for a treatment slot or who are unsure whether they need treatment. The groups strive to keep parents connected to the Department and to motivate them to enter or continue treatment. Most of the groups initiate candid discussions about substance abuse, try to break the social isolation of parents and provide a forum for sharing information on parenting and other concerns.[18]

The rules of group formation and execution are liberal. After the training, workers pair with another staff member to establish and co-lead a group. The co-leaders choose a purpose for their group, such as being "informational" or "supportive," and a profile of participants. The groups usually focus on a particular type of parent or issue such as African American women or individuals with mental health disorders. To attract participants, the leaders display fliers for parents in social service offices and distribute them to caseworkers who may refer parents. Some groups are open-ended; others run for 10 to 12 weeks.[19]

Hitting Barriers

Before initiation of the program, some impediments were already visible. The pressure from the vast changes required by the initiative made some of these barriers more formidable and caused old problems to present themselves in new ways.

Worker resistance. After the program's launch, Department employees at various levels resisted its implementation. Frontline staff lacked

information about the program and how it would affect their job and daily responsibilities.[20] No internal announcement had been made to introduce the program to caseworkers; some caseworker and supervisors learned of the initiative through a newspaper article that ran after the Department issued a press release.[21] Caulk had introduced the program to his senior staff and expected them to share information and enthusiasm about the program with supervisors and caseworkers.[22] This never occurred.

As caseworkers learned about the program, they were confused about their role. In some of the program literature, workers were cast as "treatment provider" substitutes, a reference to their leadership of support groups.[23] However, after learning about the program and the goals of the support groups from the Director's office, workers responded positively to the concept of having options to offer families in need of substance abuse treatment and related services.[24]

Veteran staff members, however, who had survived many cycles of staff turnover and policy swings, "expressed a significantly less positive response to the training."[25] This was disheartening for the AODTI staff because veteran caseworkers and supervisors were the most highly trained in social work.[26]

Department employees with MSW degrees who were working within children services units and had been with the Department for more than 10 years, compared to non-MSWs and those with less tenure, were less likely to report that the training would change their clinical practice. When the program's evaluators, hired by the Department to assess the initiative's results, discussed this with an official from the National Association of Social Workers and other experienced social work trainers, they responded that this reaction was not surprising because social workers in service for over 10 years tend to be entrenched in the habits of their daily routine.[27] This problem persists.

Mid-level managers (the agency's division heads) also resisted the initiative, impeding efforts to integrate the program into daily practice. Despite positive reviews from caseworkers regarding the first two levels of training, most were not using their new skills or the SASSI in practice.[28] The evaluators attributed this in part to lack of "clear statements" by managers and supervisors supporting the training and assessment protocols.[29]

In January 1996, three "refresher courses" were offered to revive interest in the initiative.[30] AODTI staff also developed a form for caseworkers to fill out for each case, recording their evaluation of the parent, screening for substance abuse information, the result of the assessment tool (if administered) and the worker's recommendations. In March 1996, AODTI staff met with each of the division heads to emphasize the importance of the initiative and integrating it into daily practice.[31]

Nevertheless, few caseworkers began using the intake forms. They reported being overwhelmed with work and said mid-level managers made the program appear insignificant--just the Director's "pet project."[32] In the summer of 1996, a special one-day management-training seminar was given for supervisors and their managers to restate the program goals and the Director's expectation that they implement the program.

Since then, use of the assessment tool and intake form remains sporadic. In 1997, of the 156 child welfare caseworkers trained in the AODTI, between one-half and two-thirds make an assessment. Of those who use it, nine percent do not properly use the assessment instruments or recording devices, and those who use it correctly do not make enough referrals to treatment.[33] In hindsight, the AODTI staff believes the assessment form should have been integrated into forms that caseworkers already fill out to avoid adding to their bureaucratic burden.[34] Caulk adds that he thought the importance and appeal of the initiative would be quickly apparent and would trickle down to frontline employees.[35]

Lesson from the Field

Training in substance abuse and addiction is not enough to change daily practice. Caseworkers need institutional support and pressure to incorporate new practices into their routine in ways that minimize bureaucratic chores.

Union discord. In Sacramento County, child protective services supervisors and frontline staff are unionized. The union felt uninformed about the initiative from the start and concerned about what the changes in policy and practice would mean for their membership. Job descriptions for caseworkers were suddenly changing, for example to include skills related to leading support groups for parents. Changes in the duties of caseworkers caused additional anxiety because the individual liability of frontline caseworkers for negligence in cases of child deaths had increased in Sacramento County by newly enacted legislation.[1]

Concerns about the pay-scale also emerged because staff who would organize and run a support group would be working different and possibly longer hours. The initiative threatened to increase already high caseloads--as high as 60 cases--as identification of alcoholism and drug addiction improved.[2] The union felt excluded from the decision-making process and insisted on slowing down implementation in order to seek answers to their questions.[3]

Lesson from the Field

Despite widespread frustration among caseworkers with ineffective efforts to help substance-abusing parents, caseworker unions may be concerned that any initiative to improve their effectiveness may increase the substantive demands of the job, expand the volume of work and fail to produce either positive results with parents or pay increases for caseworkers.

Since the unions' contract expired in June 1997, caseworkers and supervisors have continued working without a contract.[4] Issues surrounding the growing caseload and appropriate compensation for workers are still unresolved.[5] The union's support of the AODTI remains tentative at best, hindering full realization of the goals of the program.

Media and political pressure. The media in Sacramento paid close attention to the problems at the Department. This scrutiny intensified in January 1996, when a three-year-old child named Adrian Conway was beaten to death. He had been the subject of a Department case that had closed two months before his death when the worker concluded he was not in imminent danger. The autopsy reportedly showed a history of violent abuse and neglect.[6] According to the *Sacramento Bee*, Adrian's mother was "a drug user."[7] The media and public sharply criticized the Department practice and family preservation efforts in general.

Overall, nine children involved with the child protective services unit died in 1996, including one from a family who had been receiving multiple services from the Department.[8] Substance abuse by the parent was a factor in all nine cases.[9] The media focused on the role of substance abuse in the deaths, which coincided with the growing methamphetamine epidemic in the Sacramento area.

A "critical incident committee," formed by the County Board of Supervisors after Adrian Conway's death, examined the Department's policy and concluded that the AODTI deserved support while stepping up its monitoring of substance-abusing families. A Sacramento County Grand Jury also investigated the project in response to growing concern about the safety of children, and concluded that the project should be sustained.

Nevertheless, public support for the initiative was fragile. "Zero tolerance" of drug use by parents who are maltreating their children had become media and political buzz-words. Although "zero tolerance" can be defined in many ways, to some it means removing all children from homes with any signs of alcohol or drug abuse and no reunification of families unless the authorities are completely satisfied that substance abuse will not recur. The Department was concerned that a change in policy of this type would put too great a strain on the child protective system, especially foster care resources.[10]

Lesson from the Field

Lack of public support can hobble initiatives to reshape child welfare policy regarding substance-abusing parents, which may take time to produce results. Working with the media to inform the public and nurture support is an important part of putting such changes into practice.

In May 1997 the Board of Supervisors changed the policy of child welfare from a "strong emphasis on family preservation" to a policy "more focused on child protection."[11] Jim Hunt, who became acting Director of the Department at the end of July 1997 after Caulk's departure (and was subsequently named Director), said that implementing this change in policy doubled the caseload in six months, totally overwhelming the child protective system.[12] The Department began aggressively recruiting caseworkers to share the load, but the process has been slow. In the meantime, the AODTI lost steam. Until the caseloads are down, says Hunt, "There is no way to implement the program fully."[13] New caseworkers receive the AODTI training, but using it in practice has become optional.

Dismayed by the lack of public support for his initiative, Caulk told CASA, "The public has an unrealistic expectation that child welfare must protect all children…. When you are under attack from the outside, [trying to make big changes inside] is difficult to do. We tried it anyway."[14] Moments of public consensus regarding the best way to protect children are hard to find; the challenge is building public support for ambitious changes amidst the tumult.

Availability of treatment. Better recognition and assessment of substance abuse among parents raised the demand for treatment, which remains in short supply. The average wait for any kind of treatment is more than nine weeks.[15] In 1993, the County estimated it was 8,670 slots short for people who sought treatment, and little has occurred since to close the gap.[16] The program was not focused on designing treatment for women and children in particular. The evaluators note that many changes related to funding of treatment in California and to data collection regarding treatment make it difficult to track any changes in treatment availability.[17] The shortage of appropriate treatment appears to remain an obstacle.

Promising Results

Despite these serious problems, the Department believes that the AODTI is producing positive results for participants in the caseworker-run groups. The Department acknowledges the potential of the initiative, believes it has achieved positive effects and has subsequently packaged and marketed the training initiative to other counties in California and other states.[18]

Screening and assessment. The program has directly confronted the need for screening and assessment of substance-abusing parents. Caseworkers have new skills and a concrete tool to assess substance abuse problems. Parents may see this tool, an independent test, as unbiased, which adds credibility to caseworkers' recommendations for treatment.[19] When caseworkers use these skills and this tool, they usually appear to be effective at screening and assessment. Almost two-thirds of all parents who caseworkers assessed (63 percent) had an alcohol and drug problem, and another 14 percent were chemically dependent and in recovery.[20]

By gauging the level of need, the severity of the problem and the functioning abilities of the parent, workers that use their training have learned how to choose among many types of treatment, rather than arbitrarily assigning parents to the shortest waiting list. Careful assessments of treatment needs also provide the Department with aggregate indicators of the type and quantity of treatment it needs to demand from providers.

Department employees generally gave positive reviews of the training. They reported significant improvements in knowledge, including: awareness that addiction is a disease and that professionals can help parents; the relevance of other factors in addition to immediate sobriety when assessing risk to the child and long-term prospects for the family; eliminating the common misapprehension that the AODTI sought to make all caseworkers into drug counselors; the potential for all kinds of service providers to conduct substance abuse interventions; and awareness of phases of recovery as a measure of parent's readiness for custody and the idea that a parent can be "in recovery" for life, but still be able to handle the responsibility of parenting.[23]

Options for Recovery

The Options for Recovery (OFR) program in California is a multi-agency substance abuse treatment and related social services program targeting chemically dependent pregnant women and their children. OFR provides comprehensive, integrated and family-focused services.[21] *The program recruits and trains foster parents and relative caregivers for children of participating parents. A three-year evaluation of the program found that parents' involvement with child welfare agencies declined by 27 percent from admission to discharge; 42 percent of children returned to their families from foster care and OFR children spent an average of 149 fewer days in foster care than other children.*[22]

Lesson from the Field

Training in substance abuse and addiction may alleviate staff turnover in child welfare agencies. The inability to deal effectively with substance-abusing parents takes a serious toll on caseworkers and leads to burn-out. One worker explained, "You can only be screamed at and [expletive] so many times."

During the training, workers vent their acute frustration regarding substance-abusing parents. One commented, "You start out wanting to help everybody. Then you pick and choose [whom to help]. You can only be screamed at and [expletive] so many times." Another noted, "You watch new [workers] and after one or two years they are as cynical as you."[24] The training appeared to rejuvenate some workers by teaching them skills to deal effectively with substance-abusing parents. In spite of the obstacles to the program, the Department is working to revive the AODTI program, but the results in the number of caseworkers doing assessments are disappointing.

Access to appropriate treatment and services. Workers are able to make better use of scarce resources by matching a parent with a suitable treatment plan. But this improvement is limited by the shortage of appropriate treatment for parents who have maltreated their children.

Motivating parents. With leadership from caseworkers, the support groups for parents appear to help motivate parents to address their substance abuse problems. Group members are empathetic about the challenge of remaining drug-free, the stresses of dealing with the child welfare system and the demands of being a parent. The empathy helps parents not feel alone; they can turn to others and see examples of survival in difficult times.

Preliminary data on participation in the groups are encouraging. Initial basic data collected on graduates from a group showed an 88 percent decrease in alcohol and drug use over three months, compared to a 30 percent decrease by

those who dropped out of the program.[25] The number of children living with parents who had graduated from a group increased by 89 percent, while the number of children living with parents who dropped out decreased by 74 percent.[26] Parents who participated in the groups were more likely to attend Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings, although their attendance declined after graduating from the group.[27] A 1997 survey of all active group members showed that 91.7 percent of the women and 100 percent of the men felt that the group helped them.[28] Eighty-eight percent of the women and 95 percent of the men felt that the group had changed their use of alcohol and other drugs.[29]

More recent data also indicate that graduates of the groups retain custody of their children more often than non-group graduates and non-substance-abusing parents.[30] While these findings are encouraging, their significance is limited by the fact that the parents who are likely to choose to enter the pre-treatment groups may be among the most motivated.

Deciding when to return children home. In the training, caseworkers are taught that if a parent shows no interest in recovery, a worker should remove the child. With training about the phases of recovery, caseworkers are better able to assess if and when parents are ready to regain custody of their children.

Lesson from the Field

Even with aggressive efforts to address substance abuse problems, it is very difficult to predict which parents will succeed. Sacramento County officials who have worked on the AODTI say they can find no indicators of who will be successful in substance abuse treatment.[31] *Parents who they thought would fail have done well, and those with apparently brighter prospects have failed miserably.*

Adoption facilitation. The AODTI does not attempt to answer the question of when to remove children permanently. However, aggressive confrontation of substance abuse problems may allow caseworkers to meet the "reasonable efforts" standard earlier and more efficiently, leading to faster resolution of cases for children in foster care.

Case Study: New Jersey Division of Youth and Family Services

Rather than investing resources in re-training its caseworkers, the New Jersey Division of Youth and Family Services (DYFS) decided to purchase substance abuse advice from outside experts.

In 1995, DYFS caseworkers were frustrated with unsuccessful efforts to protect children in families with substance abuse problems and believed that DYFS should make substance abuse a higher priority.[32] At the time, DYFS policy was that intake workers should use the least intrusive methods for evaluating parents.[33] According to caseworkers, the old policy meant that caseworkers should be conservative in opening cases where the only apparent problem was drug- or alcohol-related and the child's safety did not appear to be in immediate danger.[34] At that time, caseworkers were trained that substance abuse on its own was not an indicator of abuse or neglect, and as a result, substance abuse by a parent was often ignored.[35] Where a parent appeared to be a "functioning addict," no other steps were taken to open a file or engage that person in services or treatment unless manifestations of the addiction had a visible impact on the child.[36]

At the same time, the New Jersey Child Death Review Board concluded that substance abuse was involved in over half of the child fatalities related to child abuse and neglect between 1992-1994.[37] A DYFS study found that at least half of parents identified for child abuse and neglect by DYFS were abusing alcohol or drugs, and anecdotal evidence indicated that the number of child abuse and neglect cases related to substance abuse was increasing significantly.[38] (Today caseworkers estimate that substance abuse is involved in 80 to 90 percent of the cases they handle.)[39]

As a result, DYFS concluded that caseworkers needed a new approach and new tools for handling cases with substance-abusing parents, and changed its policy to require the recognition of substance abuse in families involved with the child welfare system.[40] This policy change was incorporated into the Revised Case Handling Standards in 1996. However, this mandate revealed the inability of the system to respond to substance abuse problems.[41] Caseworkers had received no formal training in the nature or treatment of substance abuse and addiction, and did not know how to identify or assess it.[42] They had no knowledge of the dynamics of addiction or the potential dangers to a child, and they were unable to forge relationships with parents dealing with addiction.[43] Parents were neither following through on referrals nor sticking with treatment.[44]

DYFS responded by establishing a program in which certified alcohol and drug counselors (CADCs), who are professionals with expertise in substance abuse, and home visitors, who are paraprofessionals with personal experience with addiction, would work in tandem with DYFS caseworkers handling cases involving substance-abusing parents. DYFS received a grant of $512,000 from the National Center on Child Abuse and Neglect in the U.S. Department of Health and Human Services to help fund the program.[45]

Nature of the Innovation

Beginning in 1995, DYFS contracted with two local agencies to provide CADCs to assist workers from four DYFS offices in New Jersey. The CADCs would help caseworkers evaluate the child's safety, design caseplans for the families that would address their substance abuse problems and engage more parents in treatment. Through the local agencies, DYFS also hired home visitors (paraprofessionals) to help monitor and provide ongoing support and guidance to parents. The home visitors are from the parents' community, have overcome addiction and have been drug-free and sober for at least two years.

