The Impact of Substance Use Disorders On Women Involved in Dependency Court[†]

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INTRODUCTION

Women are entering substance abuse treatment in increasing numbers and, often, come to treatment as the result of their involvement in dependency court.[1] Unfortunately, traditional substance abuse treatment models are not designed to address women with children and multiple vulnerabilities. Part I of this Article reviews the literature and data discussing the relationship between child abuse and neglect and substance abuse. Part II identifies referral pathways through which women enter substance abuse treatment, focusing on the referral process in the Hillsborough County, Florida dependency courts. Part III describes the role of dependency courts in encouraging compliance with substance abuse treatment recommendations. Part IV identifies innovative substance abuse treatment models that address women and their children. Part V describes the methodology and findings of key informant interviews and file reviews, which were conducted to uncover the complex

† Editor's Note: Many of the assertions in this Article are based on the observations and experiences of the authors. *The Journal* disclaims responsibility for any factual inaccuracies contained herein.

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1. Holly A. Hills et al., Understanding the Impact of Substance Abuse on Families Involved in Child Welfare, report to the Children's Board of Hillsborough County, Florida (2002) (unpublished manuscript, on file with authors).

issues associated with women involved in substance abuse treatment as a result of abuse or neglect charges. Finally, Part VI provides recommendations to better address the substance use disorders of women involved in dependency court.

I. OVERVIEW OF LITERATURE AND DATA

A. Rates of Child Abuse and Neglect

Child abuse and neglect is not uncommon and can have fatal consequences. Many children are placed in out-of-home care during their critical developmental years because of maltreatment. From 1986 to 1997, the number of abused and neglected children in the United States jumped from 1.4 million to 3 million, a rise of more than eight times the increase in the child population.[2] The Child Welfare League of America reported that in 2000, there were 1,137 child abuse and neglect fatalities nationally.[3] Of these fatalities, only a minority, 527 (46%), had no verified prior involvement with a child welfare agency.[4] As of September 30, 2000, 547,415 American children lived in out-of-home care.[5] Many of these children had already entered, exited, and reentered out-of-home care in the past year.[6]

Florida's child abuse and neglect data is consistent with national data, as it indicates that child maltreatment is widespread, and may have fatal consequences. Between 1995 and 2000, the total number of

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2. The number of abused and neglected children rose 114.3% compared to a 13.9% increase in child population. NAT'L CTR. ON ADDICTION AND SUBSTANCE ABUSE AT COLUMBIA U., NO SAFE HAVEN: CHILDREN OF SUBSTANCE-ABUSING PARENTS (1999) [hereinafter CASA]. In all instances, the data presented represents the most recent data available.

3. Child Welfare League of Am. Nat'l Data Analysis Sys., Number of Child Abuse and Neglect Fatalities, by History with the Child Welfare System (CWLA Survey), 2000, *at* http://ndas.cwla.org/Report.asp (last visited Sept. 29, 2003) (on file with the Washington University Journal of Law & Policy).

4. *Id.*

5. Child Welfare League of America Nat'l Data Analysis Sys., Number of Children in Out-of-Home Care, 1998-2000, *at* http://ndas.cwla.org/Report.asp (last visited Oct. 20, 2003) (on file with the Washington University Journal of Law & Policy).

6. Child Welfare League of America Nat'l. Data Analysis Sys., *at* http://ndas.cwla.org/pretoc.asp (last visited Oct. 20, 2003) (on file with the Washington University Journal of Law & Policy).

children in Florida's foster care system increased 43%, while the number of children entering Florida's system for the first time increased 77%.[7] Additionally, the number of children reentering Florida's foster care system increased 191% between 1990 and 2000.[8] In 2000, sixty-five children in Florida died as a direct result of abuse and/or neglect.[9] Of these, twenty-one had previous involvement with a child welfare agency.[10]

Recently, Hillsborough County, Florida, has undertaken investigations to examine child maltreatment and parental substance abuse. In 1997, 13,444 Hillsborough County children were alleged victims of child abuse and/or neglect.[11] The Department of Children and Families substantiated 6,003 of these allegations.[12] Of those 6,003 abused or neglected children, only 2,411 received some form of intervention.[13]

B. The Relationship Between Parental Substance Abuse and Child Abuse and Neglect

The relationship between parental substance abuse and child maltreatment is well-documented. Studies suggest that chemical dependence exists in at least half of the families involved with the public child welfare system.[14] Alcohol and drug abuse is "a

7. Eric C. Brown et al., U. of S. Fla., Louis de la Parte Fla. Mental Health Inst., Dep't of Child and Fam. Stud., Measuring the Length of Stay Experiences of Florida's Foster Children xi (2001), *available at* http://cfs.fmhi.usf.edu/stateandlocal/ consortium/publications.html (last visited Oct. 3, 2003) (on file with the Washington University Journal of Law & Policy).

8. *Id.* at 18.

9. Child Welfare League of Am. Nat'l Data Analysis Sys., Number of Child Abuse and Neglect Fatalities, by History with the Child Welfare System (CWLA Survey), 2000, *at* http://ndas.cwla.org/Report.asp (last visited Oct. 20, 2003) (on file with the Washington University Journal of Law & Policy).

10. *Id.*

11. Beth A. Barrett et al., U. of S. Fla., Louis de la Parte Fla. Mental Health Inst. Dep't of Child and Fam. Stud., Hillsborough County Child Protection Study 5 (March, 1999) (unpublished manuscript on file with authors).

12. *Id.*

13. *Id.* Data indicates that 1,462 children received protective supervision, 270 children were placed in foster care, 85 children were adopted, and 594 children were placed in other out-of-home interim placements. *Id*.

