Journal of Health Care Law and Policy

Volume 3 | Issue 1 Article 4

Providing Safe Haven: The Challenge to Family Courts in Cases of Child Abuse and Neglect by Substance-Abusing Parents

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PROVIDING SAFE HAVEN: THE CHALLENGE TO FAMILY COURTS[1] IN CASES OF CHILD ABUSE AND NEGLECT BY SUBSTANCE-ABUSING PARENTS

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INTRODUCTION

Substance abuse and addiction have thrown the child welfare system into chaos, exploding the number of cases, creating impossible caseloads for caseworkers and judges, and forcing a seemingly irreconcilable clash between the fast moving clock of child development and the slow motion clock of recovery.[2] Seven of ten cases in the child welfare system today are caused or exacerbated by substance abuse, yet few professionals in the system understand the condition or are trained to deal with it.[3] Most parents who need treatment do not receive it, and the revolving door of child neglect and abuse continues to spin. In order to understand the profound and pervasive impact of substance abuse on the child welfare system, the National Center on Addiction and Substance Abuse at Columbia University (CASA) conducted a two-year analysis of the available literature and data on child abuse and neglect, an unprecedented national survey of 915 professionals working in the field of child welfare, six case studies of innova-

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1. For the purposes of this Article, "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.

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2. *See* NANCY K. YOUNG ET AL., RESPONDING TO ALCOHOL & OTHER DRUG PROBS. CHILD WELFARE: WEAVING TOGETHER PRAC. & POL'Y 5, 21 (1998).

3. *See* NATIONAL CENTER ON ADDICTION AND SUBSTANCE ABUSE AT COLUMBIA UNIVERSITY, NO SAFE HAVEN: CHILDREN OF SUBSTANCE-ABUSING PARENTS 4-5 (1999) [hereinafter CASA, NO SAFE HAVEN].

tions in the field, and numerous in-depth interviews with judges, child welfare officials, and social workers on the front line.[4]

A major finding of this research is that dramatic changes must be made in the child welfare system if we are to provide a genuine safe haven for the abused and neglected children of substance-abusing parents. Key to achieving this goal is redefining the role of the family court. This Article is based on CASA's research and describes briefly the profound effects that substance abuse has had on the child welfare system and the legal context for providing child welfare services. CASA also offers a recommended agenda for how family courts can respond to the challenge of substance abuse in the child welfare system and highlight promising innovations in the family courts and supporting practices in child welfare agencies to achieve better outcomes for families and children.

I. A SYSTEM IN CHAOS

In the late 1980s, the child welfare caseload spiked in response to the crack epidemic and has since remained high.[5] The number of children in America who were abused or neglected more than doubled from 1.4 million in 1986[6] to about 3 million in 1997,[7] a 114.3% rise that occurred while the total population of children under age 18 grew only 13.1%.[8] Some 42 of every 1000 children in the United States were abused or neglected in 1997,[9] up from 22 of every 1000 in 1986.[10]

Substance abuse drives and maintains high child welfare caseloads:

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4. This Article is based on CASA's full report, *No Safe Haven: Children of Substance-Abusing Parents*, released in January of 1999. *See id.* The authors would like to credit the work of Jeanne Reid who was the Principal Investigator for this study.

5. *See* CASA, NO SAFE HAVEN, *supra* note 3, at 11.

6. *See* ANDREA J. SEDLAK & DIANE D. BROADHURST, U.S. DEPT OF HEALTH AND HUMAN SERVICES, THIRD NATIONAL INCIDENCE STUDY OF CHILD ABUSE AND NEGLECT: FINAL REPORT, § 3, 3-18 (1996).

7. *See* Ching-Tung Wang & Deborah Daro, *Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1997 Annual Fifty State Survey* (visited May 19, 1998) <http://www.childabuse.org/50data97.html>.

8. *See* U.S. Bureau of the Census, *Living Arrangements of Children Under 18 Years Old: 1960 to the Present* (visited Sept. 22, 1998) <http://www.census.gov/population/socdemo/ms-la/tabch-1.txt>. To estimate the number of children maltreated in 1997, CASA assumed that the number of children maltreated increased from 1993 to 1997 at the same rate as the total number of reports of maltreatment over that period (7.7%), based on data from Wang & Daro, *supra* note 7.

9. *See Living Arrangements of Children Under 18 Years Old*, *supra* note 8.

10. *See* SEDLAK & BROADHURST, *supra* note 6, § 8, at 8-18.