Recognizing that access to treatment would be crucial to the program's success, DYFS signed an agreement with the New Jersey Department of Health's Division of Addiction Services to grant priority access to substance abuse treatment for parents referred by the program's pilot sites.[46] The local agencies then contacted treatment providers to seek access for parents. To assure appropriate handling of cases, the agencies purchased ongoing consultation services from physicians with special training in substance abuse and addiction.[47]

Providing additional staff expertise to caseworkers on the frontline did not preclude their need for training in substance abuse. DYFS arranged for employees at the four program sites to receive three days of training on the nature of substance abuse and addiction. When the caseworkers and supervisors who received the initial training requested more, the CADCs provided six additional days of instruction.

In practice, when the intake worker receives the initial report of suspected abuse or neglect, the worker calls the local DYFS-contracted provider of CADC counselors to schedule a home visit to evaluate the parent and the child. The intake worker and the CADC visit the parent's home together; the CADC administers a substance abuse evaluation and the intake worker gathers all relevant information including interviewing the child, if possible. The worker completes the evaluation and then, using the CADC substance abuse report and other factors, makes a determination on immediate custody of the child.[48]

If maltreatment has indeed occurred and the parent is abusing alcohol and/or drugs, the worker opens the case and a home visitor contacts the families within 24 hours. The paraprofessional works with the parent as the case proceeds, which may include everything from trying to break through a parent's denial of a substance abuse problem, to making sure the parent appears at the treatment facility by escorting the parent from her home, to serving as a role model of success.[49] The CADC continues to work directly with the parent, encouraging her

to follow treatment referrals and assessing her progress for the child welfare worker who is overseeing her case.

Untapped Resources: Paraprofessionals in Recovery

From Seattle to New York, child welfare agencies have begun to capitalize on the skills of paraprofessionals who are in recovery from addiction to motivate substance-abusing parents to seek substance abuse treatment, to engage in other social service programs and to develop a healthy environment for their children. Often working in tandem with social workers, paraprofessionals conduct home visits, monitor the parent's progress and help him or her overcome obstacles to success.

Paraprofessionals can assist parents in ways that traditional social workers cannot. They establish relationships with substance-abusing mothers based on empathy and personal experience with the multiple problems substance-abusing mothers face. This shared experience may help paraprofessionals break through the denial usually involved with addiction. Paraprofessionals may help prevent relapse and connect the parent to resources in the recovery community and the community at large. Paraprofessionals also serve as role models for parents by being a living example that parents can recover, regain custody of their children and achieve stability.

As state employees, both the home visitor and CADC must report to DFYS any indication that a child may be in danger. Although the CADC and home visitor provide advice, ultimately the DYFS caseworker is responsible for decisions regarding child custody.

Hitting Barriers

As DYFS officials implemented their new strategy, they hit several barriers:

Caseworker and CADC concerns. Even though caseworkers recognized their own deficiencies in handling cases involving substance abuse, they were not convinced that this was the right solution.[50] The program started at a time when privatization of other types of government services was underway.[51] Workers felt that "contracting out" substance abuse assessment might be a threat to their job security.[52] Senior staff worked hard to address these concerns openly and to assure caseworkers that the program was not the harbinger of privatization of child welfare for New Jersey; their efforts appeared to assuage caseworker concerns.[53]

Caseworkers also had to adjust to new roles and responsibilities concerning their cases, including coordinating and incorporating the work of the CADC and home visitor into assessments of child safety. They had to confront their own preconceptions about substance abuse when CADCs challenged their beliefs that an addict could function as an adequate parent who did not need child welfare services.[55]

Similar Efforts in Delaware

Delaware has also begun to pair CADCs with child welfare caseworkers who are investigating cases that involve a substance-abusing parent. By arguing that the program will save money by reducing foster care costs, Delaware officials won a waiver from the federal government to use federal funds normally earmarked for foster care (Title IV-E funding) for the purpose of employing CADCs. The experiment involves an extensive evaluation and preliminary results are encouraging. In two sites, the costs of foster care in cases with a substance-abusing parent within the demonstration group were decreased 20-34 percent. In one other site, although costs increased for both the demonstration and control groups, the cost increase in the demonstration group was 32 percent lower than the cost increase for the control group.[54]

CADCs also had difficult adjustments to make.[56] Because CADCs are accustomed to parents coming to them for help when they are ready, seeking out a parent at home was a new experience.[57]

The needs of DYFS parents were another challenge. Many required help with basic tasks, such as making and keeping appointments, completing forms and proving identity.[58] Many did not have phones and frequently changed addresses.[59] Their "street survival techniques" sometimes impeded the treatment process.[60] For some, addiction had arrested their psychological development at early ages.[61] According to Brian Rafferty, former Director of Substance Abuse Services at Easter Seals and current statewide Project Manager for Substance Abuse Services, the agency chosen for three of the four sites, "Not all CADCs are able to make the transition to this type of field work; it is really challenging. But most make it."[62] Careful recruitment and supervision of the CADCs became an important element of the program.

Collaborating to meet the needs of multi-problem families. In 1996, Easter Seals collected data on the parents they were serving and found the average participant was age 31 and female, and her drug of choice was cocaine, alcohol or opiates.[63] Many of these women had multiple serious problems connected to their substance abuse, requiring substance abuse treatment and a multitude of services.

Project Clear, the agency chosen for the fourth site, reported that, "These families present with not only serious, long-term substance dependency, but with generational chronic problems of a systemic and interpersonal nature. Poverty, child abuse, social isolation, domestic violence and other issues all place serious service demands on a program primarily designed to assess and respond to substance abuse dependency."

These demands required child welfare staff and local sites to develop new relationships and collaborate with a variety of service providers, from food stamp eligibility offices to Medicaid and housing service providers. This collaboration was hard because the different service providers have different cultures, disparate goals and separate funding streams.

Even forging the partnership between DYFS and the agencies that employ the CADCs and home visitors required time, effort and commitment. By September 1996 they had made progress. In its second quarterly report, Easter Seals stated, "It is evident that both DYFS and Easter Seals personnel realize that our mission is the same, the protection of children."[64] The fact that this was not apparent from the start indicates how collaboration between different public agencies can at times resemble a shotgun marriage.

Lessons from the Field

Collaboration is hard. It requires time, effort and commitment to reconcile different bureaucratic cultures, goals and funding requirements. Program leaders who neglect the hard work of forging these relationships will find otherwise sound efforts thwarted at every turn.

Lack of treatment. A pivotal gap in services became apparent when improved screening and assessment of substance abuse problems turned up so many parents who needed substance abuse treatment. Where were they to go in a treatment system that was largely unprepared to serve them? Waiting lists for treatment were weeks long and growing longer, and residential treatment was in particularly short supply.[65] Lack of child care and insurance coverage for treatment posed additional barriers.[66]

DYFS responded by devising funding mechanisms to purchase more substance abuse treatment slots for parents and coordinating their efforts with the state's Division of Addiction Services. DYFS and Addiction Services combined funds that had previously been separate to purchase more treatment. DYFS also arranged to use $500,000 in federal family preservation support funds to buy treatment.[67]

Deciding when to give up. In 1996, six months into full operation of the program, caseworkers realized that they needed standards on when to discharge parents from the program who were clearly unwilling to engage in treatment--when to give up and say that the parent no longer qualified for the program. Counselors decided to devise a discharge protocol so that parents would know "that they can no longer procrastinate or avoid making a treatment decision."[68] Site officials also hoped that a protocol would ease the large caseloads being handled by home visitors.[69]

Although they have yet to formalize this protocol, home visitors are trying to apply more systematic criteria to the decision of when to cease serving parents.[70] For parents who have completed treatment, are attending aftercare and are following their DYFS caseplan, home visitors usually stop contacting the parent; and if a parent fails to respond to four initiatives by the home visitor, then the home visitor returns the file to the CADC.[71] The CADC has a case conference with the caseworker, and if the parent seems uninterested in any substance abuse services, the CADC and home visitor drop the parent from their caseload and the caseworker assumes full responsibility for the case.

Lessons from the Field

Without a protocol on how to define when "reasonable efforts" have been made to serve substance-abusing parents, their complicated and demanding cases can overwhelm the resources of child welfare agencies, while children remain unprotected or in foster care.

Caseworkers are still struggling with the appropriate reaction to the addict who relapses. While DYFS staff realize that relapse is an element of the disease, they struggle with decision-making regarding how to protect children in the face of relapse.[72] It remains difficult for them to walk the fine line between supporting the parent's long-term recovery and keeping the child's safety first.[73]

Promising Results

Although DYFS officials have not formally evaluated the program and thus have no outcome data, reports from the field are encouraging, and New Jersey has replicated it statewide. In 1998, New Jersey budgeted an additional $1.5 million for the program.

Screening and assessment. Since DYFS intake workers have received training in substance abuse, they are better able to recognize its symptoms and have a resource--the CADC--to call upon. Incorporating the substance abuse professional into the first stages of investigation helps caseworkers meet their threshold responsibility to recognize and address substance abuse by parents. A trained and experienced counselor now performs substance abuse assessments to gauge the severity of the problem and recommend the best course of treatment.

The program and the surge in treatment referrals that it triggered have bolstered the reputation of DYFS and the Addiction Services Division as consumers in the market for substance abuse treatment. The state now has more weight in the marketplace to affect the amounts and kinds of treatment available.[74] For example, DYFS and Addiction Services realized that more 90 day treatment slots were needed in place of 28 day treatment slots.[75] When they demanded longer slots, some treatment facilities responded accordingly.[76]

Still, whether these treatment slots are entirely appropriate for the parents who are involved with child welfare agencies is unclear. Little attention has focused on the special treatment needs of women with children and women whose basic social skills are limited.[77]

Motivating parents. A primary goal of the program is to help substance-abusing parents engage in treatment. Reports from caseworkers, CADCs, home visitors and treatment providers suggest that the program is making an impact. Of all parents who have been assessed for a substance abuse problem, two of three (66 percent) enter treatment.[78]

One DYFS supervisor believes that the most important result of the program is that parents are unable to "deflect the referral."[79] In the past, parents would give a variety of excuses for not following through on treatment referrals.[80] DYFS workers faced hostility from parents who see them simply as "takers" of their children; for parents, "DYFS means removal."[81] But with the CADC's help, caseworkers who want to break through a parent's denial of a substance abuse problem and encourage her to enter treatment can now defer to an expert in the field.[82]

Because the CADC and home visitor have continual contact with parents while the case is open, parents have a new resource for motivation before and after they begin treatment. The home visitors in particular receive accolades for their work with parents. Easter Seals reported, "Home visitors have been an invaluable resource to parents in need of personal identification, food stamps and a variety of other social service entitlements. The success of the home visitors' interventions can best be measured by how many parents have entered treatment. Although the final decision to enter treatment is the parents', the time the home visitor spends with each parent discussing addiction, reviewing anger management, facing denial, obtaining identification and applying for entitlements makes a difference."[83] Home visitors have also been helpful in getting children into treatment where needed.[84]

Deciding when to return children home. With input from the CADC, intake workers are better able to assess the risk of harm to the child and develop appropriate caseplans when substance abuse is a factor.

Preparing for relapse. In all cases, the parent is also referred to a community self-help group like Narcotics Anonymous or Alcoholics Anonymous, and again the CADC and home visitor encourage parents to use the referrals.

Adoption facilitation. Nobody in the program wants to break up families. Project Clear introduces the program by stating, "Project Clear works to preserve family integrity through prevention of family dissolution and facilitation of reunification."[85] If a parent doesn't follow treatment requirements, however, DYFS may move to terminate the parent's rights. The program creates a clear record of the parent's substance abuse. CADC evaluations appear to carry weight in the court with judges who are considering the termination of parental rights.[86] As a result, the program contributes to the task of determining when "reasonable efforts" have been made to keep the family together. DYFS workers told CASA that their involvement with the program had helped them realize that removing a child from a home is not always a sign of failure.

Case Study: Connecticut Department of Children and Families

Innovations by child welfare agencies do not always involve changes from within. In the case of the state child welfare agency in Connecticut, the Department of Children and Families (DCF), the agency decided to go outside and purchase substance abuse expertise and treatment from a managed care company.

In Connecticut, the number of children reported for child abuse and neglect jumped 61 percent from 22.3 of every 1,000 in 1984 to 35.8 of 1,000 in 1993.[87] DCF began to see a preponderance of substance-abusing parents.[88] In a 1994 DCF study of 157 children who had been in foster care for at least six months, more than half of the cases (58.0 percent) involved one or more family members whose abuse of alcohol and other drugs was documented in the case record.[89] DCF's final report noted, "This is probably an underestimate."[90] Today DCF caseworkers report that up to 75 percent of their cases involve substance abuse.[91] Most parents use alcohol and/or cocaine.[92]

The DCF report urged all staff "to see substance abuse as a primary problem, which must be addressed during the provision of services in order to promote lasting change in a family.... Because of the higher incidence of child abuse and neglect in substance-abusing families, the child protection system needs to understand substance abuse, its impact upon families and the need for treatment for all family members."[94] At the time, there was no systemic way for caseworkers to address substance abuse by parents.[95] One worker said, "We felt paralyzed."[96] Unfortunately, nothing changed until tragedy struck.

In March 1995, Emily Hernandez, a nine-month-old infant was sexually abused and assaulted by her mother's boyfriend.[97] After three days in the hospital, she died.[98] Governor John G. Rowland called for an investigation, which revealed that Emily's siblings had previously been reported to DCF for abuse and neglect,[99] and DCF had investigated at least four allegations of neglect against the family in recent years.[100] Three weeks before her death, Emily suffered a broken leg, but hospital personnel waited six days to call DCF.[101]

A commission appointed by the Governor to examine the case reported, "Emily was born into a family where domestic violence, child medical neglect, physical neglect, physical abuse, adult drug abuse and gang-related threats and fears were facts of life."[104] In July 1995, Emily's biological parents were arrested and charged with possession of narcotics, possession with intent to sell and possession within 1,500 feet of a daycare center, according to the Hartford Courant.[105]

In Connecticut, a child welfare supervisor said that policy is made "in crisis, subject to the winds of the time, the political process and whatever else is out there."[93]

The child's death became a rallying cry to reform child welfare services in Connecticut. Earlier in 1995, the Governor had appointed a new commissioner of DCF.[106] With new leadership and public pressure for change, DCF launched a review of over 5,000 cases to examine how it tried to protect children. A key result was Project Substance Abuse Family Evaluation (SAFE), an initiative to provide DCF caseworkers with immediate access to substance abuse assessment and treatment for parents. Project SAFE costs the state $1.6 million a year.[107]

Concerns About Confidentiality

Federal law prohibits the release of the identity, diagnosis, prognosis or treatment of any patient in substance abuse treatment.[102] *This confidentiality hinders the ability of child welfare caseworkers to assess the readiness of parents to regain custody of their children because treatment providers will not divulge information about a parent's progress in treatment. The intent of the law is to assure that individuals in treatment can share information with a counselor without retaliation. Treatment providers can disclose information only if the parent signs a waiver allowing its release, in a medical emergency, for research purposes or by court order.*[103] *To assist efforts to protect children, some caseworkers and treatment providers seek written consent from parents through a form authorizing the release of certain information.*

Nature of the Innovation

DCF contracted with Advanced Behavioral Health, Inc. (ABH) to conduct substance abuse assessments, drug testing and substance abuse treatment for DCF parents at the company's network of providers. ABH is a non-profit managed care company created by a group of substance abuse and mental health treatment providers. The ABH network of 43 providers offers family and group therapy, individual therapy, methadone maintenance and intensive outpatient treatment at 71 sites throughout

Connecticut. Project SAFE uses some tenets of managed care. Although DCF has not negotiated prospective payment nor specific outcome measure or targets, the child welfare agency assessed its general substance abuse service and treatment needs and negotiated a contract with a managed care company to cover those needs appropriately.[108]

ABH immediately connects parents with substance abuse evaluation and treatment. Typically, after receiving a report of possible child maltreatment, DCF dispatches an investigative worker to visit the parent's home and evaluate the child and the environment. If a parent seems to have a substance abuse problem, the caseworker offers the parent the chance to get a free drug test and substance abuse evaluation immediately.[109] If the parent resists, the caseworker warns that if the child maltreatment proves serious enough to file a petition in court, the judge will order these tests.[110] Court-ordered testing is not paid for by the state (it must be paid by the parent), and it does not look favorable on the parent's record if they decline a substance abuse assessment at the inception of the case.[111] For parents who deny a substance abuse problem, the DCF worker challenges them to prove they are drug-free by getting tested.[112]

To arrange the assessment, intake workers call an ABH toll-free number. ABH's central office then contacts one of its network participants located near the parent and schedules an appointment. DCF's contract with ABH stipulates that DCF parents get priority for drug testing and evaluation. Caseworkers encourage parents to follow through on drug testing and substance abuse evaluation, and may offer transportation.[117]

ABH assessments can only be performed by a certified alcohol counselor, certified alcohol and drug counselor, masters or doctoral level professional with at least two years experience in the substance abuse field, or registered nurse with at least two years experience in the field. Some ABH counselors are bilingual.