14. J. Michael Murphy et al., *Substance Abuse and Serious Child Mistreatment: Prevalence, Risk, and Outcome in a Court Sample*, 15(3) CHILD ABUSE & NEGLECT 197 (1991). However, this is considered a conservative estimate, as other studies have found rates as

significant contributing factor" in 60% to 90% of cases referred to juvenile and family courts.[15] Alcohol and drug abuse are factors in more than 65% of cases where children are placed in foster care.[16] Individuals working within the child welfare field indicate that the main reason for skyrocketing protective services caseloads is an increase in parental substance abuse, particularly crack cocaine.[17]

Numerous research investigations also document the impact of parental substance abuse on children's care. Compared to a matched control community sample of parents, adults with an alcohol or drug disorders are 2.7 times more likely to report their abusive behavior and 4.2 times more likely to report their neglectful behavior toward their children.[18] Another investigation found that parents with substance abuse histories are significantly more likely than other parents: (a) to be repeat child abuse or neglect offenders; (b) to be rated by court investigators as presenting a high risk to their children; (c) to reject court-ordered services; and (d) to have their children permanently removed.[19] Additionally, research shows that children removed from the home due to parental substance abuse fare worse than children who were removed for other reasons. For example, children, particularly minority children, in out-of-home placement due to parental substance abuse are less likely to return to their biological parents, and are less likely to be adopted.[20] Children of

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high as 80% to 90%. *See* LAURA FEIG, U.S. DEP'T OF HEALTH AND HUM. SERVICES, DRUG-EXPOSED INFANTS AND CHILDREN: SERVICE NEEDS AND POLICY QUESTIONS (1990); Kelly Kelleher et al., *Alcohol and Drug Disorders Among Physically Abusive and Neglectful Parents in a Community Based Sample*, 84 AM. J. PUB. HEALTH 1586, 1588 (1999).

15. National Council of Juvenile and Family Court Judges, Alcohol and Other Drugs Division (2001), *at* http://ncjfcj.unr.edu/homepage/drugs.html (last visited Aug. 6, 2001).

16. CHILD WELFARE LEAGUE OF AMERICA, FAMILY FOSTER CARE FACT SHEET (2000), *at* http://www.cwla.org/programs/fostercare/factsheet.htm (last visited Oct. 20, 2003) (on file with the Washington University Journal of Law & Policy).

17. Patrick A. Curtis & Charlotte McCullough, *The Impact of Alcohol and Other Drugs on the Child Welfare System*, 72 CHILD WELFARE 535, 536 (1993). *See also* CASA, *supra* note 2.

18. Kelleher et al., *supra* note 14, at 1588.

19. Murphy et al., *supra* note 14.

20. Douglas J. Besharov, *Crack Children in Foster Care: Re-examining the Balance between Children's Rights and Parent's Rights*, 19 CHILD. TODAY 21, 24 (1990); *see also* David Fanshel, *Parental Failure and Consequences for Children: The Drug-Abusing Mother Whose Children Are in Foster Care*, 65 AM. J. PUB. HEALTH 604, 606, 607 tbl. 2 (1975); FEIG, *supra* note 14; NAT'L BLACK CHILD DEV. INST., WHO WILL CARE WHEN PARENTS CAN'T: A

drug-abusing mothers also remain in foster care for longer periods of time, and experience more foster care placements than children who were removed for other reasons.[21]

Given the relationship between parental substance abuse and child abuse and neglect, parental substance use disorder treatment appears crucial to the welfare of substance-abusing mothers and their children. However, the process through which women involved in dependency court find their way into drug treatment varies.

II. REFERRAL PATHWAYS THROUGH WHICH WOMEN ENTER SUBSTANCE ABUSE TREATMENT

Women enter substance abuse treatment through a variety of paths, but, increasingly, they begin treatment because of a court's recommendation in a child abuse or neglect case. Women entering the dependency court process in Hillsborough County, Florida often experience a common sequence of events.[22] First, an abuse or neglect report is called into the hotline. Then, an investigator goes to the address, assesses the report, and makes a determination as to whether the child(ren) should be removed from the parent's custody. At that time, depending on the initial report, the investigator may or may not assess whether substance abuse is a contributing factor in the removal decision. Within twenty-four hours of the investigator's visit, the court holds a hearing, which typically supports the investigator's removal recommendation. After the hearing, the child is officially placed with the father, another relative, or in foster care. Within thirty days, the court schedules a hearing to review elements of the case plan that address the conditions associated with the abuse or neglect.

Awareness of a custodial parent's substance abuse history or evidence that substance abuse may have played a role in instigating the initial report may result in a treatment evaluation

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STUDY OF BLACK CHILDREN IN FOSTER CARE (1989); CLARICE WALKER ET AL., NAT'L BLACK CHILD DEV. INST., PARENTAL DRUG ABUSE AND AFRICAN AMERICAN CHILDREN IN FOSTER CARE: ISSUES AND STUDY FINDINGS (1991).

21. Fanshel, *supra* note 20, at 606.

22. Information in this timeline was collected through a series of key informant and workgroup interviews conducted by the first author (H. Hills) between October, 2001 and April, 2002. Findings were reported and validated by community workgroup participants.

recommendation. While mothers may initiate that evaluation after the initial hearing, many wait until it appears as a requirement of their formal case plan. Typically, a mother can obtain a treatment evaluation within seven days of a request, however, she often has to pay for it. If the evaluation recommends that the mother participate in treatment, this will be transmitted to the Department of Children and Families (DCF) Child Protective Services caseworkers. The recommendation for treatment may or may not become part of the dependency court case plan that DCF presents to the judge.

If the recommendation is incorporated into the official case plan, it routinely takes at least five months from the date of the initial abuse or neglect report for the mother to initiate treatment, due to procedural and other legal elements of the process. As elements of the case plan are implemented, the case continues to move through the dependency court process. The mother returns to court approximately every three months, while her children remain in foster care.[23] The court may not require mothers to remain in treatment as a condition of reunification, even if substance abuse was an important factor in the initial abuse or neglect report and a treatment recommendation is part of the case plan.

Based on this sequence of events, one can reasonably infer that many elements of the standard process do not support effective transitions into substance abuse treatment, do not help maintain treatment, and do not work to facilitate prompt and successful reunification.

III. THE ROLE OF DEPENDENCY COURT ACTIONS IN ENCOURAGING COMPLIANCE WITH TREATMENT RECOMMENDATIONS

Issues associated with the protracted delays in completing dependency court requirements lead to children becoming stuck in foster care "limbo"—unable to return to their mothers and unavailable for adoption. Society began to view this limbo as extremely deleterious to children.[24] As a result, advocates began to

23. Non-relative placements allow for only one hour-long visit per week, and scheduling conflicts for both parties often lead to cancellations.