- *Research consistently demonstrates a strong connection between substance abuse and child maltreatment.*[11] For example, in one 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.[12]
- *Parents who abuse alcohol and drugs and maltreat their children usually suffer many problems at once.*[13] They tend to be socially isolated, live chaotic lives, suffer from depression and other chronic health problems, struggle with drained financial resources, and unemployment.[14] These cases do not respond to simple solutions or quick fixes.
- *Many families affected by substance abuse cycle in and out of the child welfare system.*[15] 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% had more than one allegation on record) as families without alcohol problems (34.3% had multiple allegations).[16] Two earlier studies showed similar results.[17]
- *Children of substance-abusing parents tend to be placed in foster care more frequently than others in the system and to linger in foster care.*[18] Research

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11. *See* Richard Famularo et al., *Alcoholism and Severe Child Maltreatment*, 56 AM. J. ORTHOPSYCHIATRY 481, 483 (1986); 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, 1589 (1994).

12. *See* Kelleher et al., *supra* note 11, at 1588-89.

13. *See* Cathy Spatz Widom, *Child Abuse and Alcohol Use and Abuse, in* ALCOHOL & INTERPERSONAL VIOLENCE: FOSTERING MULTIDISCIPLINARY PERSP. 291, 301 (1993).

14. *See* Jan Bays, *Substance Abuse and Child Abuse: Impact of Addiction on the Child*, 37 PEDIATRIC CLINICS OF N. AM. 881, 889 (1990); Richard D. Krugman et al., *The Relationship Between Unemployment and Physical Abuse of Children*, 10 CHILD ABUSE & NEGLECT 415, 418 (1986); Joel S. Milner & Chinni Chilamkurti, *Physical Child Abuse Perpetrator Characteristics: A Review of the Literature*, 6 J. INTERPERSONAL VIOLENCE 345, 357 (1991); Kathleen Wells & Elizabeth Tracy, *Reorienting Intensive Family Preservation Services in Relation to Public Child Welfare Practices*, 75 CHILD WELFARE 667, 669 (1996); Widom, *supra* note 13, at 304-05.

15. *See* Isabel Wolock & Stephen Magura, *Prenatal Substance Abuse as a Predictor of Child Maltreatment Re-Reports*, 20 CHILD ABUSE & NEGLECT 1183, 1191 (1996).

16. *See* NATIONAL CENTER ON CHILD ABUSE AND NEGLECT, STUDY OF CHILD MALTREATMENT IN ALCOHOL ABUSING FAMILIES: A REPORT TO CONGRESS § 3, 3-25 (1993).

17. *See* W.L. WHITE, PROJECT SAFE: FINAL EVALUATION REPORT (1988); Wolock & Magura, *supra* note 15, at 1191.

18. *See* CHILD WELFARE LEAGUE OF AMERICA, CHILDREN AT THE FRONT: A DIFFERENT VIEW OF THE WAR ON ALCOHOL AND DRUGS 68-69 (1992).

also indicates that children of substance-abusing parents are most likely to have foster care placements that last for years.[19]

- *Substance abuse also can ignite a vicious intergenerational cycle of child maltreatment and substance abuse.* Substance-abusing parents often were once victims of substantial abuse themselves.[20] The children who suffer at the hands of parents who abuse or neglect them are likelier as adults to abuse and neglect their own children[21] and to develop their own substance abuse problem,[22] which in turn further increases the chance that they will abuse and neglect their chil-

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19. *See id.*; Irene R. Bush & Anthony Sainz, *Preventing Substance Abuse from Undermining Permanency Planning: Competencies at the Intersection of Culture, Chemical Dependency and Child Welfare, in* THE CHALLENGE OF PERMANENCY PLANNING IN A MULTICULTURAL SOCIETY 79, 82 (Gary R. Anderson et al. eds. 1997).

20. *See* Angela Browne & David Finkelhor, *Impact of Child Sexual Abuse: A Review of the Research*, 99 PSYCHOL. BULL. 66, 71-72 (1986); Denise Hien & Joanna Scheier, *Trauma and Short-Term Outcome for Women in Detoxification*, 13 J. SUBSTANCE ABUSE TREATMENT 227, 230 (1996); Martie P. Thompson & J.B. Kingree, *The Frequency and Impact of Violent Trauma Among Pregnant Substance Abusers*, 23 ADDICTIVE BEHAV. 257, 261 (1998).

21. *See* Jay Belsky, *Etiology of Child Maltreatment: A Developmental-Ecological Analysis*, 114 PSYCHOL. BULL. 413, 415 (1993); Cathy Spatz Widom, *Does Violence Beget Violence? A Critical Examination of the Literature*, 106 PSYCHOL. BULL. 3, 8 (1989); Michael Windle, *Effect of Parental Drinking on Adolescents*, 20 ALCOHOL HEALTH & RES. WORLD 181, 182 (1996).