After the drug test and evaluation, ABH sends a "clinical summary" to the caseworker. If a parent has a substance abuse problem, ABH makes recommendations for appropriate treatment. Sixty percent of assessments result in a referral to treatment.[118] Most treatment lasts 10 weeks (three to four hours of outpatient treatment, three times per week).[119]

Movement Toward Managed Care

Child welfare agencies have begun to experiment with managed care.[113] *Usually in a managed care model, service providers must meet specified targets and outcomes within the framework of a contract for a prospectively determined fee, but may use their own discretion regarding how and when services will be provided.*

In 1996, the Kansas Department of Social and Rehabilitation Services reorganized its child welfare system to incorporate managed service delivery.[114] *They established targets regarding program participation, case closure within six months, child removal and recidivism. According to the Department, under the time and outcome limits imposed by new contracts, service providers "must address [parental] substance abuse."*[115] *In the fall of 1998, Kansas will begin testing the effects of increased substance abuse treatment and aftercare services, using Title IV-E funds that are available for this purpose under a federal waiver.*[116]

If ABH recommends treatment, parents are matched with an appropriate ABH network treatment provider, which is then required to make regular reports to caseworkers regarding the progress of parents, although there is no standard format for doing so. The treatment provider must report any relapse or discharge from treatment to the caseworker within 24 hours and follow-up with a written report within five days.

If the parent resists the opportunity to enroll in treatment, almost all ABH providers offer some type of support group that is a preliminary step

toward treatment--similar to the parent groups offered in Sacramento County.[120] The groups meet for four weeks, once each week, to educate parents about addiction and help them evaluate their substance use and break through denial.[121] Each provider calls the groups something different: pretreatment groups, educational groups, psycho-educational groups or early-intervention programs.[122] ABH views them as an opportunity to diffuse anger and to be less confrontational with parents who have not responded to pressure to address their substance abuse.[123] Abstinence from drug and alcohol use is required in the groups. Sometimes the inability to remain clean for the four weeks of the program illustrates to the parent that a problem exists.[124]

DCF receives monthly progress reports from ABH detailing use of the program, attendance rates of parents and the type of treatment recommended. Project SAFE's Program Coordinator, Joe Sheehan, meets with the treatment providers each month to discuss progress reports and how to improve the program.

To assure that DCF employees used ABH, Project SAFE hired a training specialist to introduce the specifics of the program to DCF supervisors. The training specialist presented a one day orientation to DCF supervisors in April, May and June 1995, and another training later in the year to discuss drug testing, confidentiality requirements, treatment issues and relapse. DCF also provided training to caseworkers during the Project's orientation, and intermittently offers "refresher" courses and general substance abuse training sessions that are mandatory for DCF employees. Within a year of the program's statewide launch in June 1995, caseworkers made 6,434 referrals to ABH.[125]

Hitting Barriers

Project SAFE initially faced three key challenges: communication between the treatment providers and the child welfare caseworkers, interagency collaboration and access to all levels of care needed by the clients.

Communication. Communication between the caseworker and treatment provider is vital to the project. Yet cultural differences between both systems needed to be bridged. For the Child Protective Service system, services are child-centered and family-focused. The goal is rapid provision of a safe and permanent setting that supports the child's development. The adult substance abuse treatment system focuses on the life-long recovery of the addicted adult where relapse is considered to be an integral part of the process.[126]

In the three year experience of Project SAFE, both systems now have a better understanding of each other's culture and language. DCF employees and treatment providers say that, with experience, the quality and consistency of their dialogue is improving. A DCF Supervisor states, "Project SAFE has been the most successful program as far as coordination between the provider and DCF is concerned."[127]

Collaboration. The program has served as a vehicle for collaboration between Department of Mental Health and Addiction Services (DMHAS) and the Department of Social Services. Each state agency provides services to the same adults, the substance-abusing parents of children on the DCF caseload. Sheehan said that the challenge has been to develop and implement systems to share information and data as well as to identify and implement joint funding models. Several data collection and information systems are now in place. Current discussions focus on collaborative funding.

Access to appropriate treatment and services. Currently, DCF's contract with ABH does not specifically provide for residential treatment.[128] ABH says that some parents will not consent to residential treatment because they worry that this is the first step toward losing custody of their children.[129] (Most facilities do not permit children.)[130] The ABH network of providers has not made many recommendations for residential treatment. A court monitor assigned to oversee DCF since 1990 has questioned whether the lack of residential treatment recommendations was due to lack of need or whether it was a reflection of the services offered in the contract.[131]

In 1997, DCF reported to the Connecticut legislature, "Traditionally treatment has focused on the substance-abusing adult, usually a male, and his or her needs and recovery."[132] This is at odds with the fact that most DCF parents are women with children. DCF is seeking ways to fund residential treatment and to tailor treatment to these women. DCF and DMHAS have developed a way for mothers in the child welfare system to use DMHAS funded programs tailored to treat mothers and their children. Both departments recognize the need for additional funding for residential services.

Promising Results

DCF is looking for funding to conduct a formal evaluation, but in its absence they are relying on their own informal data and impressions regarding the success of the program.

Screening and assessment. The program improves screening because intake workers are more aware of the problem and have ways to address it. One caseworker said, "Project SAFE has made my job so much easier."[133] Even so, caseworkers suggest that they need more training to improve awareness of alcohol abuse. Assessment has improved because the program provides a formal mechanism for immediate professional evaluations.

Access to appropriate treatment and services. By establishing a convenient and immediate path to treatment, Project SAFE has greatly improved access to treatment. In particular, it has produced a significant increase in the number of women using state-funded services.[134] ABH is tracking the number of women with children seeking treatment in order to have stronger data on which to base expansion of the program.[135]

Motivating parents. By providing immediate access to treatment, Project SAFE capitalizes on the motivation that can arise in moments of crisis. Rather than handing a telephone number to the parent and hoping she will use it, the caseworker can take the first step for the parent by making the call and scheduling an appointment.[136] Caseworkers also provide practical support, such as transportation, that may help parents get to treatment. Caseworkers receive information about parents from treatment providers, and can use it to encourage or push parents to stick with it.

The support groups provide another source of motivation. They have kept some parents interested in the possibility of treatment when the rigors of treatment seem overwhelming.[137] Caseworkers say that the groups have also helped parents see how even recreational use of some drugs while they have children can be dangerous.[138]

Sixty percent of all parents keep their appointment with ABH treatment providers.[139] Project SAFE is satisfied with this rate because their research indicates that most programs have slightly less than a 50 percent response rate.[140] After the substance abuse assessment, 30 percent of those evaluated continue with the recommended treatment.[141] DCF wants to improve this rate of retention in treatment.

Caseworkers speak highly of the program's effects on parents. A supervisor who was skeptical in the beginning said that he was pleasantly surprised how many parents were appearing for evaluations and continuing treatment. Another supervisor attributed the participation of parents to the "directness of the staff and [the staff's] belief that screening is a necessary tool in the investigatory phase."[142]

When to return children home. By training caseworkers in the nature of addiction and the process of recovery, they are better able to assess how safe a home will be for a child. Ongoing communication with treatment providers also helps them make informed decisions about the child's fate.

Preparing for relapse. After treatment, parents enter an aftercare program that begins with relapse-prevention meetings two times per week and then decreases to one time per week; aftercare services last for two to four months. One outgrowth of the program has been the Supportive Housing for Recovering Families (SHRF) project. This project provides

supportive housing and intensive case-management to SAFE's target population who are engaged in treatment and are ready to be reunited with their children in the community.[143]

Adoption facilitation. Project SAFE does not explicitly address earlier decision-making regarding permanent custody of the child. But the initiative does create clinical evaluation and reports that help create a record on which to base proceedings to terminate parental rights.

Is it Worth the Effort?

Each of the three case studies demonstrates an attempt to overcome substantial institutional structural and cultural barriers to improve child welfare practice regarding substance abuse and child maltreatment. With leadership, creative thinking and persistence, each has overcome many of them. Sacramento is the most ambitious of the three by trying to change the daily practice of child welfare caseworkers in dramatic ways; both New Jersey and Connecticut chose a more direct route of buying outside expertise to assist child welfare workers and strengthen their efforts with substance-abusing parents.

Most encouraging, they are beginning to address critical areas of practice that hinder child welfare efforts with substance-abusing parents and they appear to be producing positive results: improving screening and assessment, timely access to appropriate treatment and related services, strategies to motivate addicted parents and knowledge to inform decisions on when to return children home. Efforts to prevent and prepare for relapse and move more expeditiously to terminate parental rights when appropriate are lower priorities. If these experiments survive and thrive, they may gain the confidence and resources to address these last concerns.

V. Promising Innovations: Family Drug Courts

Judicially-supervised substance abuse treatment programs are cropping up from the grass-roots of judges' chambers nationwide. Frustrated by ineffective efforts to resolve the rising number of cases involving children maltreated by substance-abusing parents in either a timely manner or one that assures the child's safety and healthy development and encouraged by the positive outcomes in criminal drug courts, some 20 judges in family courts are trying to apply that model to the family court setting.[1] Although it is not an easy fit, there is some promise in these experiments.

The Drug Court Model

Originally developed for drug law violators as an alternative to traditional judicial proceedings in criminal cases, the drug court model seeks to use the coercive power of the court to attain abstinence from alcohol and drugs and eliminate criminal behavior.[2] Generally, drug courts target participants charged with non-violent drug offenses whose involvement with the criminal justice system is due to substance abuse; refer participants to treatment promptly after arrest; establish specific treatment goals; hold regular judicial hearings to monitor progress and compliance; use periodic drug testing; use graduated sanctions (probation or incarceration) and rewards (dismissal of charges, reduction of sentences) to hold participants accountable; and provide aftercare services following treatment to facilitate re-entry into the community.[3]

In June 1989, the first criminal drug court was established in Dade County, Florida.[*] Since then, 275 criminal jurisdictions around the nation have implemented drug court programs.[4] A review of the research on drug courts shows that they "provide closer, more comprehensive

[*] There were earlier "Narcotics Courts" in Chicago and New York but they did not emphasize treatment.

supervision and much more frequent drug testing and monitoring during the program than other forms of community supervision. More importantly, drug use and criminal behavior are substantially reduced while offenders are participating in drug court."[5]

Drug courts rely on legal sanctions available to them to enforce abstinence and participation in treatment and testing. One of the more extreme sanctions available is incarceration.[6] To employ this sanction, drug courts can have the participant plead guilty to an offense and subsequently be sentenced to probation; participation in the drug court program is then the probationary requirement imposed by the judge and incarceration can be a consequence of violating probation. Alternatively, the prosecuting attorney and participant may agree that a criminal charge will be deferred until completion of the drug court program. If the participant completes the program, then the charge is dismissed; if the client fails or drops out of treatment, the charge is reinstated and the participant is tried accordingly.[7]

The defining characteristic of drug courts is the central role and leadership of the judge, who coordinates the members of the drug court team (prosecutors, defense attorneys and treatment providers) and tries to influence, through close monitoring and direct eye-to-eye contact, the participant's behavior.[8] This monitoring is an essential component of all drug court programs.[9] Drug court participants have regular hearings--usually every two weeks--before the judge.[10] The judge receives an accurate and timely report of the participants' progress prior to the hearing and engages them in a dialogue about their progress--or lack thereof.[11]

The Birth of Family Drug Courts

In the wake of the successes of criminal drug courts, family court judges have begun to experiment with the model to address substance-abusing parents who have been cited for child abuse or neglect. Family drug courts strive to offer:

1) **Access to treatment.** Drug court programs arrange for immediate assessment and entry into treatment.

2) **Coordination.** The judge provides leadership for the fragmented array of parties involved with a family (child welfare caseworkers, legal aid professionals, housing officials, child care providers, treatment providers, attorneys, etc.). The judge facilitates communication between agencies so they share information, coordinate the caseplan and resolve conflicts.

3) **Accountability.** The judge holds all parties accountable; at each hearing, the judge expects each service provider to report with confidence that the agency met its mandate to provide services and monitor progress. The judge also expects each participant to meet the obligations set out in the program.

4) **Motivation.** The judge's use of close monitoring, direct engagement, rewards and sanctions may help motivate parents to acknowledge their substance abuse, complete treatment and work to become responsible parents. A parent who has engaged in treatment may regain custody of her child earlier than she otherwise would have. A parent who fails to comply with treatment requirements may be detained in jail or expelled from the drug court program.

5) **Informed decision-making.** Pre-hearing conferences, the accountability of service providers and frequent, direct interaction with parents help judges make informed decisions.

6) **Timely resolution of cases.** By promptly devising a caseplan and closely monitoring its fulfillment, judges can assure that "reasonable efforts" are made to preserve or reunify families in a timely manner. Drug courts specify the conditions parents must meet in order to retain or regain custody of their children. If parents fail to meet clearly stated goals, they have a weaker legal

argument opposing termination of their parental rights.

Difficulties with Family Drug Courts

The criminal drug court model does not seamlessly transfer into the civil court system. The most salient question is whether family courts should have authority to incarcerate a participant as a result of non-compliance with a caseplan. Maintaining appropriate confidentiality and sensitivity to the impact of these programs on women, the poor and minorities is also a challenge.

Incarceration. Only under certain circumstances is the government able to deprive individuals of their liberty (through incarceration or other institutional confinement), and when the government is able to do so, it must follow certain guidelines (due process) in determining whether each case merits such a response.

Most commonly, incarceration occurs because a person commits a crime. However, criminal courts must be vigilant to abide by the protections provided for explicitly in the Constitution, such as the right to an attorney, a speedy public trial, a jury trial and to confront witnesses. Because this area of the law has been litigated extensively, a map of clear rights and responsibilities for the courts and the parties has evolved. In civil courts, however, which include family courts, the responsibilities of the court are less clear. The Constitution does not speak directly to such situations in the states beyond the Fourteenth Amendment which states "[N]or shall any state deprive any person of life, liberty, or property, without due process of law…."[12]

Civil commitment, which is usually invoked when a person is mentally incompetent and a danger to themselves or others, or gravely disabled, is an example of loss of liberty outside of the criminal realm. Due process regarding civil commitment involves the right to a hearing and legal representation.[13]

Incarceration can also be based on contempt of court. People are held in contempt of court when they purposefully "obstruct or defeat the administration of justice."[14] Contempt usually involves the failure to follow through with an activity that has been ordered by the court.[15] The most recognizable form of contempt is refusal to testify in a criminal case, whereby the witness is confined to jail in order to contemplate the value of frustrating the court's purpose.

In criminal drug courts, participants face criminal charges and the likelihood of incarceration, if convicted. This premise allows for a diversionary program that can reasonably include incarceration because the participant's only other alternative includes the threat of incarceration. However, parents in family courts--civil rather than criminal courts--are usually not facing criminal charges or incarceration.[*] For these parents, family drug courts introduce the threat of incarceration that they would otherwise not face.