24. THE NATIONAL CENTER ON ADDICTION AND SUBSTANCE ABUSE AT COLUMBIA

encourage the legal process to consider this deleterious impact.[25] This effort began in the early 1990s, and led Congress to enact federal legislation that recognizes how important each year is in a child's life, and that being in a stable family setting is integral to children's long-term mental health.[26]

A. Child Welfare Reform

To push for earlier and more decisive permanency hearings, Congress passed the Adoption and Safe Families Act of 1997 (ASFA).[27] In place of the previous requirement to hold a "dispositional" hearing within eighteen months after placing a child in foster care, the Act renamed the hearing a "permanency" hearing.[28] It also requires the hearing to include a decision whether to return the child home, initiate termination proceedings, or place the child in another permanent living arrangement.[29] Furthermore, the Act requires that the hearing take place within twelve months of the child's original placement.[30]

B. Issues that Impact Reunification with Children Placed in Out-of-Home Care

Although ASFA makes clear that children have the right to be reunified with their families or made available for adoption, the Act does not articulate what specific efforts must be made to support parents and encourage reunification; it only, vaguely, states that child

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UNIVERSITY, NO SAFE HAVEN: CHILDREN OF SUBSTANCE-ABUSING PARENTS (Jan. 1999) (unpublished manuscript on file with authors).

25. Barrett et al., *supra* note 11, at 6.

26. The Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, 111 Stat. 2115 (codified as amended in scattered sections of 42 U.S.C.). The Act sought to decrease the amount of time children languish in foster care by encouraging states to streamline their permanency processes.

27. *Id*.

28. *Id*. at 2128.

29. *Id*. at 2116.

30. The twelve-month period does not begin to run from the time of the child's actual removal, but from either a judicial finding of abuse or neglect or sixty days after the child's removal from the home, whichever comes earlier. This period begins to run at the same time as the fifteen-month period for initiating termination of parental right. *Id*. at 2119.

welfare agencies must make "reasonable efforts."[31] For parents struggling with addictions, significant coordination across numerous social services will be necessary to create a suitable environment for reunification. Despite data that associates substance use disorders with 40% to 80% of all abuse and neglect cases,[32] most state child welfare offices do not make it standard procedure to ensure that parents receive treatment for their substance use disorders. In the CASA survey, 42% of caseworkers said they were not required to determine if substance abuse is present when investigating child maltreatment.[33] For parents who have substance abuse problems, there is limited evidence that they receive referral or treatment in a timely fashion, if at all, to prevent the termination of their parental rights.[34] In our own survey of DCF caseworkers in the Tampa Bay area, we found that among the thirty programs to which DCF caseworkers most commonly referred their clients, only four provided substance abuse treatment.[35]

C. Innovations in Assessment of Substance Abuse in Child Welfare Families

In response to ASFA, DCF implemented a Child Safety Assessment.[36] Its purpose is "to assure thorough assessment and provision of child safety and determine the disposition of investigation of report."[37] The assessment is part of Florida's new child welfare information system, called HomeSafenet.[38] The critical components of the new system are: tools to transfer information

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31. *Id.* at 2116.

32. Child Welfare League of America, Alcohol and other drug fact sheet (2001), *available at* http://www.cwla.org/advocacy/aodfactsheet.htm.

33. CASA, *supra* note 2, at 31.

34. *See, e.g.*, CHILD WELFARE LEAGUE OF AMERICA, ALCOHOL AND OTHER DRUG SURVEY OF STATE CHILD WELFARE AGENCIES (1998); CASA, *supra* note 2.

35. Hills et al., *supra* note 1.

36. FLORIDA GOV'T, DEP'T CHILDREN & FAMILIES, CHILD SAFETY ASSESSMENT (r19.vsd. Feb. 2001).

37. *Id.*

38. After initial testing and a review of the Child Safety Assessment's psychometric properties, Florida will add other important improvements to the child welfare system. THE FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES SERVICES, PROGRESS REPORT FOR THE GOVERNOR'S BLUE RIBBON PANEL ON CHILDREN PROTECTION (2003).

needed for planning services; accountability for ongoing services; a case plan summary; monitoring of case plan progress; and systematic data collection on caregiver substance use.[39]

Significantly, the Child Safety Assessment includes several questions related to parental use and abuse of drugs and alcohol.[40] The inclusion of these items and the potential data that will be derived from them are important steps in providing substance abuse treatment to families in need. These questions should encourage evaluations for substance use disorders in all protective investigations and acknowledge the integral role substance use disorders play in child abuse and neglect complaints.

D. Innovations in Judicial Action: Family Drug Courts

Part of the solution to connecting parents to the services they need lies in improving assessments, referrals, engagement strategies, and perhaps, developing and implementing family drug courts. A family drug court is:

> a drug court that deals with cases involving parental rights in which an adult is the party litigant, which comes before the court through either the criminal or civil process, and which arise out of the substance abuse of a parent, and include custody and visitation disputes; abuse, neglect, and dependency matters; petitions to terminate parental rights; guardianship proceedings; or other loss, restriction, or limitation of parental rights.[41]

The purpose of family drug (or drug treatment) court is to improve the way courts handle child abuse and neglect cases that involve a parent with a substance use disorder. An additional reason for

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39. *Id.*

40. CHILD SAFETY ASSESSMENT, *supra* note 36. Specific questions that address alcohol and drug abuse include: Does the child or adolescent exhibit behavior(s) that may be indicative of abuse or neglect? Included in this list is reference to the child's alcohol or drug use. Does the caregiver's drug or alcohol use affect his or her ability to adequately care for child(ren)? Do the child(ren) live in a crack house or similar environment? *Id.*

41. CAROLINE S. COOPER & SHANIE BARTLETT, OFF. OF JUST. PROGRAMS: DRUG COURT CLEARINGHOUSE AND TECH. ASSISTANCE AT AM. U., JUVENILE AND FAMILY DRUG COURTS: PROFILE OF PROGRAM CHARACTERISTICS AND IMPLEMENTATION ISSUES (1998).

creating family drug courts is to facilitate compliance with ASFA.