22. *See* COMMITTEE ON PREVENTION OF MENTAL DISORDERS, INSTITUTE OF MEDICINE, REDUCING RISKS FOR MENTAL DISORDERS: FRONTIERS FOR PREVENTATIVE INTERVENTION RESEARCH 159, 162 (Patricia J. Mrazek & Robert J. Haggerty eds., 1994); Bo Bergman & Bo Brismar, *Characteristics of Violent Alcoholics*, 29 ALCOHOL & ALCOHOLISM 451, 456 (1994); Browne & Finkelhor, *supra* note 20, at 71-72; Frederick S. Cohen & Judianne Densen-Gerber, *A Study of the Relationship Between Child Abuse and Drug Addiction in 178 Patients: Preliminary Results*, 6 CHILD ABUSE & NEGLECT 383, 387 (1982); Richard Dembo et al., *The Relationship Between Physical and Sexual Abuse and Illicit Drug Use: A Replication Among a New Sample of Youths Entering a Juvenile Detention Center*, 23 INT'L J. ADDICTIONS 1101, 1116 (1988); Rhonda E. Denton & Charlene M. Kampfe, *The Relationship Between Family Variables and Adolescent Substance Abuse: A Literature Review*, 29 ADOLESCENCE 475, 493 (1994); W.R. Downs & L. Harrison, *Childhood Maltreatment and the Risk of Substance Problems in Later Life*, 6 HEALTH & SOC. CARE COMMUNITY 35, 44 (1998); Vincent J. Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Deaths in Adults*, 14 AM. J. PREVENTIVE MED. 245, 250 (1998); Michael Fendrich et al., *Childhood Abuse and the Use of Inhalants: Differences by Degree of Use*, 87 AM. J. PUB. HEALTH 765, 767 (1997); Patricia A. Harrison et al., *Multiple Substance Use Among Adolescent Physical and Sexual Abuse Victims*, 21 CHILD ABUSE & NEGLECT 529, 536 (1997); Karen M. Jennison & Kenneth A. Johnson, *Alcohol Dependence in Adult Children of Alcoholics: Longitudinal Evidence of Early Risk*, 28 J. DRUG EDUC. 19, 30 (1998); Willie Langeland & Christina Hartgers, *Child Sexual and Physical Abuse and Alcoholism: A Review*, 59 J. STUD. ON ALCOHOL 336, 344 (1998); Brenda A. Miller, *The Interrelationships Between Alcohol and Drugs and Family Violence, in* DRUGS & VIOLENCE: CAUSES, CORRELATES, & CONSEQUENCES 177, 199 (Mario De La Rosa et al. eds., 1990); Kenneth J. Sher et al., *The Role of Childhood Stressors in the Intergenerational Transmission of Alcohol Use Disorders*, 58 J. STUDIES ON ALCOHOL 414, 425 (1997); Widom, *supra* note 13, at 295; Michael Windle, *Concepts and Issues in COA Research*, 21 ALCOHOL & HEALTH RES. WORLD 185, 188 (1997).

dren.[23] These phenomena may combine to create a devastating pattern of child maltreatment and substance abuse that can repeat from one generation to the next.

- *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.*[24] The number of children receiving in-home services through a child welfare agency has dropped 58.3% from 1.2 million in 1977 to just 500,000 in 1994.[25] This drop has occurred as the number of multi-problem families with urgent and complex needs has expanded.
- *The number of children adopted out of foster care remains low.* Only 8% of the half-million children in foster care are adopted; the majority (60%) return to their families and the remainder (32%) live with other family members or graduate to independent living arrangements.[26] 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 6%, from 118,216 in 1987 to 125,248 children in 1992, the most recent year for which data are available.[27] 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.[28] Only 31,000 children in the child welfare system were adopted in 1997.[29]

As the caseloads have risen and remained stubbornly high, some family court judges have seen their own caseloads jump to 40 or 50 per day.[30] This level of caseload requires that they assess the credibility of the mother or father, the caseworker and other witnesses, and possibly

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23. *See* Downs & Harrison, *supra* note 22, at 36; Miller, *supra* note 22, at 199; Widom, *supra* note 13, at 294.

24. *See* SEDLAK & BROADHURST, *supra* note 6, § 8, at 8-18; Wells & Tracy, *supra* note 14, at 670.

25. *See* DEP'T OF HEALTH AND HUMAN SERVICES, NATIONAL STUDY OF PROTECTIVE, PREVENTATIVE AND REUNIFICATION SERVICES DELIVERED TO CHILDREN AND THEIR FAMILIES 4-3 (1997).

26. *See* MICHAEL R. PETIT & PATRICK A. CURTIS, CHILD ABUSE AND NEGLECT: A LOOK AT THE STATES 69 (1997).

27. *See* PATRICK A. CURTIS ET AL., CHILD ABUSE AND NEGLECT: A LOOK AT THE STATES 78 (1995).

28. *See* PETIT & CURTIS, *supra* note 26, at 124.

29. *See* Department of Health and Human Services, *President Clinton Announces Expansion of the Internet to Increase Adoptions* (visited Dec. 2, 1998) <http://www.acf.dhhs.gov/news/whfsn24.htm>.