This raises the challenge for family drug courts to devise a mechanism by which they gain the authority to incarcerate non-compliant parents. A few family courts hear both criminal and civil cases; in these courts, if a parent faces both criminal and civil charges, the judge can use the court's jurisdictional authority to hear criminal cases and impose jail sentences. But most civil cases of child abuse and neglect do not involve an underlying criminal charge that could trigger incarceration, and most family courts do not hear criminal cases. By default, family drug courts are using contempt of court as the basis for incarceration of parents who do not comply with the court-ordered caseplan.[†]

In this context, family drug courts are vulnerable to the criticism that they are overreaching and inappropriately treating the disease of addiction as a crime. Parents are candidates for the program because they are addicted and in need

[*] A parent may be charged with a crime related to the abuse or neglect of a child if the local district attorney's office chooses to prosecute the parent for such acts. The District Attorney must weigh the availability of evidence, the probability of a conviction and the interests of the child. As in other criminal cases, the prosecutor must prove certain factors beyond a reasonable doubt. A parent may also be charged with a drug-related offense.

[†] Because each state has its own set of rules regarding contempt, each state's parent drug court model varies.

of treatment. Although some argue in their defense that family drug courts are "voluntary," courts and child welfare agencies may look at failure to enroll in the program as a sign that a parent is not committed to her children--which could hurt her chances to retain or regain custody of them and creates significant pressure on her to enroll. This compromises the voluntary nature of such compliance.

Confidentiality. Confidentiality has historically been a priority in family court proceedings and legal records. At the open drug court hearings, pre-trial conferencing and other interactions among the court, child welfare agency representatives and the treatment provider, the potential for confidential information about the parent or child to be exposed is enormous. As a result, some family drug courts have tried to assure that parents have a legal advocate to assist in each hearing so that confidential information not required by the court or legally protected from the court and other parties neither becomes part of the parent's file nor a matter of public record. Although parents usually sign confidentiality waivers regarding information on their progress in treatment, parents may feel coerced to participate in the program and obligated to surrender such rights.

Disparate impact. The ultimate and indisputable goal of family drug courts is sober, drug-free, functioning parents and safe, healthy children. But the preponderance of minority children from poor families in the child welfare system makes family drug courts vulnerable to the charge that they incarcerate minority parents for "crimes" that would not result in incarceration for white parents in similar circumstances.[16]

Case Study: Family Drug Court in Reno, Nevada

The first judge to open a drug court focused on substance-abusing parents cited for maltreatment was Judge Charles McGee of Reno, Nevada. During 17 years as a general jurisdiction, juvenile court and family court judge, McGee had seen how substance abuse permeates the legal system. The rising number of child abuse and neglect cases involving parental substance abuse (driven largely by methamphetamine use) helped create pressure for a new approach.

In 1991, substance abuse was a factor in 66 percent of all child maltreatment cases in Washoe County (the greater Reno area); by 1994, the number had jumped to 97 percent.[17] Heavy caseloads meant caseworkers could make only "reconnaissance caseplans" and meet with parents once a month.[18] Backlogs in the judicial system left children to drift for years in foster care.[19] When asked to determine that "reasonable efforts" had been made for families struggling with addiction and to terminate parental rights, "it didn't take long to realize that the system didn't give some of them a chance," said McGee.[20]

Compounding the problem was the "recycling" of children and families through the criminal and family court because of problems related to substance abuse. The same families were being reported repeatedly to legal authorities for child abuse and neglect, juvenile delinquency and other criminal offenses.[21] He wanted a more effective way to use the power of the bench to help children and parents with substance abuse problems.

Having learned about criminal drug courts from a colleague in Las Vegas, McGee designed a family drug court. The program began in February 1995 with a budget of $15,000, which doubled to $30,000 in 1996. The participating agencies and the court's administration budget have absorbed some administrative costs, and Tru Vista, a private foundation, has provided a grant of $30,000 to pay for a casemanager. While no social services agency funds substance abuse treatment in Reno, the court secured funds from the county child welfare agency to pay for treatment.

Nature of the Innovation

In Judge McGee's court, each parent makes a commitment to refrain from alcohol and drug use, to meet with the judge twice a month for progress hearings and to accept sanctions for

failure to comply with any ordered obligations. In exchange, the program provides one year of substance abuse treatment, increased social services and a support system consisting of the judge, his staff, a casemanager employed by the court to coordinate services, the treatment provider and the child welfare caseworker.

The program targets substance-abusing parents who have been found by the child welfare agency to have maltreated their children; some also face criminal charges related to drug possession.[22] (Although he carries a family court docket, Judge McGee is an elected general jurisdiction judge with the power to adjudicate criminal cases.) If participants fail a drug test, the judge usually mandates that they be incarcerated for two days. For parents with no criminal case pending, McGee finds them in contempt of court for violating an obligation of the program and they are similarly penalized.

Potential clients are identified by child welfare caseworkers or staff in the criminal courts (the public defender, other judges or probation officers) and are recommended to the family drug court program. Judge McGee established a policy of "zero tolerance" for alcohol and drug use.[23] For McGee, this disqualified candidates on methadone maintenance, a pervasive attitude in drug courts in general.[24]

The respondents who appear before Judge McGee are mostly women, struggling with addiction and desperate to be reunited with their children.[25] Most women have a history of domestic violence, sexual and physical abuse, and several children by different fathers.[26] Many are in destructive relationships with men who "take advantage of them," according to McGee.[27]

McGee found two treatment programs in Washoe County willing and able to provide assessments and treatment to participants: an intensive outpatient program called "CHOICES," which monitors clients by conducting drug tests three times a week, and a residential program called "Step II," which allows children to live with parents and does not drug test. Both programs are designed for women. Court staff monitor the capacity of each treatment program and accepts new participants only if treatment is immediately available. In addition, Judge McGee hired a "service coordinator," based in his court, to assure that participants receive the range of services they require beyond treatment.

Once referred to the drug court, a staff member at a treatment facility assesses the client and makes a recommendation. Parents must appear every other Wednesday before the judge for a hearing. Prior to each hearing, the judge confers with staff involved with the case to discuss the parent, drug test results and related issues. All staff members from each agency that have contact with parents in the program must attend the conference.[28]

At each hearing, participants are held accountable for failed drug tests or missed treatment appointments. Other drug court participants sit in the gallery, creating pressure on parents to describe honestly their activities. Failure to appear for drug testing or positive test results usually triggers two days in jail.[29] Depending on the number of failed tests, the participant may be handcuffed and removed immediately from the courtroom to serve jail time. Caseworkers make arrangements for the care of the child. For participants further along in the program who relapse, community service may be allowed or jail time can be deferred to the weekend to prevent employment conflicts. The program has approximately 36 participants. Parents participate in the program for 12 to 18 months. They must remain sober and drug-free for three months before they can "graduate." After graduation, the judge may require that they attend hearings periodically to update him on their progress with recovery and parenting their children.

Hitting Barriers

McGee has run into few barriers because the court system and child welfare system in Reno is small compared to others in the country, and he enjoys a high level of clout in the community. Any innovation, however, requires modifications and fine-tuning and the judge is

the first to admit that the program is "a work in progress."[30]

Changing responsibilities. Staff members of the agencies serving drug court participants are required to assume these responsibilities in addition to those they already carry, coordinate with one another, work within a model of changing rules and be responsive to the judge's requests.[31] In the first year of the program, the number of review hearings that child welfare workers had to attend almost doubled from 87 to 162.[32]

Judge McGee has relied on the power of his personality and the soundness of the innovation to overcome these problems. He says that "teamwork" is the hallmark of the family drug court,[33] and despite some concerns from other actors in the child welfare system, he has been remarkably successful in persuading them to work together.[34]

Unclear legal boundaries. The family drug court is deeply involved in the lives of the participants because it is trying to affect their behavior and fundamental choices about their lives. This intense level of involvement may raise concerns about confidentiality and decision-making.

At the pre-trial conference and the hearing, information which is usually confidential (medical history, for example) become open topics for conversation.[35]

The family drug court in Reno has tried to address these problems by requiring parents to sign a waiver of their confidentiality rights in order to participate in the program.

In addition, the agreement that participants sign before joining the program states that "failure to comply with this order may result in a finding of contempt by this court where in which jail time and/or community service may be imposed or dismissal from the family drug court program." For parents facing criminal charges, dismissal from the program is violation of their probation, a serious offense that usually results in incarceration. For parents not facing criminal charges, dismissal hurts their chances of regaining custody of their children. But refusing to enter the drug court program may also be a strike against them when child welfare officials make decisions about the custody of their children.

In short, parents have important decisions to make with serious legal ramifications. Although the judge and public defender work to assure that all participants have effective counsel, some parents may lack the information and optimal advice to make sound decisions.[36]

Lesson from the Field

Parents need legal representation to assure that they understand the unusual requirements of family drug courts and the ramifications of electing to participate or refusing to do so.

Collaboration. While some staff members feel that the drug court has been a collaborative endeavor, others say that they simply complied with demands that they participate.[37] Fortunately, because Reno is a relatively small city, each of the actors already knew each other well, creating a sense of collegiality and flexibility that may be hard to find elsewhere.[38] Judge McGee's strong reputation among his colleagues has allowed him to barter his "good will" in the community for latitude in starting the program.

Inconsistent sanctions. While the judge enjoys a high degree of flexibility in determining how to handle each case, he became concerned about the lack of uniformity in applying sanctions and the possible appearance of a disparate impact on participants. As a result, his staff has developed sanction guidelines that they hope will assure equal treatment of all parents.[39]

Lesson from the Field

The flexibility that family drug court judges enjoy on how to handle cases should not compromise the fair and uniform application of sanctions, such as incarceration. This is especially important in the context of abiding concerns regarding the impact of child welfare interventions on minority Americans.

Promising Results

Although no formal evaluation has been done, the program produced 74 graduates from a total of 169 participants.[40] Forty-five people have been dismissed from the program, 29 for non-compliance and 16 by personal choice.[41] Of graduates, only two have been reported for new incidents of child maltreatment.[42]

Screening and assessment. Screening has improved only because caseworkers are more aware of substance abuse due to their involvement in the drug court and the new opportunity to help clients confront their addiction. The family drug court has not offered any special training on substance abuse to caseworkers. Assessment for drug court participants has improved because the treatment provider immediately evaluates each participant.

Access to appropriate treatment and services. Access to treatment that attends to at least some concerns of women, such as child care, has greatly improved because treatment is available immediately for drug court participants and children may accompany their mothers. But it is unclear how many are refused admission to the program due to a shortage of treatment. Access to services beyond treatment has improved due to the efforts of the "service coordinator" who works to assure that parents get the services they need when they need them.

Motivating parents. The judge tries to use the intense involvement of the court to motivate parents.[43] In the courtroom, when one parent begged, "I have no friends, no family in the area. I need support," the judge promised, "If you do this, I will support you. But it will not be easy for you."[44]

McGee says that parents who are desperate and in crisis can be motivated to change.[45] Some women who participate in the program told CASA that they feel they are treated fairly.[46] A few women stated that Judge McGee is "wise to the ways of the world" and is effective at breaking through the denial and dishonesty of the addict.[47]

Moreover, the open forum and presence of all participants in the gallery also help break through denial and motivate parents. Participants regularly attend group therapy together and from those sessions know each other and the details of one another's lives. In this setting, accolades and admonishments may become more meaningful.

Returning children home. Biweekly hearings and pre-hearing conferences focus the judge and social workers on the parent's progress, what services are being provided and whether additional services are needed. A clear caseplan and close monitoring of progress allow for more informed decisions regarding child custody.

Preparing for relapse. Judge McGee has integrated some elements of aftercare into the program. He has required that parents check in with him after graduation. The CHOICES program has created a support group for graduated parents. Judge McGee recognizes that these parents need long-term support and monitoring, and has been exploring the possibility of establishing a housing facility solely for mothers in recovery.

Adoption facilitation. The program could facilitate adoption by meeting a "reasonable efforts" test for terminating parental rights. Constant review of cases puts drug court cases on a quicker timeline than other family court cases. But speeding up the adoption process is not the judge's immediate goal. He promises candidates that if they complete the program and work hard they will be reunified with their children--"guaranteed."[48]

Case Study: Parent Drug Court, First Judicial Circuit in Pensacola, Florida

In February 1996, Judge John Parnham of the First Judicial Circuit in Pensacola, Florida (Escambia County) decided to try the criminal drug court model in his family court. A growing load of cases involving substance abuse and child maltreatment had left caseworkers from the Florida Department of Children and Families (DCF) sighing, "Not another drug case."[49] Some decided that cases of newborns who had been prenatally exposed to drugs "had no reward--nothing good ever came of them."[50] In Pensacola, up to 90 percent of all child welfare cases involve abuse of alcohol and drugs--usually crack cocaine and marijuana.[51]

Judge Parnham decided that the best way to help children would be to get their parents clean and sober. Because parents in his court usually have a history of multiple attempts at treatment, he concluded that treatment could not succeed unless people have jobs, learn more about raising children and gain a sense of independence. He views the court as the only force that can hold various actors within the child welfare system and social service system collectively accountable for the quality of services they provide parents. For him, the drug court model is a way to embody a holistic approach toward parents and create accountability among service providers as well as the parent.

The existing court budget has absorbed the costs of the administration of the drug court program. DCF finances the treatment, initially committing $60,000 dollars to the program for 20 treatment slots, and increasing its contribution to $90,000 for 30 slots a year.[52]

Nature of the Innovation

Parents are eligible for the drug court if they have a chronic substance abuse problem, have a child in foster care and have a non-violent criminal or child welfare history. All but three participants have been female.[53] A parent promises to participate in treatment, submit to random drug testing, appear at weekly "drug court" hearings and consent to follow any sanctions imposed by the court. In exchange, parents receive treatment, services and support from the court and DCF caseworkers. Reunification with children is the ultimate reward; incarceration is the penalty for repeated failures of drug tests or other non-compliance. Before graduation from the program, a parent must usually remain clean and sober for 90 consecutive days. The judge describes the program to potential participants, "If you want a realistic opportunity to change your life for you and your children, this is the best option."[54]

The treatment program designed for the drug court includes three phases.[55] The first, which lasts for four weeks, involves intensive outpatient services (four hours a day, four days per week); group therapy (1½ hours, three times a week); and drug testing twice a week.[56] The second, which lasts for two to four months, involves outpatient services (eight hours a week); group therapy twice a week; and drug testing twice a week.[57] The third, lasting eight to 12 months, involves outpatient services (three hours a week); group therapy once a week; drug testing once a week.[58] In total, the program may take up to 18 months.

The judge monitors progress of clients through regular court hearings. If a controversial issue is likely to come up in a hearing, such as the pregnancy of a parent's teenage daughter, the judge clears the courtroom. If the issue is an adult topic of conversation, such as sexual abuse, the judge may ask that all children be removed from the courtroom.[59]

If a parent fails to meet any treatment obligations or attend weekly hearings, the DCF caseworker and treatment provider notify the judge, try to locate the parent and discern the reason for the slip. If there is a reasonable excuse, such as a sick child, the parent must immediately consent to drug testing and address the problem with a counselor. Handling missed meetings or failed drug tests through testing and counseling is the preferred strategy. However, if a client shows a pattern of missed appointments or is not supplying reasonable excuses for a

missed session or drug test, the treatment provider recommends to the judge that a sanction be ordered, usually incarceration for a night or more. Sanctions are not uniformly determined to allow the judge to tailor responses to each parent.[60]

The court gains authority over the parent by finding the parent in contempt of court. Under Florida law, a parent may be found in contempt of court for not following court-ordered provisions in a caseplan; contempt carries a penalty of incarceration for up to one year. Judge Parnham gives potential participants a full explanation of the program, the consequences it carries and its voluntary nature.[63] He also appoints counsel, who then must explain the program and other options to the parent before she enters the program.[64] Parents who decide to participate then waive their right to a jury trial and plead guilty to the contempt, which is based upon the parents' non-compliance with orders of the court.[65] This results in a sentence of one year probation.[66]

The drug court program becomes the probationary requirement for the parent. If the parent breaks any probation commitments, she can be penalized with jail time. If she drops out of the program or is expelled, she must serve up to one year in jail. These penalties are enforced and are an automatic result of the guilty plea to contempt.