Key components of a family drug court are: (1) screening and assessment; (2) use of a non-adversarial approach; (3) a continuum of alcohol and drug treatment with accompanying wraparound rehabilitative and logistic services that support families and recovery; and (4) alcohol and other drug testing.[42] Additionally, the judge, treatment personnel, and an integrated case manager are considered essential members of a professional team who closely monitor participants' compliance with treatment through a system of rewards and sanctions.[43]

Family drug courts are developed primarily when a jurisdiction has an ongoing adult and, typically, juvenile drug court. The development of juvenile and family drug court programs is considered "extremely complex and considerably more difficult than adult drug court development" due to the difficult issues and potential number of parties involved.[44] Typically, family drug court initiatives are initiated by a judge with experience in juvenile or adult drug court, an interest in family law, and an interest in reducing the number of children entering the foster care system.[45] Usually, the judge will take it upon himself or herself to convince county funding agencies to back the program, and will get social service agencies, such as treatment providers, to commit funding to the program.

Currently, approximately twenty jurisdictions in ten states have family drug court programs.[46] Some of the earliest and best known programs are in Reno, Nevada; Escambia County, Florida; Miami, Florida; Las Vegas, Nevada; and New York, New York.[47] The Center for Substance Abuse Treatment is conducting an outcome study on the effectiveness of family drug courts.

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42. Charles M. McGee, *Family Drug Court: Another Permanency Perspective*, 48 JUV. & FAM. CT. J. 65, 65-67 (1997).

43. *Id.*

44. COOPER & BARTLETT, *supra* note 41, at I.C.

45. McGee, *supra* note 42, at 65-67.

46. Sharon G. Elstein, *Family Drug Courts May Hold the Key for Abused and Neglected Children of Substance Abusers*, 18 A.B.A. CHILD L. PRAC. 1, 6 (1999).

47. *Id.* Courts and treatment professionals in Hillsborough County, Florida, are currently developing a family drug court. They have recently traveled to an organizational conference and completed site visits to Pensacola, Florida and Reno, Nevada to evaluate the models employed and to determine how to import these characteristics into the local community.

IV. INNOVATIVE MODELS OF SUBSTANCE ABUSE TREATMENT FOR WOMEN AND THEIR CHILDREN

The vast majority of substance abuse treatment programs were designed to serve male clients, not to address the special issues that mothers with dependent children present.[48] Around the country, programs have been and are being developed that are tailored specifically to assist mothers with substance use disorders. The most promising programs offer services for both mothers and their children, recognizing that treatment must embrace the parental role.[49] While some of these programs are residential and allow children to live with their mothers, some outpatient programs offer a form of child care so mothers can attend treatment sessions.[50]

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48. Child Welfare League of America, Alcohol and other Drugs Fact Sheet (2001), *available at* http://www.cwla.org/advocacy/aodfactsheet.htm.

49. Kathleen Wobie et al., *Women and Children in Residential Treatment: Outcomes for Mothers and Their Infants*, 27 J. DRUG ISSUES 585-606 (1997); Shirley D. Coletti et al., *Specialized Therapeutic Community Treatment for Chemically Dependent Women and Their Children*, *in* COMMUNITY AS METHOD: THERAPEUTIC COMMUNITIES FOR SPECIAL POPULATIONS AND SPECIAL SETTINGS 115-28 (George De Leon ed., 1997); P. Hughes et al., *Retaining Cocaine-Abusing Women in a Therapeutic Community: The Effect of a Child Live-in Program*, 85 AM. J. PUB. HEALTH 1149-52 (1995); Cheryl Zlotnick et al., *The Impact of Outpatient Drug Services on Abstinence Among Pregnant and Parenting Women*, 13 J. SUBSTANCE ABUSE TREATMENT 195 (1996).

50. Typically, programs offer the following services: on-site childcare; parenting and child care skills classes; play groups; child development classes; prevention services for children under eighteen; family services; sexual abuse and domestic violence support groups exclusively for women; GED classes; job preparation; on-the-job training; prenatal care; nutritional counseling; health education; pediatric exams; comprehensive psychological and developmental assessments; transportation; and health care. Examples of these programs can be found in the following references: L. Metsch et al., *Implementation of a Family-Centered Treatment Program for Substance-Abusing Women and Their Children: Barriers and Resolutions*, 27 J. PSYCHOACTIVE DRUGS 73-83 (1995); Zlotnick et al., *supra* note 49; A. Carten, *Mothers in Recovery: Rebuilding Families in the Aftermath of Addiction*, 41 SOCIAL WORK 214-23 (1996); J. Camp & N. Finkelstein, *Parenting Training for Women in Residential Substance Abuse Treatment: Results of a Demonstration Project*, 14 J. SUBSTANCE ABUSE TREATMENT 411-22 (1997); M. Kaplan-Sanoff & S. Lieb, *Model Intervention Programs for Mothers and Children Impacted by Substance Abuse*, 24 SCHOOL PSYCHOLOGY REV. 186-99 (1995); J. Falk, *Project Exodus: The Corrections Connection*, *in* CHILDREN IN FAMILIES AT RISK: MAINTAINING THE CONNECTIONS (L. Combrinck-Graham ed., 1995); F. Feinberg, *Substance Abusing Mothers and Their Children: Treatment for the Family*, *in* CHILDREN IN FAMILIES AT RISK: MAINTAINING THE CONNECTIONS (S. Stevens & N. Arbiter eds., 1995); C. Winick & J. Evans, *A Therapeutic community Program for Mothers and Their Children*, *in* ADDICTION AND PREGNANCY: EMPOWERING RECOVERY THROUGH PEER COUNSELING 143-59 (Barry R. Sherman ed., 1997); F. Suffet et al., *Pregnant Addicts in a Comprehensive Care*

Empirical data validating long-term outcomes for women's substance abuse treatment programs remains limited; most substance abuse treatment facilities designed for mothers are new and have not yet made their outcome data available in professional, peer-reviewed literature. Despite limited efficacy data, however, the tenet that mothers can be engaged and retained more successfully in treatment if they can bring their children with them has become an accepted conclusion. Though limited, data indicates that it is beneficial to include children early on in the design and implementation of a mother's substance abuse treatment. For instance, women stay in residential drug treatment significantly longer if they are permitted to have their children with them.[51] Additionally, the earlier a mother's child is permitted to reside with her at a substance abuse treatment facility, the longer she will remain in treatment.[52]