30. *See* CASA, NO SAFE HAVEN, *supra* note 3, at 5 (citing Personal Communication with Geoffrey Alprin, Associate Judge, District of Columbia Superior Court, 1998); RICHARD ROSS, A DAY IN PART 15: LAW AND ORDER IN FAMILY COURT xvii (1997).

make a profound decision for a child in as little as ten minutes.[31] Judges and their staff have limited training and knowledge of substance abuse.[32] Further, overwhelmed and uninstructed courts cannot sufficiently monitor clients and help them maintain motivation to seek treatment or participation in other services. Even when attendance to services is ordered, compliance with court orders to enter treatment is low.[33] However, judges may be reluctant to terminate parental rights if services have not been offered or if an adoptive situation is not readily available. Most family court judges simply are not equipped to address constructively substance abuse connected to child abuse and neglect.

II. THE LEGAL CONTEXT

In response to the extraordinarily high foster care caseloads in the late 1970s, the Adoption Assistance and Child Welfare Act of 1980[34] mandated that child welfare agencies make "reasonable efforts" to preserve or reunify families.[35] 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."[36] However, neither the original statute nor subsequent modifying legislation defines this term.[37] According to the National Council of Juvenile and Family Court Judges, "[t]hese efforts may consist of the provision of direct services, financial or in-kind benefits or counseling assistance."[38]

The Adoption and Safe Families Act of 1997 (ASFA)[39] revised the Adoption Assistance and Child Welfare Act of 1980 in two major ways. First, it established circumstances in which "reasonable efforts" are not required before termination of parental rights (such as when the

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31. *See* CASA, NO SAFE HAVEN, *supra* note 3, at 5.

32. *See generally id.*

33. *See* Leslie Atkinson & Stephen Butler, *Court-Ordered Assessment: Impact of Maternal Noncompliance in Child Maltreatment Cases*, 20 CHILD ABUSE & NEGLECT 185, 185 (1996); Richard Famularo et al., *Parental Compliance to Court-Ordered Treatment Interventions in Cases of Child Maltreatment*, 13 CHILD ABUSE & NEGLECT 507, 510-11 (1989).

34. Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96-272, 94 Stat. 500 (codified in scattered sections of 42 U.S.C.) (amended 1997).

35. *See* NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES ET AL., MAKING REASONABLE EFFORTS: STEPS FOR KEEPING FAMILIES TOGETHER 7-8 (1987) [hereinafter MAKING REASONABLE EFFORTS].

36. *See* 42 U.S.C. § 675(5)(E).

37. *See* NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES ET AL., *supra* note 35, at 7-8.

38. *Id.* at 11.

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

parent committed murder, involuntary manslaughter, or felonious assault that resulted in serious harm to the child or another child of the parent).[40] Second, ASFA shortened the timelines for permanent decisions regarding children in foster care from eighteen months to twelve months.[41] While the goal of these amendments was to shorten the amount of time children languish in foster care, few in the child welfare system appeared to be effectively meeting the old timeline, and few expect to do so on the shorter one. At the beginning of 1999, most states were still deciding how to implement the law.

To realize the intent of the law and achieve better outcomes for children, the child welfare system must be capable of identifying the problems facing families, assessing their need for services, determining what services to provide and how to pay for them, and demonstrating that they have made reasonable efforts to resolve family problems that result in abuse and neglect. Because substance abuse and addiction destroy or profoundly compromise the ability of parents to provide a safe and nurturing home for their children, and because it is so pervasive among parents in the child welfare system, failing to address substance abuse and addiction inevitably stymies efforts to comply with the law and achieve positive outcomes for children.

III. CREATING ORDER OUT OF CHAOS

Family courts are essential components of an effective approach to preventing and mitigating substance-related child abuse and neglect; however, other institutions and organizations must also come to the table. Family courts can play an essential coordinative role in bringing these institutions and organizations together and can assure their accountability as well as that of the parents. The agenda for family courts, and child welfare agencies as well, includes six major steps: adopt guiding principles for action; start with prevention; dramatically reform child welfare practice; fund comprehensive treatment; provide substance abuse training for all court, child welfare, social and health service professionals; and evaluate outcomes, increase research, and improve data systems.

A. Adopt Guiding Principles for Action

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

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40. *See* 42 U.S.C. § 671(15)(D).
41. *See id.* § 675(5)(C).

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 them and who refuse to enter treatment or who, 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; and
4. The goal of the child welfare system is to form and support safe, nurturing families for children—where possible within the biological family or, where not possible, with an adoptive family.[42]

Keeping these principles front and center in courts' decision-making process will help them set priorities for action and make timely decisions.

B. Start with Prevention

The best hope of preventing child abuse and neglect by substance-abusing parents is preventing drug and alcohol abuse and addiction. The problem is too big and too devastating in human and economic terms to retreat to remediation only.