In order to document understanding and voluntariness, the parent signs multiple documents, including confidentiality waivers and a contract agreeing to participate in the program.[67] Before any final paperwork is filed, the parent is questioned at length and on the record about her knowledge of the process, its meaning and her voluntariness.[68] Because contempt of court is not a felony, the parent will not have a criminal record. All records in the family drug court are sealed, preventing any employer or other party from procuring confidential material without the use of a subpoena.[69] Upon receiving someone new into the program, Judge Parnham promises, "We'll commit to help you as long as you try to help yourself."[70]

Drug Testing

The child welfare system is increasingly using drug testing to evaluate and monitor drug use by parents. Drug testing involves collecting a sample of blood, urine or hair from a parent and examining it in a laboratory for the presence of illicit drugs or their metabolites. Drug testing can report drug use only for a certain window of time.[61] *Although a person's blood or urine can be tested for the presence of alcohol or its by-products, alcohol remains in the body for so little time that such testing has limited value.*[62]

By itself, the usefulness of drug testing is limited. The threat or the results of a drug test may help a caseworker break through a parent's denial of substance abuse. The test results can also help create a record for decisions made by caseworkers. However, caseworkers who receive negative drug test results regarding their clients should not ignore other indicators of a substance abuse problem. Drug testing is not a substitute for comprehensive assessment of an individual's substance abuse problem; it is simply an additional tool.

Hitting Barriers

Escambia County, the home of Judge Parnham's court, had years of experience with a criminal drug court, which boosted confidence in his idea to apply the model to his family court. A lengthy series of meetings--attended personally by the judge--with DCF managers and caseworkers, and a local treatment provider called "Pathways," which was already working with the criminal drug court, paved the way for his innovation. Nevertheless, Judge Parnham hit some bumps in the road.

Lesson from the Field

Coordinating the many service providers who are involved with substance-abusing parents in child welfare cases can be a Herculean task for judges. Regular meetings--monthly or before each hearing--are an important mechanism to mandate communication and hold all actors accountable for their obligations.

Treatment and services for women. Close monitoring of parents in treatment revealed the weaknesses of programs that were not designed for women. As a result, Pathways now offers treatment tailored to mothers.[71] Women are separated from men in treatment and, thus far, the Deputy Court Administrator has received positive feedback from the treatment provider and participants.[72] This program focuses on women's issues and their sources of stress. The treatment provider also hopes to provide on-site child care.

To increase its menu of services that are tailored for women, the family drug court has also decided to integrate the Women's Services Program comprising Women's Intervention Services and Education (WISE) and the Women's Transition Center (WTC) a local non-profit organization that helps pregnant and parenting substance-abusing women, into the program.[73] WISE helps women find housing and employment, runs gender specific support groups and employs counselors with caseloads of approximately 20 women.[74] Women's Services is voluntary for parents in the program.

Coordination. Coordinating this panoply of actors proved difficult. In mid-1997, "communication fell apart" between the court and DCF, leading to misunderstandings about how the program should work.[75] In early 1998, Judge Parnham tried to jump start the program by organizing monthly meetings of all service providers involved with drug court cases. These meetings re-connected the parties and helped revive their commitment to the goals of the program and its procedures. By May of 1998, the program had regained its earlier momentum and ability to operate. The Senior Deputy Court Administrator, Robin Wright, who administers the program stated, "This experience showed us that it is not enough to coordinate implementation of an innovation; everyone must continue to work on teamwork."

Lawsuit. In the summer of 1998, the Pensacola drug court faced its biggest challenge; one woman challenged the authority of the court to incarcerate her as a result of non-compliance with the family drug court program. The case was scheduled to go to trial in August 1998. However, the woman decided to drop the suit and join the drug court program.[76]

Promising Results

Although Judge Parnham has not initiated a formal evaluation of the family drug court, his sense of its positive results has driven him and DCF to expand eligibility to parents involved with other divisions of DCF beyond child protective services.[77]

As of October 1998, 39 parents had participated in the drug court and 21 had graduated. Fifty-two children have been reunited with their parents. Six were pending reunification as of October 1998. Eighteen parents were terminated from the program; 38 children of those parents were freed for adoption or permanent guardianship.[78]

Screening and assessment. Screening and assessment have improved slightly since inception of the family drug court. Its presence has raised awareness of substance abuse and created some confidence that DCF has a way to address it.[79] During DCF's 12 week orientation for new caseworkers, one week is devoted to substance abuse;[80] caseworkers do not receive any additional training for the program.

Access to appropriate treatment and services. Access to appropriate treatment has greatly improved. While treatment slots are generally available in the area, the program added intensive outpatient slots to DCF's menu of treatment. If after assessment, it is clear that outpatient treatment is not appropriate for the parent, the treatment provider and judge move to place her in a residential program. The judge's staff has also worked to find appropriate treatment for pregnant mothers and parents with multiple mental disorders.[81]

Access to the economic, social and health services that many addicted women need has also improved with the addition of WISE/WTC to the program, which brought housing and employment assistance, and support groups to

the menu of services normally offered by child welfare caseworkers.

Motivating parents. Because parents volunteer for the program, they are already interested in recovery and know that the penalty for relapse could be incarceration. The use of praise and sanctions appears to motivate some parents to follow their caseplan. Close monitoring allows quick intervention if parents falter during the recovery process. The team approach in the court helps the parent resolve a myriad of issues, such as legal problems, relationship problems, employment problems and housing difficulties. Where there had been a perception of no compliance by parents and no enforcement of their obligations, caseworkers now see accountability and change.

Lesson from the Field

To help prevent relapse by parents who complete drug court programs, judges can help them make connections in their communities to self-help and support groups of individuals in recovery from addiction.

Returning children home. A clear caseplan and close monitoring improve the quality of decisions regarding child custody.

Preparing for relapse. A mandatory component of treatment is attendance at AA and NA meetings. Attendance is also encouraged after completing the program.[82] Participants sign a waiver consenting to AA and NA participation to preclude any arguments that a court cannot order someone into 12-Step treatment because of church and state issues. Although not originally part of the drug court program, the treatment provider has begun offering aftercare services. A drug court graduate support group was developed that includes participants from all local drug courts, not just the family drug court. Pathways also has a support group for family court participants. Judge Parnham is also considering making connections for parents to churches and other organized religious groups.[83] Because treatment includes a voluntary spirituality component, he sees helping participants make these connections after treatment as a natural progression. He has observed that after participants receive such close attention during the program, the loss of such support upon graduation can be traumatic for them.

Adoption facilitation. Caseworkers see the program as a way to make timely decisions regarding the welfare of children and to mobilize all possible resources to give parents the best possible chance for reunification. They say that if parents cannot become sober, drug-free and ready for reunification through this program, they are not likely to ever do so.[84] Nevertheless, in practice, DCF rarely terminates parental rights. One reason is that most children reside in kinship care, which DCF does not treat with the same urgency as regular foster care.[85]

Case Study: Family Drug Treatment Court in Suffolk County, New York

In March 1997, Judge Nicolette Pach of Suffolk County, New York concluded, "Suffolk County Family Court is overwhelmed with children of substance-abusing parents."[86] She estimated that 75 percent of the family court caseload of child maltreatment involved substance-abusing parents.[87] Reports suggested that 12 percent of births in the county in 1996 involved one or more substance-abusing parents.[88] Judge Pach felt that the agency charged with handling these cases, Suffolk County Department of Social Services (DSS), did not have the requisite substance abuse expertise to handle these cases, nor was it able to provide the "wide range of services" substance-abusing parents need due to their overwhelming caseload.[89] Services for these parents were fragmented across agencies and sundry providers. "This diffusion of resources undermines the impact of the Court's intervention," she said.[90]

Judge Pach tried giving substance-abusing respondents a pamphlet from the County Division of Alcohol and Substance Abuse Services describing where they could get an assessment of their substance abuse problem and a recommendation for treatment.[93] But this had little effect. In desperation, she held a non-compliant parent in jail to ensure attendance in court and placement in treatment.[94] To her surprise, this tactic worked.[95] "It got the parent's attention," she said.[96] Even so, the lack of connections to treatment and related services hobbled her efforts. Judge Pach became increasingly frustrated by time wasted while parents were unable to find treatment.[97]

Judge Pach also became aware of the lack of knowledge about substance abuse throughout the child welfare system, including the courts. She decided to learn more so that she could "stop guessing what I should be doing and start knowing what I should be doing."[98]

After learning about the family drug courts in Reno and Pensacola, Judge Pach decided to apply the model to her own docket. In December 1997, she began accepting parents into the state's first family drug court on a shoe-string budget of in-kind donations from participating agencies and Medicaid funding for treatment. Only after beginning to accept a caseload did she secure a $400,000 grant from The Robert Wood Johnson Foundation and $150,000 from the county legislature. "My advice," she said, is: "Don't wait for the money."[99]

Nature of the Innovation

Judge Pach's family court targets substance-abusing parents who have neglected their children. All participants must voluntarily agree to participation, admit to the allegation of neglect and recognize that they have a substance abuse problem. Further, they must sign a waiver permitting ongoing access to their substance abuse treatment records.[100]

In Judge Pach's court, parents who appear to have substance abuse problems are immediately assessed for substance abuse and undergo drug-tests in the courthouse. Based on the results of the assessment, a courthouse-based case-management team enrolls the parent in the program and a substance abuse counselor from the team makes a referral to treatment. The case-management team, supervised by Judge Pach, provides close monitoring and a resource for services such as housing, transportation and medical services for the parent and her children. In exchange, the parent agrees to complete all requirements of treatment and those dictated by the judge and her case-management team.

The Dependency Court Recovery Project, Juvenile Court, County of San Diego

Reducing the amount of time children spend in foster care is a goal for many judges around the country. Two factors encouraged Judge James R. Milliken to propose The Dependency Court RECOVERY PROJECT, a plan for reform of the family courts in San Diego. First, children were spending years in foster care. Second, a review of case records indicated alcohol and drug use by parents was a contributing factor in 80 percent of cases.[91]

The RECOVERY PROJECT began with the following goals: to implement a substance abuse recovery management system, to provide treatment on demand, to implement a drug court, to increase participation by volunteer child advocates, to redefine roles of the professionals in the child welfare system, to utilize mediation and family group-conferencing and to improve an automated tracking system.

The program implemented preliminary components in 1997 and received $2.7 million from the County Board of Supervisors in October 1997. The county has been seeking funding for an evaluation but has been unsuccessful.[92]

Participants must attend regular hearings throughout the 12 month program to report their progress to the judge. Any failure of a drug test or failure to appear at a hearing or other appointment could result in a sanction by the

court--possibly jail time. The authority for any sanction originates from civil contempt of court. The judge rewards progress with praise and presents, such as gift certificates to McDonald's for family outings. Judge Pach has arranged for court-appointed counsel to be on hand to represent clients.[101]

Judge Pach has carefully considered how the system of rewards and sanctions should reflect the values of the family court and the goal of better outcomes for children.[102] She feels strongly that denying children visitation with their parents should not be used as punishment for a parent's relapse. "If sober quality time with the children is possible, I won't curtail it in response to a parent relapsing or missing appointments," she said.[103]

To design the program, Judge Pach assembled a steering committee for the project in early 1997. The steering committee members include representatives from the Department of Social Services, the Office of Probation, the County Health Department, the County Division of Drugs and Alcohol, the Sheriff's Department, the County Executives Staff, the New York Office of Court Administration's Center on Court Innovation, the Family Court Staff, the Suffolk County Criminal Drug Court Coordinator and the Supervising Judge of the District Court from the Suffolk County District Court Drug Part (County Criminal Drug Court). The steering committee has met monthly since March 1997 and subcommittees have met intermittently to discuss specific issues. Judge Pach launched the program with in-kind donations of services from this steering committee.

In conjunction with DSS, Judge Pach organized and houses a case-management team in the courthouse to assure that parents receive appropriate treatment and services.[104] To assemble the team, she sought the help of the Education and Assistance Corporation (EAC), a non-profit organization in Suffolk County with experience in substance abuse and judicially-supervised case-management.[105] The team includes a liaison from Child Protective Services at DSS to monitor child safety and facilitate access to DSS programs.[106]

To secure treatment slots for participants, Judge Pach sought help from the County Division of Drugs and Alcohol, DSS, New York State Office of Alcoholism and Substance Abuse Services, EAC and a group of local residential and outpatient treatment providers.[107] The Clinic Administrator of the County Division of Alcohol and Substance Abuse Services agreed to negotiate referral agreements with the treatment providers.[108]

Finally, Judge Pach arranged for the County Health Department to provide a 19 hour substance abuse training program to the entire family drug court staff.[109] She felt that everyone in the program needed a basic understanding of substance abuse in order to operate the program effectively.

Lesson from the Field

Establishing a family drug court, which requires investments of time and money from many public agencies and funding sources, requires that judges leave the bench to demonstrate their commitment to the project and rally enduring support.

Hitting Barriers

Judge Pach showed unwavering commitment to the innovation, while welcoming input for how to design and implement it. This collaborative process involved convening and leading more than a dozen meetings and forging partnerships between leaders in the health and social service system who did not know each other and had little knowledge of what each other did for a living. Just as Judge Parnham had found, this required leaving the bench to rally professional and financial investment from the County's social welfare system and legislature for an initiative that had little initial support.

This painstaking process seems to have avoided some of the pitfalls experienced in other case studies, such as break-downs in communication and gaps in treatment and services. By creating her own case-management team, she

circumvented the caseworkers who might otherwise have resisted changing their daily practice. Yet Judge Pach's family court is still young, and she will undoubtedly hit barriers as the project unfolds.

As of December 1998, the program had enrolled 33 participants with 81 children.[110] The court administrator is working on coordinating the parent drug court with the criminal courts to facilitate communication between judges regarding parents with both civil and criminal cases.[111]

Promising Results

Although Judge Pach has been unable to raise funding for a formal evaluation of her drug court, preliminary developments are encouraging. As of December 1998, of the 33 participants, 30 have been in compliance with the expectations of the program.[112] The drug court happily reported an individual success; in May 1998 a participant in the drug court delivered a drug-free baby. [113]

Screening and assessment. While little has happened to change the quality of child welfare workers' screening for substance abuse, assessment has improved because the court-based case-management team includes a certified addiction counselor to conduct assessments immediately.

Access to appropriate treatment and services. The court has negotiated informal agreements from treatment providers to serve drug court participants who otherwise generally had a difficult time finding treatment. The court is monitoring treatment capacity in the community and forging new relationships with providers that could help improve access and pose opportunities to fashion treatment tailored to women with children. Access to other services has greatly improved due to the Judge's effort to garner support and services from a wide array of social service agencies. Her court-based case-management team further monitors the provision of these services.

Motivating parents. While Judge Pach does not hesitate to use incarceration when she deems necessary, she--along with Judges McGee and Parnham--appears eager to give positive reinforcement to parents as well, impressing upon them how much she "wants them to succeed."[114]

Returning children home. Training in the nature of addiction and recovery, thorough assessments and ongoing monitoring help Judge Pach make informed decisions regarding children.

Adoption facilitation. One of Judge Pach's primary goals for the drug court is to shorten the time it takes to resolve cases--whether by reunifying families, freeing children for adoption or by finding another permanent solution. She has declared that through the program, "We should know within the first year if a parent will get the children back or not…. At some point we need to give the child a shot at a permanent, safe and nurturing home."[115]

Do Drug Courts Belong in Family Courts?

Each of these three case studies demonstrates both the promise and peril of applying the drug court model in a family court. The strategy appears to produce significant results in many critical areas of practice: improving screening and assessment, timely access to appropriate treatment and related services; strategies to motivate addicted parents and knowledge to inform decisions on when to return children home. As with the case studies in Chapter IV, efforts to prevent and prepare for relapse and move more expeditiously to terminate parental rights when appropriate are generally lower priorities.