A. Program Descriptions and Outcomes

The substance abuse treatment programs for women and their children that have emerged over the past decade exemplify the diverse nature of the programs available to pregnant women and mothers. This section describes some of these programs and provides outcome data when available.[53]

The Coalition on Addiction, Pregnancy, and Parenting (CAPP), located in Boston, Massachusetts, is a twelve-month residential substance abuse treatment program in which mothers are allowed to live with their young children. Aside from receiving stable housing, parents also attend weekly parenting skills classes and child development groups. Aftercare services are provided once mothers complete the program, and these include individual counseling, home visits, and case management services. Published outcomes indicate that mothers enrolled in the parent skills classes demonstrated increased self-esteem, greater parenting knowledge, and better

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Program: Results of a Follow-up Survey, 51 AM. J. ORTHOPSYCHIARTY 297-306 (1981).

51. Patrick H. Hughes et al., *Retaining Cocaine-Abusing Women in a Therapeutic Community: The Effect of a Child Live-In Program*, 85 AM. J. PUB. HEALTH 1149, 1149-52 (1995).

52. Wobie et al., *supra* note 49, at 594.

53. For more detailed, tabular information, contact the authors.

parenting attitudes compared to mothers who were not enrolled in the parenting skills classes.[54]

PAR Village, located in St. Petersburg, Florida, is a model residential program.[55] The eighteen-month program contains an on-site licensed childcare facility.[56] In order to graduate, mothers must save $1,500 and arrange housing and childcare.[57] Approximately 80% of mothers who enter the program successfully complete treatment.[58]

Another program designed to assist substance abusing women is the Center of Chemical Addiction Recovery Efforts (CARE), located in the Center for the Vulnerable Child at Children's Hospital in Oakland, California.[59] This program offers services entirely free of charge and targets substance abusing mothers with infants and toddlers.[60] CARE indicates that 50% of mothers remain in treatment for five months, and those women who receive family services are four times more likely to remain abstinent for the first or second month of treatment.[61] The latter finding underscores the need to involve families in the treatment process.

Project Connect, located in Rhode Island, is considered another promising program.[62] The child welfare system identifies parents after a substantiated allegation of abuse or neglect, and program participation serves as an alternative to mandatory foster care placement.[63] The program consists of home-based therapeutic and case management services, including substance abuse assessment and counseling.[64] Available data indicates that mothers averaged a ten-

54. *See* Camp & Finkelstein, *supra* note 50, at 411-22.

55. *See generally* Coletti et al., *supra* note 49; Shirley D. Coletti et al., *PAR Village for Chemically Dependent Women: Philosophy and Program Elements*, 12 J. SUBSTANCE ABUSE TREATMENT 289, 289-96 (1995); Hughes, *supra* note 51, at 66.

56. *PAR Village for Chemically Dependent Women*, *supra* note 55, at 290.

57. *Id*. at 292.

58. Coletti et al., *Specialized*, *supra* note 49.

59. *See* Zlotnick et al., *supra* note 49.

60. The program specifically targets mothers with children who are infants up to age three. *Id*. at 197.

61. *Id*. at 198-200.

62. *See* Lenore J. Olsen, *Services for Substance Abuse-Affected Families: The Project Connect Experience*, 12(3) CHILD & ADOLESCENT SOC. WORK J. 183 (1995).

63. *Id*. at 184.

64. *Id*. at 185.

month stay,[65] 62% of mothers made gains in their drug problem,[66] and 45% of mothers were reunited with their children, compared to 18% of mothers who did not enter treatment.[67]

The Women's Residential Treatment Center at the Center for Drug Free Living in Orlando, Florida, extends residential services to both substance abusing mothers and their children.[68] The facility offers on- and off-site GED classes, computer facilities, on-site medical facilities, and a day care center and nursery.[69] Outcomes indicate that while only 38% of participants successfully complete treatment, 88% of these participants reside at the treatment center with their children.[70] Additionally, mothers who live with their children at the center remain in the program for an average of 253 days, compared to ninety-two days for mothers who reside in the program without their children.[71] Data also indicates that mothers remain in treatment longer and are more likely to remain drug-free if their children reside with them early in treatment.[72] These mothers also exhibit higher self-esteem and lower depression compared to mothers living at the center alone.[73]

The Amity treatment program is located on a twenty-three acre ranch in Phoenix, Arizona.[74] The facility offers residential services for women and their children, and the program lasts fifteen to eighteen months.[75] Six-month post-treatment outcome data indicates that only 31% of those who completed treatment had used drugs, compared to 64% of those who did not successfully complete

65. *Id.*
66. *Id.* at 187.
67. *Id*. at 190.
68. *See* Wobie et al., *supra* note 49.
69. *Id*. at 591-92.
70. *Id*. at 594-95.
71. *Id*. at 593.
72. *Id*. at 596-97.
73. *Id*. at 598-99.
74. *See generally* Sally J. Stevens et al., *Women and Children: Therapeutic Community Substance Abuse Treatment*, *in* COMMUNITY AS METHOD: THERAPEUTIC COMMUNITIES FOR SPECIAL POPULATIONS AND SPECIAL SETTINGS 129 (George de Leon ed., 1997); Sally J. Stevens & Naya Arbiter, *A Therapeutic Community for Substance-Abusing Pregnant Women and Women with Children: Process and Outcome*, 27 J. PSYCHOACTIVE DRUGS 49 (1995); Sally J. Stevens et al., *Women Residents: Expanding Their Role to Increase Treatment Effectiveness in Substance Abuse Programs*, 24 INT'L J. ADDICTIONS 425 (1989).
75. Stevens & Arbiter, *supra* note 74, at 52.

treatment.[76] Additionally, 77% of those who completed were working six months after treatment, while only 48% of dropouts were employed.[77] Lastly, twelve-month follow-up data indicates that only 15% of those who completed treatment had been arrested, compared to 47% of the dropouts.[78]

Drug treatment programs designed for women and their children are receiving increased attention across the country. Many innovative programs have been piloted in Florida. It is important to note, however, that services for women and their children currently represent only a small fraction of available services.[79] In Hillsborough County, no residential programs for women and their children currently exist.