Family courts should capitalize on all contacts with public services agencies to encourage them to incorporate prevention of child abuse and neglect, as well as treatment of substance-abusing parents in social programs. While an all-out attack on these problems is beyond the purview of a family court or child welfare agency acting in isolation, agencies can participate in concerted actions with other organizations or individuals to mount a comprehensive prevention effort.

Courts should also attempt to assure assistance for all members of families involved with the child protective system, not just the subject of the case at hand. Although we know that children who suffer maltreatment at the hands of substance-abusing parents are at high risk for later problems,[43] from substance abuse to suicide attempts, few

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42. *See* CASA, NO SAFE HAVEN, *supra* note 3, at 9.

43. *See* Anthony M. Graziano & Joseph R. Mills, *Treatment for Abused Children: When is a Partial Solution Acceptable?* 16 CHILD ABUSE & NEGLECT 217, 219 (1992); Howard B. Moss et al., *Timing of Paternal Substance Abuse Disorder Cessation and Effects on Problem Behaviors in Sons*, 6 AM. J. ADDICTIONS 30, 30 (1997); John I. Takayama et al., *Children in Foster Care in the State of Washington: Health Care Utilization and Expenditures*, 271 JAMA 1850, 1854 (1994); Anthony J. Urquiza et al., *Screening and Evaluating Abused and Neglected Children Entering Protective Custody*, 73 CHILD WELFARE 155, 156 (1994); Migs Woodside et al., *Medical Costs of Children of Alcoholics: Pay Now or Pay Later*, 5 J. SUBSTANCE ABUSE 281, 285 (1993).

resources are devoted to helping these children with counseling and support services when child welfare systems have identified them.[44]

C. *Dramatically Reform Child Welfare Practice*

Family court judges and child welfare officials should employ five 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; relapse prevention and management; and facilitating adoption for children when parents fail to engage in treatment.

1. *Screening and Assessment*

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, engage the parent in a conversation about it, use drug testing, and respond effectively to the parent and help motivate him or her to seek help. Assessing the severity of the problem requires more expertise than can reside in either the child welfare worker or a supporting professional. Family court judges can require that such screening and assessment take place for cases that come before their courts.

2. *Timely and Appropriate Treatment*

Family court judges and child welfare agency directors should encourage or 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.[45] These treatment programs generally include mental and

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44. *See* MEREDITH MINKLER & KATHLEEN M. ROE, GRANDMOTHERS AS CAREGIVERS: RAISING CHILDREN OF THE CRACK COCAINE EPIDEMIC 205-06 (1993); LESLIE MITCHEL & CYNTHIA SAVAGE, NAT'L COMM. FOR THE PREVENTION OF CHILD ABUSE, THE RELATIONSHIP BETWEEN SUBSTANCE ABUSE AND CHILD ABUSE 7 (1991); Nan P. Roman & Phyllis B. Wolfe, *The Relationship Between Foster Care and Homelessness*, 55 PUB. WELFARE 4, 9 (1997).

45. *See* Susan Egelko et al., *Evaluation of a Multisystems Model for Treating Perinatal Cocaine Addiction*, 15 J. SUBSTANCE ABUSE TREATMENT 251 (1998); Ronith Elk et al., *Behavioral Interventions: Effective and Adaptable for the Treatment of Pregnant Cocaine-Dependent Women*, 27 J. DRUG ISSUES 625, 647 (1997); Antonnette Graham et al., *Miracle Village: A Recovery Community for Addicted Women and their Children in Public Housing*, 14 J. SUBSTANCE ABUSE TREATMENT 275, 281-84 (1997); Lauren M. Jansson et al., *Pregnancy and Addiction: A Comprehensive Care Model*, 13 J. SUBSTANCE ABUSE TREATMENT 321, 329 (1996); Stephen Magura & Alexandre B. Laudet, *Parental Substance Abuse and Child Maltreatment: Review and Implications for Intervention*, 18 CHILDREN & YOUTH SERVICES REV. 193, 204 (1996); Stephen Magura et al.,

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.[46]

The need to provide this kind of treatment is increasingly urgent given the federal welfare reform law, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996,[47] which limits the benefits recipients can receive to five years;[48] many states have set a two-year limit.[49] How the nation responds to this challenge will have a direct impact on the safety and well being of the nation's children.

3. Strategies to Motivate Parents

Family court judges and child welfare agency directors 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.[50] 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

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Effectiveness of Comprehensive Services for Crack-Dependent Mothers with Newborns and Young Children, 31 J. PSYCHOACTIVE DRUGS (forthcoming); Amelia C. Roberts & Robert H. Nishimoto, *Predicting Treatment Retention of Women Dependent on Cocaine*, 22 AM. J. DRUG & ALCOHOL ABUSE 313, 327 (1996); Edward Saunders, *Project Together: Serving Substance-Abusing Mothers and Their Children in Des Moines*, 82 AM. J. PUB. HEALTH 1166, 1167 (1992); M. Duncan Stanton & William R. Shadish, *Outcome, Attrition, and Family-Couples Treatment for Drug Abuse: A Meta-Analysis and Review of the Controlled, Comparative Studies*, 122 PSYCHOL. BULL. 170, 187-188 (1997); Richard R. Szuster et al., *Treatment Retention in Women's Residential Chemical Dependency Treatment: The Effect of Admission with Children*, 31 SUBSTANCE USE & MISUSE 1001, 1010 (1996); Cheryl Zlotnick et al., *The Impact of Outpatient Drug Services on Abstinence Among Pregnant and Parenting Women*, 13 J. SUBSTANCE ABUSE TREATMENT 195, 199-200 (1996).