Evaluations of outcomes from experiments with family drug courts are necessary to determine whether children benefit and legal protections accorded parents remain inviolate. Family drug courts must take careful steps to assure that the principles of due process, confidentiality and fairness are respected. Concerns about family

drug courts also center on the value of coerced treatment and whether such efforts come too close to turning the disease of addiction into a crime worthy of punishment. Yet many who work in the field of addiction argue that serious consequences are sometimes essential to get addicts to enter and remain in treatment. This can be an important tool for the child welfare system, which must attend to the urgent developmental needs of children.

Family drug courts are an effort by judges to impose accountability not only on substance-abusing parents, but also on a social welfare system that is fragmented, uncoordinated and generally ill-prepared for the multiple, intertwined problems of families with substance abuse problems. In Suffolk County, Judge Pach set up her own miniature case-management team with the approval of the local social services agency that acknowledged it could not meet the challenge. It is worth asking whether courts should be trusted with the responsibility of running social services. But it is also worth asking, if they do not, who will protect the children?

VI. An Agenda for Action

Federal and state legislation sets a framework and loose guidelines for child welfare practice, and makes little mention of substance abuse. Although the federal Adoption and Safe Families Act of 1997 reduced the time allowed to resolve cases of child maltreatment from 18 months to 12 months, few in the child welfare system appeared to be meeting effectively the old timeline, and few expect to do so on the shorter one. On the issue of substance abuse during pregnancy, efforts to articulate policy in state law are stymied in controversy.

The limited use of legislative initiatives to meet the challenge of substance abuse and child maltreatment reflects how little consensus exists regarding what to do. These cases do not respond to quick fixes and scream for prevention strategies to avoid the terrible consequences that occur before they even reach the doors of child welfare agencies. They cry out for more effective prevention of alcohol and drug abuse.

The problem facing the child welfare system is primarily one of practice: how to identify the problems facing families; how to assess the need for services; what services to provide; how to pay for them; and what constitutes "reasonable efforts" to treat parents and hold families together. In this challenging environment, it makes sense to focus on crafting practice guidelines that can be tested, replicated and adopted as they demonstrate their effectiveness and command confidence.

Unfortunately, decisions about child welfare policy and practice at the local level are often made in the heat of crisis--usually following a child's death while under the watch of the child welfare system and the media explosion that ensues. Policymakers need to step back and recognize that substance abuse has fundamentally altered the challenge of

protecting the nation's children and that practice needs to change dramatically.

CASA proposes the following guiding principles and recommendations to enable the child welfare system to respond effectively to the chaos and calamity it now faces.

Guiding Principles

To respond to the reality and consequences of a caseload now dominated by substance-abusing parents, CASA suggests the following guiding principles:

1) Every child has a right to have his or her substance-abusing parents get a fair shot at recovery with timely and comprehensive treatment.

2) Every child has a right to be free of drug- and alcohol-abusing parents who are abusing or neglecting their children and who refuse to enter treatment or despite treatment are unable to conquer their abuse and addiction.

3) Every child has a right to have precious and urgent developmental needs take precedence over the timing of parental recovery.

4) The goal of the child welfare systems is to form and support safe, nurturing families for children--where possible within the biological family and where not possible with an adoptive family.

Recommendations

With these guiding principles in mind, CASA urges action on five recommendations:

I. Start with prevention.

Preventing substance abuse in general should be the top priority.

For those parents who become involved with alcohol and drugs, preventing child maltreatment within their families is essential. The problem is too big and too devastating in human and economic terms to retreat to remediation only.

1) Each of us must take responsibility to prevent substance abuse and addiction. Government at every level, institutions public and private, and every citizen, at work and at play, must take responsibility to prevent substance abuse and addiction. The savage impact of parental drug and alcohol abuse and addiction on helpless children demands action by all of us. The best hope of preventing child abuse and neglect by substance abusing parents is preventing drug and alcohol abuse and addiction.

2) Incorporate prevention of child abuse and neglect and treatment of substance abusing parents in other social programs. While an all-out attack on these problems is beyond the purview of a child welfare agency acting in isolation, agencies can participate in concerted actions with other organizations or individuals to mount a comprehensive prevention effort. For example, CASA is testing a model of intervention with substance-abusing mothers who receive welfare benefits that depends on the active involvement and collaboration of many public agencies including child welfare. In addition, by providing treatment to women--even those who ultimately do not regain custody of their children--child welfare officials are helping to reduce substance abuse and to prevent the maltreatment of any children they may have in the future.

3) Treat substance abuse and related problems during pregnancy. A woman's pregnancy and the birth of her child create a window of opportunity to prevent child maltreatment because a woman's motivation to address her substance abuse problem often rises at this time.[1] It is vital to capitalize on this window of opportunity; as stated earlier, in New York City, more than one quarter of child fatalities attributed to abuse and neglect involve children prenatally exposed to alcohol and/or drugs.[2] In addition to her substance abuse problem, the mental health disorders that often accompany substance abuse in women, such as

depression and post traumatic stress disorder, may be treated and significantly improve her ability to be a responsible parent.[3]

Interventions during pregnancy by physicians who offer referrals to counseling and treatment increase the odds that a woman will at least reduce her drug and alcohol abuse during pregnancy and give birth to a baby of higher weight than women who do not receive such interventions.[4] In one study, two-thirds (65 percent) of pregnant alcoholics who were counseled by a physician subsequently cut their drinking in half.[5] Efforts to test mothers during pregnancy or at birth for alcohol or drug abuse should occur in tandem with efforts to assure that they have access to appropriate counseling and treatment.[6]

Healthy Start

The Healthy Start program, begun in Hawaii and replicated nationally, aims to reduce family stress, enhance child development and prevent abuse and neglect. The program targets high risk families at the time of birth and visits them at home, providing education, counseling and referrals to services.[14] *In Hawaii, the program has formal agreements with hospitals to conduct brief interviews of mothers and screen their medical records to look for signs that a child is at risk of maltreatment. Para-professionals or nurses visit families weekly for the first six to 12 months of the child's life and continue to visit less frequently until the child reaches age five. If assessments of the child's development indicate delays, further assessments and services are offered. Home visitors may appear in family court and provide reports that help resolve cases. Evaluations of the program in Hawaii indicate lower rates of child maltreatment than in families not receiving services.*[15]

Despite this important opportunity, physicians frequently fail to ask pregnant patients about substance abuse.[7] Doctors, nurses and other healthcare professionals need training on how to identify substance abuse in pregnant women, counsel her in a non-judgmental way and help her get treatment.[8] New Jersey's Healthy Start program bolsters the work of healthcare professionals by pairing pregnant substance-abusing women with paraprofessionals in recovery who encourage pregnant women to enter treatment.[9]

4) Provide home-based support during pregnancy and early childhood. Home visiting programs are one of the most promising ways to prevent child abuse and neglect.[10] In these programs, a healthcare professional (usually a nurse) or a paraprofessional visits pregnant women or mothers of newborns at home and provides education about parenting skills, emotional support and referrals to social services.[11] About 20 states operate home visiting programs designed to help prevent child abuse and neglect and promote healthy child development.[12] A 15 year follow-up of women who were visited by nurses during pregnancy and through the child's second birthday found that they were almost half as likely to be identified as perpetrators of child abuse and neglect when compared to a control group of women who had not received such visits.[13]

In Seattle's "Birth to 3" advocacy project, paraprofessionals with a caseload of up to 15 work intensely with addicted mothers for three years beginning at the birth of the child. Advocates help women set goals and make connections to services. Initial results of the program show that 85 percent of the women in the program completed substance abuse treatment.[16] Parents with infants who were exposed to alcohol or illegal drugs during pregnancy need particular attention. The Options for Recovery Program in California recruits specially trained caregivers to help mothers care for these children.[17]

5) Nurture healthy children. Although we know that children who suffer maltreatment at the hands of substance-abusing parents are at high risk for later problems, from substance abuse to suicide attempts, few resources are devoted to helping these children with counseling and support services when child welfare systems have identified them.[18] To help meet this need, the U.S. Department of Health

and Human Services has approved waivers to allow states to use Title IV-E funding to provide extensive services to children in foster care.[19] One program, Project Protect in Massachusetts, stresses the importance of collaboration between medical, legal and social service agencies to serve children who are living in families devastated by substance abuse and violence.[20] Addressing some of the medical and mental health needs of these children is a preventive opportunity that we should not--and cannot afford to--miss.

II. Dramatically reform child welfare practice.

Child welfare officials and family court judges should employ five critical components of practice to respond effectively to substance abuse: 1) protocols to screen and assess for parental substance abuse in every investigation of child abuse and neglect; 2) timely and appropriate treatment for parents; 3) strategies to motivate parents; 4) prevention of and planning for relapse; and 5) facilitating adoption for children when parents fail to engage in treatment.

1) Child welfare agency directors should establish protocols that assure that child welfare workers screen for substance abuse in all parents who are investigated for maltreating their children and assess the severity of the problem. Without a strategy to screen for and assess the problem of substance abuse, it will likely go untreated and child maltreatment will continue. Every frontline child welfare worker in the country should know how to recognize the signs of substance abuse, how to engage the parent in a conversation about it, how to use drug testing and how to respond effectively to the parent and help motivate him or her to seek help. Assessing the severity of the problem requires more expertise, which can either reside in the child welfare worker (as in Sacramento County) or in a supporting professional (as in New Jersey, Connecticut and the family drug courts in Nevada, Florida and New York).

Screeners should always look for alcohol as well as illegal drug abuse, including marijuana. Too often the media and politicians focus myopically on the consequences of so-called "hard" illegal drug use--especially crack cocaine--at the expense of recognizing that alcohol is the number one drug of abuse in this country and is commonly associated with substance abuse-related child maltreatment.

2) Child welfare agency directors and family court judges should arrange for timely, appropriate treatment and services for substance-abusing parents. Evaluations of treatment programs that are tailored to the multiple needs of women have found encouraging results.[21] A study of comprehensive programs for new mothers, whose primary drugs were crack cocaine and alcohol, found that after nine months of completing treatment, 77.8 percent of mothers were sober and drug-free.[22]

These treatment programs generally include mental and physical health services for women, child care assistance (some allow women to bring children with them to treatment), pediatric services for children, individual and single-sex group therapy, marital or family counseling, parenting education, literacy programs and job training.[23] They are sensitive to the lack of self-esteem suffered by many of these women, the lack of social skills and maturity, the prominent role of being subjected to violence during their lives and the challenges of poverty and unemployment they often face.[24]

Many female addicts require residential treatment that is longer than the 28 day (or shorter) reimbursement limit in many insurance or managed care policies. Treatment that lasts at least three months is associated with significant reductions in drug use, predatory illegal activity, sexual risk behaviors and suicidal thoughts.[25] Many addicts require even longer periods of treatment. Aftercare is also critical. Insurers and managed care providers who skimp on the length and quality of treatment are seeking a bargain that doesn't exist.

The need to provide this kind of treatment is increasingly urgent given the federal welfare reform law, which limits the benefits women can receive to five years; many states have set a two year limit. How the nation responds to this challenge will have a direct impact on the safety and well-being of the nation's children.

3) Child welfare agency directors and family court judges should use strategies to motivate parents to engage in treatment. The threat of permanently losing custody of children is a big reason why many women enter treatment and remain sober and drug-free.[26] But the threat of losing custody is not always enough. Alcohol and drug addiction can sap and destroy natural parental instincts. Child welfare officials need other strategies to motivate mothers.

Although their efforts have not been rigorously evaluated, the use of paraprofessionals to engage parents in treatment is a particularly promising innovation.[27] Help and encouragement from a woman who has been "there" may resonate with an addicted woman in a unique and powerful way. Support groups like those in Sacramento County may also bolster the motivation of parents. The appropriateness of treatment is another important factor in the motivation of addicts.[28] Treatment programs that focus on the needs of women report better retention rates than those that have not been tailored for women.[29]

Women in Recovery

In 1997, CASA spoke with a group of women in substance abuse treatment. This is what one said about her children:

My son was in [foster care]. I picked up [and started using drugs again] because I was stressing and I was upset about not having my son with me. I didn't think I was ever going to get my son back, and my whole thing at the time was [that] I was quitting for my son. But right now, I'm not just quitting for my son, I'm quitting for both of us.

--CASA Focus Group, June 13, 1997

Family drug courts are a promising innovation to motivate parents. The intense monitoring, frequent face-to-face engagement with a judge and immediate carrots and sticks--including threat of incarceration for criminal or civil contempt--may influence a parent's behavior in ways that the current system of infrequent monitoring, loose connections to caseworkers and a distant threat of losing parental rights have not. Yet only careful evaluations of the family drug courts sprouting across the country will provide the answer.

4) Child welfare agencies and family court judges should take steps to prevent and prepare for relapse before closing cases. Because substance abuse is a chronic disease, relapse is not necessarily a sign that treatment has failed.[30] Caseworkers and judges need to understand how relapse, when recognized and addressed, can be a phase in the recovery process, rather than a sign that attempts toward recovery are futile. They need to employ strategies to prevent relapse and plan for child safety if it occurs, particularly in the first three months after treatment when relapse is most likely.[31] Without these strategies, child welfare officials are consigning themselves to the dismal work of re-opening cases as child maltreatment recurs.

Preventing relapse involves creating and strengthening skills to cope with the anxiety that is often linked to relapse.[32] Mothers need aftercare that addresses the stresses of parenting, and they may prefer support group programs that are all-female.[33] Families with low-incomes are most likely to lack the social networks and financial resources that provide support and relief for parents who are under stress. For them, making connections to support groups, individuals who are in recovery and affordable child care may be particularly important.

Child welfare officials can help create this network of support in three ways. They can connect an individual to a support group such as Alcoholics Anonymous or Narcotics Anonymous and encourage attendance. They can employ paraprofessionals--women who are in recovery from alcohol and drug addiction--to

work with women who have substance abuse problems and provide support that may extend beyond the formal closing of cases. And they can prepare a plan for protecting the child's safety if the parent lapses, such as helping to establish a protocol in which a relative or friend agrees in emergencies to care for the child while the parent seeks to prevent a lapse from becoming an all-out "relapse."[34]

Child welfare officials need to continue monitoring cases and offering support for at least three months after a parent completes treatment and regains custody of his or her children.[35] Though many child welfare officials say they cannot afford such support, one observer notes that they already are doing so in the form of opening, investigating, closing and re-opening cases, a cycle that may repeat itself many times given the chronic nature of addiction.[36] The child welfare system is providing long-term services to these families, a costly practice that fails to protect children.

Children need adults to attach to in order to experience relationships, become socialized and grow to be functioning members of society. If, despite society's best supports, the adults biologically related to the child cannot provide this nurturing, the best interests of the child and society require that essential connections be made in other ways.[37]

5) Child welfare agency directors and family court judges should remove barriers to permanent placement when appropriate by establishing criteria for reasonable efforts when a parent is abusing alcohol and/or other drugs. Due to the urgent developmental needs of children and the chronic nature of substance abuse, the best outcome for some children is placement in a home with adoptive parents or a legal guardian. One of the biggest barriers to adoption is the inability of child welfare officials and family court judges to decide when "reasonable efforts" have been made to help a family.

Ideally, child welfare officials and family court judges could determine which substance-abusing parents are least likely to benefit from interventions and most likely to continue abusing or neglecting their children.[38] This would allow public officials to move more assertively to terminate parental rights, divert resources from these parents and focus on parents who are more likely to benefit.[39] Unfortunately, it is difficult to predict who will respond to treatment and when they will do so.[40]

Deciding when it is appropriate to sever parental rights remains more art than science, but the child welfare system can establish a framework for timely resolution of cases by assuring that individuals get a fair shot at becoming responsible parents and then moving expeditiously to terminate parental rights if they fail to take advantage of it.

However, some important indicators do exist. A woman who makes an effort to get prenatal care or substance abuse treatment, and who identifies with her parental role is more likely to be ready to become a responsible parent than one who makes no such efforts, expresses no such identification and refuses the efforts of others to help her.[41] Parents who refuse to enter appropriate treatment, drop out early from treatment or persistently deny responsibility for their child's abuse or neglect are most likely to re-abuse or neglect their children.[42] These behaviors should trigger proceedings to free the child for adoption or other permanent placement, even while child welfare officials continue to offer services with the hope of reunifying the family if the parent makes significant progress in her parenting abilities before the proceedings are complete.