V. LOCAL ANALYSIS

A. Ongoing Working Group Discussions

Between January and July of 2001, a working group of professionals in Hillsborough County discussed issues related to linking women to and sustaining women in substance abuse treatment, particularly those women involved in dependency court. This diverse group provided a wealth of knowledge and important perspectives, including their thoughts about the treatment referral process for women in Hillsborough County dependency court. They also facilitated a service system mapping exercise and key informant interviews.

1. Key informant interviews

Key informant interviews were conducted with four important and informed groups: (1) DCF employees involved in case plan development; (2) substance abuse treatment professionals; (3) dependency court staff; and (4) substance abuse treatment

76. *Id*. at 54.
77. *Id*.
78. *Id*.
79. Child Welfare League of America, Alcohol and other Drugs Fact Sheet (2001), *available at* http://www.cwla.org/advocacy/aodfactsheet.htm.

participants, most of whom were involved with DCF and dependency court. Informed consent was obtained, and a standard series of questions were asked. Questions ranged from services this population needs to issues of motivation and retention in treatment. Interviews took sixty to ninety minutes to complete.

2. Results of key informant interviews[80]

a. What kinds of services do women facing abuse or neglect charges typically need?

Women involved in dependency court need a range of services, including some that previously may not have been considered within the bounds of traditional service delivery. Respondents described the need for transportation, child care, housing, clothing, medical evaluations, educational or vocational assistance, and mental health services, in addition to substance abuse treatment. Many women need assistance in dealing with their children's school system, in addressing their children's medical needs, and in acquiring fundamental parenting skills. Most of these women have mental health disorders in addition to their substance use and require long-term treatment with a counselor or case manager. Many have had traumatic experiences and need interventions that address sexual abuse and domestic violence.

b. Is treatment readily available? What, if any, barriers exist?

Outpatient treatment is available, but individual therapy, family-oriented therapy, and residential treatment are extremely limited or unavailable.

Financial limitations present a huge barrier to getting substance abuse treatment. When living at the poverty level, having to pay for such things as cab fare, bus fare, and babysitting poses obstacles to engaging in treatment. In many cases, clients must pay for an initial evaluation, which can also be a barrier to entering treatment.

80. Responses to key informant interviews have been collapsed across informant groups.

Furthermore, the cost of weekly urine tests can be prohibitively expensive.

Many other barriers to obtaining treatment exist, particularly because current treatment models still discharge participants if they do not comply with treatment demands. For example, when case plans have overlapping requirements, participation in treatment may make it impossible to accomplish other case plan requirements, such as acquiring a job. While access to day care may allow parents to continue treatment, the lack of afternoon and evening childcare often prevents parents from acquiring jobs. Mothers may also be dissuaded from initiating treatment until a treatment plan is legally formalized, which often takes a long time, as recommendations may be made weeks or months after the initial investigation. Additionally, women are often offered housing that is far from their treatment facility and in an unsafe area. Many women have little social support, so if their car breaks down or they need child care no assistance is available, and often caseworkers have limited familiarity with available treatment services and with a woman's needs.

c. How does substance abuse get identified? What barriers exist to identification?

There are no standardized questions about substance abuse. Furthermore, if substance abuse is not identified in the initial investigation, it is unlikely to become part of the case plan, and legal issues prohibit introducing drug abuse at a later date. For example, drug tests are not routinely done during the initial evaluation, and a judge will not admit the results of a drug test if there is not a clear indication of why the test was performed.

Individual investigators may have limited information and experience regarding drug abuse and addiction because they are forced into dual roles of advocating both for and against reunification. Thus, they may find that they are conflicted about helping the mothers. Additionally, some dependency court staff are uncertain as to whether so much emphasis should be placed on substance abuse treatment when other identified needs—such as parenting skills, mental health treatment, and financial assistance—exist.

Referral to substance abuse treatment is variable, and can hinge on the type of drug the mother uses and the circumstances surrounding her use. Treatment involvement is not thoroughly assessed through the court process. If clients have only attended and participated minimally, they will probably receive credit for meeting the requirements of their case plan, even though the treatment provider may feel strongly that the woman has not really received full treatment.

d. How does communication work between the court, the social service system, and treatment service providers? Are demands placed on systems that cannot be met?

Few, if any, links exist between the dependency court staff, the investigating caseworkers, and service providers. Providers have no direct line of communication with the judge to inform him or her how the individual is doing in treatment, and they are not routinely asked to go to court or provide updates on client progress. Furthermore, the case plan review does not focus heavily on treatment compliance.[81]

Accessing treatment can be complicated further if a woman has to wait for money to be appropriated so she can get a treatment evaluation. It may take days or weeks to get an appointment for an evaluation, so a woman can know if substance abuse treatment is recommended. Once the evaluation is complete, the document recommending treatment must work its way through the court system. The result is a four to six month delay before the woman is officially referred to substance abuse treatment. During this delay, the ASFA timeline continues, increasing the likelihood that the court will terminate the mother's parental rights.

The manner in which information is communicated also affects how cases are handled. Investigators may offer treatment compliance reports, but if they do not provide documentation, the judge may not necessarily weigh the information heavily when making his or her decisions. However, a judge may take a mother's report of treatment

81. A caseworker offers what is a common scenario: "The day before a court hearing, the client may call to get an appointment for an evaluation, she gets an appointment for two weeks later, judge continues it for six months, client skips the appointment." Hills et al., *supra* note 1.

compliance as fact and continue the case for several months, without asking for any further feedback from the treatment provider.

e. What is working well in the system? What are areas that could use improvement?

Communication among providers has improved, particularly because monthly meetings provide an opportunity to staff difficult cases and expand resource bases. The treatment community has also started to incorporate evidence-based models of family intervention. Initial steps have been taken to co-locate substance abuse providers and child protective investigators.

Improvement in the area of efficiency is needed, as each agency has it own caseworker, which means multiple and often redundant home visits, interviews, and case plans. Furthermore, ASFA accelerated the timeline for terminating parental rights,[82] which makes achieving symptom, housing, and economic stability a very intense process for women with multiple deficits. Reunification attempts are also stressed, because the average mother only gets to visit her children for one hour, once a month.