46. *See* Graham et al., *supra* note 45, at 281-84; Egelko et al., *supra* note 45, at 253.

47. 42 U.S.C. § 601 *et seq.*

48. *See id.* § 608(a)(7)(A).

49. *See, e.g.*, ALASKA STAT. § 47.27.030(b) (Michie 1998) (continued assistance after 24 months contingent on participation in a work activity); CAL. WELF. & INST. CODE § 11454(a)(2) (West 1998) (same); FLA. STAT. ANN. § 414.05 (West 1998) (amended 1999) (24-month limit as default); 305 ILL. COMP. STAT. 5/4-17(a) (West Supp. 1999) (continued assistance after 24 months contingent on participation in a work activity); IND. CODE ANN. § 12-14-2-5.1(a) (Michie 1997) (24-month limit as default); MD. CODE ANN. art. 88A, § 51(a)(2) (1998) (continued assistance after 24 months contingent on participation in a work activity); MISS. CODE ANN. § 43-17-5(j) (Supp. 1999) (amended 1999) (same); MONT. CODE ANN. § 53-4-603(5)(a) (1999) (amended 1999) (same); N.C. GEN. STAT. § 108A-27.1 (1998) (24-month limit as default).

50. *See* Karen Bell et al., *Predicting Length of Stay of Substance-Using Pregnant and Postpartum Women in Day Treatment*, 14 J. SUBSTANCE ABUSE TREATMENT 393, 394 (1997).

engage parents in treatment is a particularly promising innovation.[51] Help and encouragement from a woman who has "been there" may resonate with an addicted woman in a unique and powerful way.

Family drug courts are a promising innovation to motivate parents. Family drug courts are an outgrowth of criminal drug courts, whereby the court administers graduated rewards and sanctions to coerce treatment attendance and abstinence from substance use. Although careful evaluation must still be done, 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.

4. Relapse Prevention and Management

Family court judges and child welfare agency directors should take steps to prevent and plan for managing relapse before closing cases. Because substance abuse is a chronic disease, relapse is not necessarily a sign that treatment has failed.[52] 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 relapse occurs, particularly in the first three months after treatment when relapse is most likely.[53] 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.[54] Mothers need aftercare that addresses the stresses of parenting and may prefer sup-

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51. *See* Therese M. Grant et al., *An Intervention with High Risk Mothers Who Abuse Alcohol and Drugs: The Seattle Advocacy Model*, 86 AM. J. PUB. HEALTH 1816, 1817 (1996); Diane Kravetz & Linda E. Jones, *Women Reaching Women: A Project on Alcohol and Other Drugs of Abuse*, 12 ADMIN. SOC. WORK 45, 51 (1988); *Linking Women with Personal Advocates Reduces Substance Exposed Pregnancies*, 97 SUBSTANCE ABUSE FUNDING NEWS 13, 13 (1997).

52. *See* Dennis C. Daley & Miriam S. Raskin, *Relapse Prevention and Treatment Effectiveness Studies*, *in* TREATING THE CHEMICALLY DEPENDENT AND THEIR FAMILIES 128, 134 (Dennis C. Daley & Miriam S. Raskin eds., 1991); G. Alan Marlatt, *Relapse Prevention: Theoretical Rationale and Overview of the Model*, *in* RELAPSE PREVENTION: MAINTENANCE STRATEGIES IN THE TREATMENT OF ADDICTIVE BEHAVIORS 3, 31 (G. Alan Marlatt & Judith R. Gordon eds., 1985).

53. *See* Daley & Raskin, *supra* note 52, at 131; Marlatt, *supra* note 52, at 35.

54. *See* Helen M. Annis et al., *Gender in Relations to Relapse Crisis Situations, Coping and Outcome Among Treated Alcoholics*, 23 ADDICTIVE BEHAVIORS 127, 130 (1998); Marlatt, *supra* note 52, at 35; David N. Nurco et al., *Aftercare/Relapse Prevention and the Self-Help Movement*, 25 INT'L J. ADDICTIONS 1179, 1191 (1990-1991).

port group programs that are all female.[55] 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, to individuals who are in recovery, and to affordable childcare may be particularly important.