Defining Reasonable Efforts

The first four elements of practice recommended by CASA--screening and assessment, access to timely and appropriate treatment and services, a strategy to motivate mothers, and prevention and preparation for relapse--provide a framework of "reasonable efforts" that are required when a parent is abusing alcohol and drugs. Judges can look at the results of these concerted efforts and decide when parents are unresponsive to the best efforts of public agencies or when they are ready to regain custody of their children.

Other possible triggers are a parent's abandonment of a child, a parent who repeatedly maltreats a child and a parent who uses alcohol and drugs during more than one pregnancy.[43] Judges should also consider whether a parent has relatives or friends who can help protect and care for the child during relapses and whether the bond between parent and child is strong.[44] The intensive needs of infants, especially those with medical problems, should also be important considerations when deciding whether a parent is fit to raise a child.

Ideally only when comprehensive efforts have been made to engage parents in effective treatment and heal families ravaged by substance abuse should the child welfare system give up, but resources are not available in many situations to mount such efforts. For some children, the best outcome may indeed be "giving up." Judges can consider open adoptions (where the biological parent maintains a relationship with the child after adoption is finalized) when they want to sustain the bonds that have formed between children and parents. But these children should not be condemned to languish for years in foster care while a child welfare system dithers with futile efforts to reunify families or fails to marshal the necessary resources and action to terminate parental rights and state legislatures do not provide needed resources.

III. Fund Comprehensive Treatment

Comprehensive treatment that is appropriate for parents is the linchpin of strategies to prevent further maltreatment by substance-abusing parents. Such treatment should be accompanied by a host of related services that can enhance its effectiveness: literacy, parenting skills, and job training, healthcare and social services. Yet the supply of this treatment falls dramatically short of demand.[45] Federal and state policymakers must recognize and respond to this critical need. Innovators in the child welfare field must commit their efforts to marshal federal, state and private resources to fund treatment that will work with substance-abusing parents who maltreat their children.

Child welfare directors and judges must be vocal about the urgent and vital need for more treatment slots. In addition, directors of state-level mental health and substance abuse agencies should be vigilant that appropriate, publicly funded treatment is available and accessible to parents within the child welfare system. Treatment providers also need to respond to the needs of substance-abusing parents, particularly mothers. Additional federal funding should be specifically designated for residential programs that permit women and children.

State Sources for Funding Substance Abuse Treatment

- *The National Association of State Alcohol and Drug Abuse Directors (NASADAD) can provide state contacts and further assistance to those seeking funding from state alcohol and drug programs.*
- *Federal law requires that states spend 10 percent of their Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant on alcohol and drug prevention and treatment services for women.*

Sources for Funding Substance Abuse Treatment

- *The largest single source of funding for treatment is Medicaid. Medicaid is a jointly-funded, Federal-State health insurance program for certain low-income and needy people. It covers approximately 36 million individuals.*
- *Federal Title IV-B of the Social Security Act funds (Child Welfare Services and Promoting Safe and Stable Families (formerly Family Preservation)) focus on strengthening families, preventing abuse, and protecting children.*
- *Federal Title IV-E of the Social Security Act allows a state to use foster care money (under IV-E) to fund other programs including services for children and their families and parental substance abuse treatment.*
- *Title XX Social Services Block Grants can be used to provide services to children and families.*
- *The Center for Substance Abuse Treatment (CSAT) supports treatment programs, and particularly provides funding for treatment for pregnant and parenting women.*
- *The Center for Substance Abuse Prevention (CSAP) supports alcohol and drug education and prevention efforts.*
- *The National Institute on Alcohol Abuse and Alcoholism (NIAAA) provides funding for research and demonstration projects.*
- *The National Institute on Drug Abuse (NIDA) provides funding for research and demonstration projects.*
- *Federal law requires that states spend 10 percent of their Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant on alcohol and drug prevention and treatment services for women.*
- *The National Association of State Alcohol and Drug Abuse Directors (NASADAD) can provide state contacts and further assistance to those seeking funding from state alcohol and drug programs.*

IV. Provide substance abuse training for all child welfare, court, social and health service professionals.

Social service providers from agency directors to frontline child welfare workers, judicial officials from judges to lawyers, and social and health service professionals need training in the nature and detection of substance abuse and addiction, and what to do when they spot it. Substance abuse training should be a required element in certification and licensing requirements for child welfare professionals.

The case studies demonstrate two different ways to integrate an understanding of substance abuse and addiction into child welfare practice: provide focused and intensive training for caseworkers so that they can screen for and assess the severity and appropriate treatment of substance abuse and addiction (Sacramento County), or provide only basic training on substance abuse to those who work on child welfare cases and purchase higher level expertise from outsiders to assist and strengthen their efforts in practice (New Jersey, Connecticut and the family drug courts in Reno, Nevada, Pensacola, Florida, and Suffolk County, New York). Based on the experience in these sites, the latter strategy appears to be an easier fit, at least in the short term, for caseworkers who resist dramatically reconfiguring their job responsibilities. In the long term, a rethinking of the job responsibilities for caseworkers may be in order, given that some 70 percent of cases involve substance abuse.

In either case, child welfare directors and judges need to accept responsibility for training themselves and their employees to understand, recognize and respond effectively to the substance abuse problems that are driving their caseloads. For social service workers, masters degree programs and post-graduate courses can contribute by including this basic training at a minimum. In addition, social worker unions should encourage their members to receive substance abuse training by treating it as a vital component of effective practice.

Chief Justices, attorneys general and bar associations should place an emphasis on training all court personnel in substance abuse issues. The Supreme Judicial Court Substance Abuse Project Task Force in Massachusetts has recommended comprehensive substance abuse training for all judges, clerk magistrates, probation officers and court-appointed professionals such as guardians and defense counsels, and hiring specialists who can assist judges by performing timely substance abuse evaluations and making treatment recommendations.[46] Further, substance abuse should be considered a worthwhile and needed topic for continuing legal education programs, particularly in those states that require attorneys to participate in continuing legal education.

V. Evaluate outcomes, increase research and improve data systems.

States need to respond regularly and uniformly to national efforts to track basic information about the families involved with the child welfare system. Federal officials should encourage and assist states to meet basic data reporting requirements. Data systems are inadequate to provide basic information on children under supervision, caseworker caseloads, substance involvement or outcomes. States must place a priority on updating case filing and tracking by the agency by upgrading information systems and computers.

Child welfare officials and family court judges need to collect better data and evaluate the outcomes of their efforts in cases when substance-abusing parents maltreat their children. Until recently, little was known about how to help addicted mothers achieve a sober and drug-free lifestyle and become responsible parents. A small but growing number of evaluations of interventions with pregnant and parenting women who are addicted is providing important lessons to leaders in the field who are ready to invest in effective models. Child welfare officials need to build on this research by evaluating their own innovative efforts.

Sound evaluations require good outcome measures. Until recently, much of the research in the field of child welfare focused solely on whether cases were open or closed, or whether children were in foster care or with their biological families.[47] These outcomes say little about the long-term prospects for children of substance-abusing parents. The new generation of evaluations, some of which are underway, should include measures of parental functioning, substance use and abuse, the child's safety during relapses, indicators of child health and developmental progress, the recurrence of maltreatment and long-term resolution of cases.[48]

Most importantly, research should focus on how to motivate individuals to seek treatment, how to discern predictors of success in treatment and on benchmarks of progress that parents who have been referred to treatment must hit in order to demonstrate to child welfare officials their commitment to both recovery and their children.

Where to Begin?

To implement these strategies, child welfare officials and judges must overcome significant structural and cultural hurdles in the field. Innovators are learning lessons the hard way; others can integrate these lessons learned from those experiences into their own programs from a more comfortable distance:

I. Learn how to integrate services across agency lines.

Child welfare agencies and family courts cannot by themselves effectively serve the multi-problem families with substance abuse problems who land in the child welfare system. They need to forge relationships across agency lines to coordinate service delivery, accommodate differing timelines whenever possible and eliminate efforts that are either duplicative or at cross purposes. These collaborations require hard work, face-to-face meetings and creative thinking to resolve problems. They are often thwarted by cultural, bureaucratic and funding barriers.[49] Even basic concerns about confidentiality can be a stumbling block to joining efforts.[50]

A good place to start is to convene the leaders of agencies--both public and private--who serve families involved with the child welfare system to develop shared values (such as functional, sober and drug-free parents who do not maltreat their children) and urgent joint action (such as assessing and meeting the treatment needs of addicted individuals who are in moments of crisis).[51] Child welfare officials and treatment providers may have little in common, but they do share an important goal: preparing an individual to handle the stresses and responsibilities of being a parent is a critical component of both recovery from addiction and the protection of children.[52]

In family drug courts, judges provide the leadership that brings the key individuals to the table--and keeps them coming back. In child welfare agencies, leadership has to start at the top to create the pressure needed for employees to resolve stumbling blocks that would otherwise paralyze fragile collaborations. Shared goals, adequate funding and positive results provide the glue that makes these new relationships endure over time.

II. Prepare to change organizational culture and practice--one employee at a time.

Reorienting child welfare practice to address substance abuse effectively involves recasting job responsibilities and qualifications in ways that are bound to raise anxiety about job security and pay, and skepticism about the wisdom of the innovation. The process of implementing these changes may suddenly push employees from a sense of competence to one of incompetence, from a sense of stability to one of confusion.[53] As one observer of organizational change has noted, "People resist *being* changed--especially when the change appears to have a payoff primarily for someone else."[54]

Changing organizational policy, practice and culture is a painstaking process that requires commitment and time from agency directors and judges. Like those in so many social service systems, child welfare employees have seen many "innovations" come and go like the latest fashion, and large public reports that predict doom and produce negligible response. Enlisting these seasoned employees is a task that no one should underestimate.

The rough experience in Sacramento County demonstrates the price of neglecting this challenge. The case studies in New Jersey, Florida and New York demonstrate the rewards of forging agreement among program participants about the nature of the problem and confidence in the proposed innovation that will sustain participants through the inevitably rocky process of implementing it.[55]

Conclusion

The tight connection between substance abuse and child maltreatment can be daunting. But inaction in the face of children who are suffering abuse and neglect that could very well have been prevented is an option no one supports. As a nation and as members of our communities, we need to reshape the public response to the crisis in our child welfare system. We can do this by facing up to the role that alcohol and drugs play in maltreatment, by taking clear steps outlined in this report to protect children who suffer at the hands of parents who abuse alcohol and illegal drugs, and by investing in treatment to secure and support one of America's most valuable resources--our families.

CHAPTER I.

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CHAPTER II.

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CHAPTER III.

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Question: What are the biggest barriers to getting parents into appropriate substance abuse treatment? (CIRCLE ALL THAT APPLY.)

a. lack of outpatient treatment
b. lack of residential treatment
c. lack of motivation by the parent
d. lack of child care (other than foster care)
e. lack of insurance coverage for treatment
f. other: _____

Because only one of them--lack of motivation-- represented an internal characteristic, this bias may somewhat compromise the results from this survey question.

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CHAPTER IV.

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APPENDIX A

Survey Questionnaire

SURVEY ON
CHILD MALTREATMENT AND SUBSTANCE ABUSE

The National Center on Addiction and Substance Abuse at Columbia University is conducting a study of child maltreatment cases that involve substance abusing parents. We are seeking the views of professionals who work in child welfare and family courts regarding the nature of the problem and opportunities to improve outcomes for children and families. Please circle the answers of your choice, or fill in the blank where required. ***We expect that some questions will require your best guess. Your responses will be confidential.***

I. YOUR NAME: _____

II. YOUR JOB TITLE AND BRIEF JOB DESCRIPTION: _____
_____

III. THE CITY OR TOWN AND STATE IN WHICH YOU WORK:

City or town: _____
State: _____

IV. TYPE OF COMMUNITY IN WHICH YOU WORK (CIRCLE ONE):

a. major urban area
b. suburb of a major urban area
c. small city or town
d. rural community
e. a combination of _____

V. YEARS YOU HAVE WORKED IN CHILD WELFARE/FAMILY COURT: _____ years

VI. COLLEGE AND GRADUATE DEGREES, IF ANY, YOU HAVE:

a. Associate degree
b. Bachelors degree
c. Masters degree of _____
d. Doctoral degree of _____

****

1) The number of child abuse and/or neglect reports rose from 1.9 million in 1985 to 3.1 million in 1995. In your opinion, what are the most important causes of this increase?

Most important cause: _____
Second most important cause: _____
Third most important cause: _____

2) In your area, what percentage of child abuse and/or neglect cases involve substance abuse (excessive drinking and/or abuse of illegal or prescription drugs)?

a. 75% or more
b. 50% - 74%
c. 25% - 49%
d. less than 25%
e. don't know

3) Do child welfare workers routinely screen parents for substance abuse?

a. yes
b. no
c. don't know

4) IF YES, how do they screen for substance abuse? (CIRCLE ALL THAT APPLY.)

a. by questioning parent regarding substance use
b. by using assessment tools such as CAGE or SASSI
c. drug test for illegal drug use
d. other: _____
e. don't know

5) Is there a place on child welfare intake forms where the presence or absence of substance abuse by parents must be recorded?

a. yes
b. no
c. don't know

6) Have child welfare workers received any training in substance abuse?

a. yes
b. no
c. don't know

7) IF YES, what kind of training and for how long? _____
_____
_____

8) When parents in child abuse and/or neglect cases are substance abusers, what kind of substance do parents most commonly abuse? (CIRCLE ONE.)

a. alcohol only
b. illegal drugs only
c. a combination of alcohol and illegal drugs
d. prescription drugs only
e. a combination of prescription drugs and alcohol
f. other: _____
g. don't know

9) WHEN ILLEGAL DRUGS ARE USED, what drug do parents most commonly abuse?

a. marijuana
b. powder cocaine
c. crack cocaine
d. heroin
e. methamphetamine
f. other: _____
g. don't know

10) What percentage of child abuse and/or neglect cases in which a parent is a substance abuser involve:

solely physical abuse? _____%
solely sexual abuse? _____%
solely neglect? _____%
a combination of physical or sexual abuse and neglect? _____%

11) Are children of substance abusing parents more likely, equally likely or less likely to remain with their parents compared to children whose parents are NOT substance abusers?

a. more likely
b. equally likely
c. less likely
d. don't know
EXPLAIN: _____
_____
_____

12) Are children of substance abusing parents who are removed from their homes likely to be in foster or kinship care for more time, the same amount of time or less time than children whose parents are NOT substance abusers?

a. more time
b. same amount of time
c. less time
d. don't know

EXPLAIN: _____
_____
_____

13) In your area, under what conditions do family courts return a child to a parent with a history of substance abuse? (CIRCLE ALL THAT APPLY.)

a. parent completes treatment
b. parent has been abstinent for a period of time
c. parent appears ready and able to assure child safety
d. other: _____
e. don’t know

14) When family courts return children to parents with a history of substance abuse, how often do parents relapse into drug and/or alcohol abuse?

a. always
b. sometimes
c. rarely
d. never
e. don't know

15) When parents have a history of substance abuse, in what percentage of cases does abuse or neglect recur?

a. 75% or more
b. 50% - 74%
c. 25% - 49%
d. less than 25%
e. don't know

16) What are the most common behaviors by parents who are substance abusers that lead to termination of parental rights? (CIRCLE ALL THAT APPLY.)

a. severe abuse
b. repeated abuse
c. severe neglect
d. repeated neglect
e. one failure to complete substance abuse treatment
f. more than one failure to complete substance abuse treatment
g. a birth of a baby who tests positive for illegal drugs
h. more than one baby who tests positive for illegal drugs
i. other: _____
j. don't know

17) In your opinion, what behaviors by parents who are substance abusers SHOULD lead to termination of parental rights? (CIRCLE ALL THAT APPLY.)

a. severe abuse
b. repeated incidents of abuse
c. severe neglect
d. repeated incidents of neglect
e. one failure to complete substance abuse treatment
f. more than one failure to complete substance abuse treatment
g. a birth of a baby who tests positive for illegal drugs
h. more than one baby who tests positive for illegal drugs
i. other: _____
j. don't know