Relationships between parties can be difficult at times. Caseworker turnover complicates the picture, as mothers often have to establish a relationship with a new caseworker in the middle of the court process. Also, the paperwork burden on caseworkers is tremendous, which limits the amount of time that they can follow up with clients who are not attending treatment or who have other special needs.

Limited training is often cited as a problem. For example, the current guardian *ad litem* system is comprised of volunteers who represent children, but they might not be aware of social or cultural family norms. Caseworkers also have limited training, specifically regarding substance abuse indicators. While their training gives them an overview, caseworkers would benefit from more shadowing and role-playing experiences, which will make them more comfortable with the experience.

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82. Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, 111 Stat. 2115, 2118-2120 (codified as amended in scattered sections of 42 U.S.C.).

Within the Hillsborough County practice community, residential services for women and their children are largely unavailable. Transportation to treatment is available in some programs. Current treatment programs are not designed for long-term contact, which makes it much more difficult for mothers to achieve symptomatic, behavioral, vocational, and economic goals. Women in Hillsborough County dependency court often need housing, but arrest records often prevent their approval, which, in turn, prevents reunification. Furthermore, women who have severe medical or mental health needs do not receive all of the services they need while in substance abuse treatment, because those services are not integrated. One treatment provider's comment illustrates the problems that exist within the current system: "[i]f you have a 28-year-old mom with four kids who is pregnant, she has an eighth grade education, never held a job, has no husband . . . your program has to get her out in six to nine months but this is not enough time to work with her to get her out of the system permanently."

f. What keeps a woman motivated to stay in treatment?

Despite their serious addictions, most women want to get their children back. While they can lose motivation to address their substance dependence after their parental rights are terminated, they often return to treatment after having another child and getting involved in a new dependency court proceeding. While access to her children during treatment can keep a mother motivated to remain in treatment, unlimited access—such as when children are placed with a relative—may slow the pace of her recovery.

g. What makes it hard for a woman to succeed in treatment and avoid relapse?

The jobs available to this population of women tend to be in the service industry, are low paying and do not foster independence. Furthermore, it is very difficult to reconcile the demands of treatment with the need to work. Many of the mothers involved in dependency court are also involved in criminal court proceedings. It is difficult for women to meet both dependency and criminal court requirements,

and sometimes they feel it might be easier to ignore the requirements and go to jail.

h. Women discuss their perspectives on the dependency court process

Women who are in substance abuse treatment as part of their dependency court requirements felt that the counselors with whom they interacted needed to know more about addictions and the recovery process. Women often felt that the parties involved in the process expected changes to "happen overnight" and that these expectations were unrealistic. They described the need for greater emphasis on family-based interventions and greater use of peers as role models.

Women stated they were devastated by the loss of their children and the loss of information about their children's behavioral patterns. They wished that their children could access more services while in foster care. Overall, they requested more frequent visitation, communication, and contact. Women also uniformly expressed a need for stable housing and safe working environments. One woman stated, "[w]e need to have a stable place; you can't be working in the labor pool and living on the street or on the verge of homelessness."

3. Review of foster care data files

The working group obtained hard copies of seventy-three data files that had been previously extracted from the case records of families involved in Hillsborough County dependency court. The working group reviewed these files to determine if they contained various substance abuse indicators. The files included information related to critical incident reports, case plans, and data on parental substance abuse evaluation, diagnosis, and treatment. Each file was examined for the following: substance abuse indicators or treatment history in the report made during the initial abuse or neglect investigation; referrals to substance abuse treatment; evidence that the parent was evaluated for a suspected substance abuse problem; evidence that the parent initiated substance abuse treatment; and evidence that the parent was diagnosed with a substance use disorder.

4. Results of the extracted file review

The data files were examined for critical incidents related to substance abuse.[83] Of the seventy-three files reviewed, thirty-three (45%) listed parental substance abuse as a critical incident. The custodial or care-giving parent was diagnosed with a substance use disorder in forty-four (60%) of the cases.

Despite the high rate of cases involving parental substance abuse, only nine (12%) recommended substance abuse treatment as part of the case plan. However, some parents did receive substance abuse treatment during the course of their dependency court involvement, despite the relative scarcity of case plan recommendations. Twelve cases (16%) had at least one parent enrolled in substance abuse treatment, and twenty-one cases (29%) had at least one parent who underwent a substance abuse evaluation.[84]

This limited file review suggests that services as basic as substance abuse evaluations are not routinely recommended as part of case plans, despite the fact that many of these files indicated a history of parental substance abuse that was likely tied to the child abuse and neglect.

VI. OBSERVATIONS AND RECOMMENDATIONS

Many cases of abuse and neglect may be identified before it is necessary to remove children from their homes. Social service agencies need to review their child abuse identification training. Agency staff also need to be knowledgeable about the community resources available to support families. Because there is a high rate of caseworker turnover, training poses a challenge. Agencies need to offer frequent networking or training activities that familiarize staff with available community resources.

People who receive community support are less likely to face abuse or neglect charges. Thus, communities and public health

83. Child welfare workers define critical incidents as those circumstances prompting a child's removal from the home.

84. The assumption was made that those involved in treatment underwent an evaluation prior to the start of their treatment.

departments need to invest funds in child abuse prevention through innovative models of support and care.

Identifying substance abuse as a contributing factor is crucial in initial abuse or neglect investigations. Investigators and caseworkers need clear instruction regarding the extent to which substance abuse should play a part in child abuse or neglect reports. If standardized questions are employed, decision rules should be developed to help guide the case plan development process. Children's services should seek input from defense attorneys and judges involved in the dependency court or family drug court process regarding these decisions.

Investigators and caseworkers need methods to assess a custodial parent's level of substance abuse and its threat to the child's safety. The Annie E. Casey Foundation has a training module available to assist caseworkers in recognizing and assessing substance abuse patterns.[85] The Casey materials discuss how to pursue interviews with parents who are suspected of being acutely intoxicated.[86] Child welfare workers are responsible for determining the degree to which parental drug use poses a risk to the child; thus, it is imperative that they are trained not only to identify substance use related problems, but also to determine the potential risks that such use poses. Drug problem identification and management training should be part of new employee orientation, in-service training, and refresher courses.