Family court judges can encourage connection to Alcoholics Anonymous and Narcotics Anonymous, support use of paraprofessionals by child welfare agencies, and encourage the inclusion of safety plans in caseplans that will map how a parent intends to keep her child safe in the event of possible relapse.

Family court judges and attorneys should encourage child welfare agencies 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.[56] 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.[57] The child welfare system is providing "long-term services" to these families, a costly practice that fails to protect children.

5. Adoption Facilitation

Family court judges and child welfare agency directors 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.

Ideally, 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.[58] This would allow child welfare agencies to move more assertively to terminate pa-

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55. *See* Kathleen Coughey et al., *Retention in an Aftercare Program for Recovering Women* 33 SUBSTANCE USE & MISUSE 917, 918 (1998).

56. *See* Douglas J. Besharov, *The Children of Crack: A Status Report*, 54 PUB. WELFARE 32, 35 (1996); Jane R. Wyman, *Multifaceted Prevention Programs Reach At-Risk Children Through Their Families*, 12 NIDA NOTES 5, 7 (1997). *See also* William A. Hunt & Dale A. Bespalec, *Relapse Rates after Treatment for Heroin Addiction*, 2 J. COMM. PSYCHOL. 85, 85 (1974) (finding that relapse rates stabilize after three to six months).

57. *See* Besharov, *supra* note 56, at 33-37.

58. *See* Robert T. Kinscherff & Susan J. Kelley, *Substance Abuse: Intervention with Substance Abusing Families*, 4 APSAC ADVISOR 3, 4 (1991).

rental rights, divert resources from these parents, and focus on parents who are more likely to benefit.[59] Unfortunately, it is difficult to predict who will respond to treatment and when they will do so.[60]

Some important indicators, however, 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.[61] 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.[62] 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.

D. 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, job training, healthcare, and social services. Yet supply of this treatment falls dramatically short of demand.[63] Judges, attorneys, and child welfare directors 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.

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59. *See id.*

60. Mary S. Lawson & Geraldine S. Wilson, *Parenting Among Women Addicted to Narcotics*, 59 CHILD WELFARE 67, 70 (1980).

61. *See id.* at 75; Alma J. Carten, *Mothers in Recovery: Rebuilding Families in the Aftermath of Addiction*, 41 SOC. WORK 214, 221 (1996).

62. *See* Bays, *supra* note 14, at 881-904; David P.H. Jones, *The Untreatable Family*, 11 CHILD ABUSE & NEGLECT 409, 413 (1987); Ronald Zuskin & Dianne DePanfilis, *Child Protective Services: Working with CPS Families with Alcohol and Other Drug (AOD) Problems*, 8 APSAC ADVISOR 8, 10-11 (1995).

63. *See* Mary R. Haack & Janet A. Deatrick, *Training Health Care Professionals to Deliver Comprehensive Care to Drug-Affected Children and Their Families*, *in* DRUG DEPENDENT MOTHERS AND THEIR CHILDREN 135, 144 (Mary R. Haack ed., 1997); Norma Finkelstein, *Treatment Issues for Alcohol- and Drug-Dependent Pregnant and Parenting Women*, 19 HEALTH AND SOC. WORK 7, 8 (1994).

E. Provide Substance Abuse Training for All Court, Child Welfare, Social, and Health Service Professionals

Judicial officials from judges to lawyers, social service providers from agency directors to frontline child welfare workers, 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.[64] Substance abuse training should be a prerequisite for family court judgeship and a required element in certification and licensing requirements for child welfare professionals.

Judges and child welfare directors 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. 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; it also recommends hiring specialists who can assist judges by performing timely substance abuse evaluations and making treatment recommendations.[65] 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.

F. Evaluate Outcomes, Increase Research, and Improve Data Systems

Family courts and child welfare officials need to collect better data and evaluate the outcomes of their efforts in cases where 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. Current data systems are inadequate for providing basic information on children under supervision, judicial or caseworker caseloads, parental substance involvement, or outcomes for families.[66] States must place a priority on updating case records and tracking by the agency by upgrading information systems and computers.

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64. *See generally,* CASA, NO SAFE HAVEN, *supra* note 3.

65. *See* SUPREME JUDICIAL COURT SUBSTANCE ABUSE PROJECT TASK FORCE, A MATTER OF JUST TREATMENT 27-46 (1995).

66. *See* CASA, NO SAFE HAVEN, *supra* note 3, at 85.

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.[67] 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.[68]

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

IV. FAMILY COURTS TAKE THE LEAD

Federal and state laws leave the key policy decisions regarding substance-abusing parents to family courts and child welfare agencies. Given this freedom, a handful of judges and child welfare directors are putting new strategies into practice, and despite formidable barriers—some overcome, some not—they appear to be making progress toward realizing some elements of the agenda outlined above. CASA studied the use of family drug courts in family courts in three sites around the country. CASA also studied three child welfare agency-based initiatives that would assist courts and the child welfare system in confronting substance abuse. In practice, the efforts of either family courts or child welfare agencies to address substance abuse require collaboration between the two—and other agencies and organizations as well. Below is a description of the nature of family drug courts and experiences from three currently operating courts. Also described are three child welfare agencies that illustrate how changes in child welfare agency practice can assist family courts in realizing better outcomes for children and families.