EXPLAIN: _____
_____
_____

18) In your area, are any of the following alternatives to traditional adoption commonly used when a parent is a substance abuser? (CIRCLE ALL THAT APPLY.)

a. open adoptions
b. guardianship by a kinship caregiver
c. other: _____
d. none are commonly used
e. don't know

19) How do child welfare agencies and family courts decide what type of treatment is appropriate for a parent who is a substance abuser? (CIRCLE ALL THAT APPLY.)

a. based on caseworker's assessment
b. based on what treatment is available
c. other: _____
d. don't know

20) What are the biggest barriers to getting parents into appropriate substance abuse treatment? (CIRCLE ALL THAT APPLY.)

a. lack of outpatient treatment
b. lack of residential treatment
c. lack of motivation by the parent
d. lack of child care (other than foster care)
e. lack of insurance coverage for treatment
f. other: _____

21) What is the average wait before entry to RESIDENTIAL treatment becomes possible?

a. no wait/immediate entry
b. less than 1 month
c. 1 to 3 months
d. more than 3 months
e. don't know

22) What is the average wait before entry to OUTPATIENT treatment becomes possible?

a. no wait/immediate entry
b. less than 1 month
c. 1 to 3 months
d. more than 3 months
e. don't know

23) In general, how effective is substance abuse treatment at substantially reducing or eliminating substance abuse by parents who enter treatment?

a. very effective
b. somewhat effective
c. somewhat ineffective
d. very ineffective
e. don't know

24) IF TREATMENT IS GENERALLY INEFFECTIVE, why?

a. poor quality of treatment
b. parents lack motivation to deal with substance abuse problem
c. lack of community-based support for addict after treatment
d. addiction is inherently untreatable
e. other: _____

25) When a family court orders a parent to enter substance abuse treatment, what percentage of parents actually enter treatment?

a. 75% or more
b. 50% - 74%
c. 25% - 49%
d. less than 25%
e. don't know

26) In child abuse and/or neglect cases, what percentage of parents who complete substance abuse treatment participate in an after-care program (e.g. Alcoholics Anonymous or Narcotics Anonymous)?

a. 75% or more
b. 50% - 74%
c. 25% - 49%
d. less than 25%
e. don't know

27) In your opinion, should evidence that a woman used illegal drugs or drank heavily during pregnancy, in and of itself, lead to removal of the child at birth?

a. yes, it should
b. no, it should not
c. don't know

28) In child abuse and/or neglect cases involving substance abusing parents, what changes in policy or practice would you recommend? _____
_____
_____
_____
_____
_____

Would you be willing to talk further about these issues with a staff member of the National Center on Addiction and Substance Abuse? If so, please write your phone number and the best time to reach you.

PHONE NUMBER: _____
BEST TIME: _____

Would you like to receive a summary of the results of the survey? yes _____

If yes, to what address should we send the results?
_____
_____
_____

Thank you very much for your time!

Appendix B
Survey of Child Welfare Professionals, Methodology

From October 1997 through January 1998, The National Center on Addiction and Substance Abuse at Columbia University (CASA) distributed a 28-question written survey to 3,486 professionals (judges, attorneys, child welfare agency directors, child advocates and frontline child welfare staff) in the child welfare system. A copy of the survey appears in Appendix A.

The sample was randomly drawn from membership lists from several professional organizations: The National Council of Juvenile and Family Court Judges, the National Association of Council for Children, the National Association of Court Appointed Special Advocates. In addition, using membership lists from the Child Welfare League of America and the American Public Welfare Association, CASA distributed the survey to the 51 United States state child welfare directors and the child welfare agency directors from the 52 largest counties (by population). Four child welfare agencies also agreed to distribute our survey to their frontline workers and supervisors in their respective cities: New York, NY, Los Angeles, CA, Pensacola, FL and Wichita, KS.

Christopher Bruzios coded the survey and entered the survey for analysis. Marc Glassman, Ph.D. advised CASA on survey weighting and analysis.

Response Rate

CASA received 915 surveys, representing a response rate of 26.2 percent. CASA received at least one survey from each state in the country. (See Table 1, Response Rate by Job Title, and Table 2, Distribution of Respondents by Job Category.)

Demographic Information

CASA grouped respondent data into four geographic zones following U.S. Census Bureau classifications. Responses are fairly evenly distributed between the four zones. The Northeast had a slightly lower response rate than the other three zones and had a disproportionately higher number of frontline worker responses. A higher number of court-appointed special advocates responded from the South (47.6 percent of all court appointed special advocates were from the South). A higher number of attorneys responded from the West than any other region. (See Table 3, Distribution of Respondents by Geographic Zone.)

Forty-two percent of the respondents reported being from a major urban area; 18.1 percent of respondents reported working in a small city; 9.4 percent of respondents reported working in a suburb of a major urban area; 5.0 percent of respondents reported working in a rural setting. All state child welfare directors reported representing "all state."

Of the total sample 42.0 percent had doctoral degrees (largely attorneys and judges); 22.8 percent of all respondents had a master's degree; 32.5 percent of all respondents have a bachelor's degree and 2.7 percent of all respondents had an associate's degree. Essentially, all respondents are college educated. Among frontline staff, 35.8 percent had a master's degree, 63.8 percent had a bachelor's degree and 0.4 percent had an associate's degree.

Sample Design and Weighting

The sample for this study would ideally be comprised of representative sub-samples of the members of the professional groups which constitute the child welfare system, i.e., judges, attorneys, state and county child welfare directors, court appointed special advocates and "frontline" child welfare agency staff. However, achieving this requires the availability of

suitable population sampling frames from which to draw the sub-samples. Such sampling frames exist only for child welfare agency directors; the cost and time required to develop the remaining sampling frames was prohibitive. Given that fact, the questionnaire was distributed to 3,486 individuals either randomly drawn from the membership lists of purposively selected organizations or those currently occupying agency directorships in the 50 states and 52 largest counties in the United States.

Nine hundred and fifteen of these individuals elected to participate in the study. Due to the lack of data on the size or composition of the total population in each of these groups, the representativeness of these individuals, either as members of their respective professional groups or in toto as a sample of the national population of child welfare professionals cannot be assumed. For this reason, CASA decided to weight the survey results giving equal weight, i.e., equal representation, to each of the six occupational groups and each of the four census regions in all tabulations based on the total sample. That is to say, judges, attorneys, state and county child welfare directors, court appointed special advocates and social workers each represent approximately 16.7 percent of the weighted sample. Similarly, respondents from the Northeast, South, Midwest and West regions of the country each represent 25.0 percent of the weighted sample.

We recognize that some professional groups, e.g., judges and frontline staff, even in a demonstrably representative sample, would have lesser or greater influence on the total sample results simply as a function of differences in their relative sizes. This is, of course, what is intended in a study whose purpose is to reflect a "natural population" state of affairs, i.e., smaller subgroups contribute less to the overall results than do larger subgroups. However, without knowing the relative sizes of these sub-samples on a national scale, it seemed reasonable to consider the "voice" of each professional group and each region to be equally important in setting the national agenda for public policy in child welfare. Viewed from this perspective, each professional group and region should receive equal consideration in forging this agenda, regardless of its actual size.

Weighting the sample to give equal voice to each sub-sample also seemed appropriate given the survey's purpose to examine opinions and perspectives, rather than to collect epidemiological data regarding child maltreatment. By way of analogy, "natural" population sampling would define the total sample in a way consistent with a "House of Representatives" view of the total population; each state is represented in proportion to its population or relative size. "Equal voice" sampling is consistent with a "Senate" view of the total population in that each state is represented equally regardless of its relative size.

The fact that we could not weight the sample to reflect the unknown population distribution of child welfare professions in terms of key demographic variables like professional group and region, coupled with our belief that the "equal voice" sampling perspective better suited the agenda-setting purposes of the study were the rationales for our decision to weight the data as described above. Having done so, the reader should understand that the weighting, in effect, constructs a "synthetic" total sample which does not reference the actual, i.e., the "natural population" of child welfare professionals, whatever that may be.

For the few comparisons of responses between professional and geographic categories, CASA used unweighted data. That is, there was no advantage to weight the data when comparing, for example, how child welfare workers and child welfare agency directors responded to a particular question.

TABLE 1
RESPONSE RATES BY JOB TITLE

JOB TITLE	RESPONSES RECEIVED	TOTAL SURVEYS SENT	RESPONSE RATE (PERCENT)
Judges	160	650	24.6
Attorneys	203	650	31.2
Child Welfare Directors	83	111	74.8
State	35	51	68.6
County	48	60	80.0
Court Appointed Special Advocates	185	650	28.5
Frontline Staff	284	1,425	19.9
New York	90	600	15.0
Los Angeles	79	600	13.2
Pensacola	61	160	38.1
Wichita	52	65	80.0
TOTAL	**915**	**3,486**	**26.2**

TABLE 2
DISTRIBUTION OF RESPONDENTS BY JOB CATEGORY

JOB TITLE	NUMBER OF RESPONDENTS	PERCENT OF TOTAL SAMPLE
Judges	160	17.5
Attorneys	203	22.2
Child Welfare Directors	83	9.1
Court Appointed Special Advocates	185	20.2
Frontline Staff	284	31.0
TOTAL	**915**	**100**

TABLE 3
DISTRIBUTION OF RESPONDENTS BY GEOGRAPHIC ZONE

GEOGRAPHIC ZONE	PERCENT OF RESPONDENTS
Northeast	20.1
South	27.6
Midwest	24.4
West	27.9
TOTAL	**100**

Appendix C
Case Study Methodology

The purpose of CASA's case study research was to examine a child welfare agency or family court that has implemented or is implementing an innovation i.e., a planned, conceptual change in policy and practice, to improve outcomes for children whose parents are substance abusers. In order to choose appropriate case study subjects, CASA used the following strategy:

CASA developed a list of possible candidates for case study subjects through its comprehensive literature review and interviews with leaders in the field. The literature review is a primary basis for determining the focus of a case study and case study site selection.[*] As a result of this research and earlier CASA reports, CASA determined guiding principles for site selection. According to Yin (1994), theory and policy are proper influences on case study site selection.[†]

CASA theorized that innovations within the child welfare agency and the family courts would be most relevant to this report. Stake (1995) notes, "Balance and variety are important: opportunity to learn is of primary importance." [‡] After assembling a list of final candidates, CASA considered which selection of subjects would provide the appropriate cross-section of approaches and developments within child welfare system.

In choosing a suitable case study subject and subsequently conducting a case study, access to data and information is a pivotal consideration.

In order to be considered for CASA's study, potential case study candidates were required to be willing to provide CASA researchers access to a wide range of personnel, internal and external written communications, data and outcome research. CASA researchers requested access to various personnel, including leaders, managers and employees, past and present, who have been involved in or affected by the conceptualization, development and implementation of the innovation, and to selected parents.

The child welfare agency or family court also needed to provide quantitative data, policy statements, memos, correspondence, budgets, case records and other relevant documents describing the innovation and demonstrating the nature of the change. The child welfare agency or family court must allow CASA researchers to observe policy and administrative meetings regarding the innovation, and the components of the innovation in practice. In addition, the candidate would be required to provide access for CASA researchers to any outcome or process evaluation data.

Research Questions

The following research questions guided the case study research. During the site selection process, CASA considered the ability of each candidate to respond to the questions and the projected demonstrative value of that information.

1) In the child welfare agency or family court, what was the problem that led to the innovation, and what precipitated action?

2) What was the proposed innovation and how would it address the problem?

[*] Yin, R. (1994). *Case Study Research: Design and Methods, Second Edition*. Thousand Oaks, CA: Sage Publications; Yin, R. (1993). *Applications of Case Study Research*. Thousand Oaks, CA: Sage Publications.
[†] Yin, R. (1994). *Case Study Research: Design and Methods, Second Edition*. Thousand Oaks, CA: Sage Publications; Yin, R. (1993). *Applications of Case Study Research*. Thousand Oaks, CA: Sage Publications.
[‡] Stake, R. (1995). *The Art of Case Study Research*. Thousand Oaks, CA: Sage Publications.

3) How was the innovation implemented and what barriers were overcome?

4) How does the innovation work in practice, and how does this differ from its original conception?

5) How did the innovation address or not address CASA's perception of critical weaknesses in policy and practice regarding child welfare cases that involve substance abuse

6) What have been the outcomes of the innovation and what lessons have been learned?

Appendix D
Cost Methodology

Calculating Spending on Child Welfare

CASA based its projections of 1995 spending on estimates of government spending on child welfare by The Urban Institute (UI), which has conducted the most comprehensive analysis of national child welfare spending published to date. UI estimates that federal spending in conjunction with required state matching funds in 1995 equaled $14.4 billion.[1] This estimate includes Title IV-E Foster Care, Title IV-E Adoption Assistance, Title IV-E Independent Living, Title IV-B Child Welfare Services, Child Abuse Prevention and Treatment Act (CAPTA) funding and Title XX Social Services Block Grant money, state matching funds and additional identifiable state and local money.

Limitations of Cost Estimations

This estimation of costs has two major limitations: first, it does not account for changes in spending patterns between 1995 and 1999. However, surveys by the National Committee to Prevent Child Abuse show no clear trend in increases or decreases in child welfare spending in recent years.[2] We have assumed, for purposes of this report, that 1998 national child welfare costs are similar to those in 1995. Second, this estimate is conservative. The UI reports that its estimates do not account for all child welfare monies because some states could not separate these funds from other non-child welfare funding streams.

Proportion of Cases Attributable to Substance Abuse

As has been acknowledged in other sources, reliable national data documenting the prevalence of substance abuse among child welfare cases is not available. Although the State Automated Child Welfare Information System (SACWIS), the Adoption and Foster Care Analysis and Reporting System (AFCARS), and other national data collection programs are evolving, data collection systems are still far from fully operational.

The data that are available suffer from three major methodological problems that make it impossible to confirm the prevalence of substance involvement among child welfare cases. First, study samples may not be large enough to account for sampling errors. Second, samples represent only certain areas of the country. Third, the definitions of substance abuse and addiction vary.

Little methodologically-strong data regarding parents involved with the child welfare system exist. Although there are some parallels between the population of parents cited for child abuse and neglect and recipients of other social services, it is incorrect to assume that prevalence of use, abuse and dependence is equal to those of other social service recipients. Research establishing the prevalence of substance involvement (use, abuse or dependence) generally relies on inconsistent definitions of these terms and of the degree of substance involvement. Moreover, studies are inconsistent in defining whether substance involvement is the primary or causal reason for a parent's involvement with the child welfare system or whether substance involvement is an ancillary or co-occurring problem.[3]

The most rigorous studies analyzing documented cases this decade indicate that 50 to 78 percent of all cases are reportedly affected by substance abuse.[4] CASA's survey and others indicate that child welfare professionals consider the lower end of this range to be an underestimate.[5] Forty percent (39.7) of child welfare professionals responding to the CASA survey estimate that substance abuse causes or contributes to at least 75 percent of their cases. An additional 39.9

percent estimate that substance abuse affects 50 to 75 percent of their caseload.[6] CASA's case studies identified prevalence rates between 60 and 97 percent.[7]

Based upon a substantial review of the literature related to the prevalence of substance abuse among parents involved with the child welfare system and CASA's own survey of child welfare professionals, CASA estimates that substance abuse causes or contributes to about 70 percent of child welfare cases.

CASA believes its estimate that 70 percent of the child welfare caseload is substance-involved is a fair characterization of the landscape of child welfare spending. We acknowledge that this estimate does not mean that 70 percent of all parents involved with the child welfare system would not be there if their substance abuse problem were addressed or that 70 percent of cases involve parents who are addicted. Rather, in 70 percent of the child welfare cases, substance use or abuse is a critical factor associated with a parent's appearance in the child welfare system; and a critical factor in a parent's successful and permanent departure from the system.

Estimated Costs Attributable to Substance Abuse

Total child welfare spending in 1998 equaled approximately $14.4 billion. Applying CASA's estimated prevalence (70 percent), costs linked to substance abuse in the child welfare system are approximately $10 billion. This estimate does not imply that by addressing substance abuse we could eradicate these costs entirely. Rather it gives an estimate of the magnitude of costs linked to this condition and a starting point for developing better estimates of avoidable costs.

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