The criteria used to determine when to remove a child from the home and when to refer a parent to substance abuse treatment are unclear. Further efforts should be made to give investigators and caseworkers clearer guidelines. Standards, guidelines, and definitions regarding the level of substance or alcohol abuse that is considered harmful to children need to be developed and disseminated. Furthermore, referral processes for substance abuse treatment are not systematic. Even when disorders are identified, caseworkers do not always initiate referrals, and are often unfamiliar with the community treatment resources available to their clients.

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85. Annie E. Casey Foundation, Family to Family Tools, *at* http://www.aeof.org/initiatives/familytofamily/tools.htm (last visited Oct. 25, 2003) (on file with the Washington University Journal of Law & Policy).

86. *Id.*

A great deal of literature exists that supports the use of escorts and transportation to facilitate a successful referral process.[87] For example, innovative models of peer mentoring are used in some areas.[88] The court system needs to support the early identification of mothers with substance use disorders, so they can be referred to treatment quickly. Additional resources, strategies, and collaborative efforts are needed to accomplish higher rates of successful referrals; and service providers and referring agencies need to systematize the evaluation process so that appointments can be made, evaluations conducted, and findings forwarded to the mother and the court.

Many factors complicate the ability to move from evaluation to treatment. Decreasing the time between a client's referral to treatment and the initial appointment has been advocated for many years,[89] and has been found to be effective with alcoholics,[90] drug-free outpatients,[91] and methadone clients.[92] Court system issues that delay case plan adoption and treatment recommendations work against a mother trying to move into recovery and reunify with her children. Methods for rapid referral and engagement need to be evaluated and accepted by all parties.

Despite a court's recommendation for substance abuse treatment, most women do not become successfully engaged in treatment. Research indicates that engagement improves when there is greater outreach on the initial contact, including using incentives for and escorts to treatment.[93] Though some strategies have been employed to

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87. *See, e.g.*, Mary Ann Chutuape et al., *Methods for Enhancing Substance Dependent Patients from Inpatient to Outpatient Treatment*, 61 DRUG & ALCOHOL DEPENDENCE 137 (2001); Robert E. Both et al., *Substance Abuse Treatment Entry, Retention, and Effectiveness: Out-of-treatment Opiate Injection Drug Users*, 42 DRUG & ALCOHOL DEPENDENCE 11 (1996).

88. Peer mentoring is a component of the SISTERS Program in South Bronx, New York. ADDICTION AND PREGNANCY: EMPOWERING RECOVERY THROUGH PEER COUNSELING (Barry R. Sherman et al. eds., 1998).

89. Frederick Baekeland & Lawrence Lundwall, *Dropping Out of Treatment: A Critical Review*, 82 PSYCHOL. BULL. 738 (1975).

90. William R. Miller, *Motivation for Treatment: A Review with Special Emphasis on Alcoholism*, 98 PSYCHOL. BULL. 84 (1985).

91. Michael J. Stark et al., *Hello, May We Help You? A Study of Attrition Prevention at the Time of the First Phone Contact with Substance-Abusing Clients*, 16 AM. J. DRUG AND ALCOHOL ABUSE 67 (1990).

92. George Woody et al., *Rapid Intake: A Method for Increasing Retention Rate of Heroin Addicts Seeking Methadone Treatment*, 16 COMPREHENSIVE PSYCHIATRY 165 (1975).

93. *See* sources cited *supra* note 87.

facilitate referrals to treatment, increased contact between caseworkers and treatment staff will further facilitate successful engagement. The application of specific motivational interventions, such as Motivational Enhancement Therapy would also influence engagement and retention rates.

The number of available treatment services must increase to meet the rising demand for substance abuse treatment. In many communities, substance abuse treatment is very limited. Few programs link specialized services for women with on-the-job training and housing assistance. Women with mental health disorders and histories of substantial physical and sexual trauma may need several years of counseling, vocational training, and housing assistance before they can support their families and exist independently. However, current treatment programming takes a short-term perspective, even with women who have such complex rehabilitative needs.

The growth of family dependency drug court or family drug court strategies should be encouraged. As substance abuse may be a contributing factor in 60% to 90% of all dependency court cases, it is recommended that whether or not a judge is operating in the context of a family drug court, the court should require that parents participate in substance abuse treatment.[94] Courts should also ensure that the programs to which they are referring women use techniques to engage women in treatment and comprehensively address the complex issues that women face. Judges must communicate with treatment providers and work to reduce the adversarial nature of treatment recommendations. Finally, courts should encourage and monitor women's ongoing participation in treatment, thus recognizing the importance of this intervention in improving the parent-child relationship.

Caseworkers, court workers, and judges need information about the role of relapse in substance abuse treatment, particularly that successful outcomes can be achieved after multiple failed attempts at

94. Nancy Young, Oral and Written Testimony to the House of Representatives Committee on Ways and Means Subcommittee on Human Resources on the Impact of parental Substance Abuse on Placement of Children in Foster Care (Mar. 25, 2000), *available at* http://www.cffutures.com/Presentations/Testimony300.pdf.

sobriety. All people involved in dependency court actions should be trained regarding what constitutes effective substance abuse treatment and the typical patterns of relapse and recovery.

Caseworkers and court personnel remain uncertain as to whether substance abuse treatment is effective and whether it is likely to reduce the odds of a family returning to dependency court. Additional research should be conducted to follow families with both substance abuse problems and child welfare involvement to demonstrate whether engagement in substance abuse treatment improves parental rights and family reconciliation.

CONCLUSION

Obviously, the psychological complexities of substance use disorders interfere with a parent's ability to judge the safety of children in their care. At a time when they are seriously afflicted with a substance use disorder, the child welfare and treatment systems challenge mothers. These systems, however often are limited in their knowledge and ability to recommend and deliver the comprehensive array of services that these mothers need. A significant effort should be made to improve the relationship between the court, child welfare workers, and treatment providers. Funding agencies must provide leadership and financial support for innovative models of evidence-based practice that can increase the likelihood of long-term positive outcomes for these families.