A. Family Drug Courts

Judicially-supervised substance abuse treatment programs are cropping up from the grassroots of judges' chambers nationwide.

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67. *See* STEPHEN MAGURA & BETH SILVERMAN MOSES, OUTCOME MEASURES FOR CHILD WELFARE SERVICES 5 (1986).

68. *See id.* at 6-8.

Frustrated by ineffective efforts to deal with 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 twenty judges in family courts are trying to apply that model to the family court setting.[69] Although it is not an easy fit, there is some promise in these experiments.

B. 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 promote abstinence from alcohol and drugs and eliminate criminal behavior.[70] Generally, drug courts target participants charged with non-violent drug offenses whose involvement with the criminal justice system is due to substance abuse.[71] They 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 long-term recovery.[72]

In June 1989, the first criminal drug court was established in Dade County, Florida.[73] Since then, 275 criminal jurisdictions around the nation have implemented drug court programs.[74] A review of the research on drug courts shows that they "provide more comprehensive supervision and more frequent drug testing and monitoring than other forms of community supervision. More importantly, drug use

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69. *See* CASA, NO SAFE HAVEN, *supra* note 3, at 61 (citing Telephone Interview with Susan Weinstein, Staff Counsel, National Association Drug Court Professionals (Dec. 1998)).

70. *See* CAROLINE S. COOPER, AMERICAN UNIVERSITY NATIONAL CENTER FOR STATE COURTS, DRUG COURTS: AN OVERVIEW OF OPERATIONAL CHARACTERISTIC AND IMPLEMENTATION ISSUES 3 (1995).

71. *See* NATIONAL CENTER ON ADDICTION AND SUBSTANCE ABUSE AT COLUMBIA UNIVERSITY, BEHIND BARS: SUBSTANCE ABUSE AND AMERICA'S PRISON POPULATION 193 (1998) [hereinafter CASA, BEHIND BARS].

72. *See id.* at 193-94.

73. *See id.* at 194. There were earlier "Narcotics Courts" in Chicago and New York, but they did not emphasize treatment. *See id.*

74. *See* Steven Belenko, *Research on Drug Courts: A Critical Review, in* NAT'L DRUG COURT INST. REV. 3 (1998).

and criminal behavior are substantially reduced while offenders are participating in drug court."[75]

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.[76] 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.[77]

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 participants' behavior.[78] This monitoring is an essential component of all drug court programs.[79] Drug court participants have regular hearings—usually every two weeks—before the judge.[80] 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.[81]

C. *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:

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

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75. *Id.* at 1.

76. *See* CASA, BEHIND BARS, *supra* note 71, at 203; COOPER, *supra* note 70, at 37.

77. *See* CASA, BEHIND BARS, *supra* note 71, at 189; COOPER, *supra* note 70, at 37.

78. *See generally* Belenko, *supra* note 74; JOHN GOLDKAMP, DEP'T OF JUSTICE, NAT'L INST. OF JUSTICE AND TREATMENT INNOVATION: THE DRUG COURT MOVEMENT (1994).

79. *See* COOPER, *supra* note 70, at 39.

80. *See id.* at 42.

81. *See id.* at 47.

- *Coordination.* The judge provides leadership for the fragmented array of parties involved with a family (child welfare caseworkers, legal aid professionals, housing officials, childcare providers, treatment providers, attorneys, etc.). The judge facilitates communication between agencies so they share information, coordinate the caseplan, and resolve conflicts.
- *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.
- *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.
- *Informed decision-making.* Pre-hearing conferences, the accountability of service providers, and frequent, direct interaction with parents help judges make informed decisions.
- *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.[82]

D. Family Drug Courts in Operation

CASA studied three family courts currently implementing the family drug court model: Judge Charles McGee's court in Reno, Nevada;[83] Judge John Parnham's court in Pensacola, Florida;[84] and Judge Nicolette Pach's court in Suffolk County, New York.[85] These

82. *See* CASA, NO SAFE HAVEN, *supra* note 3, at 62-63.

83. *See id.* at 64-67 (citing Personal Communication with Charles McGee, Judge, Reno, Nev. (Nov. 1997)).

84. *See id.* at 68-71 (citing Interview with John Parham, Judge, Pensacola, Fla. (Nov. 1997)).

85. *See id.* at 71-74 (citing Interview with Nicolette Pach, Judge, Suffolk County, N.Y. (Mar. 17, 1997); Personal Communication with Nicolette Pach, Judge, Suffolk County, N.Y. (June 1997)).

judges observed that their caseloads were overwhelmed by parents experiencing problems with substance abuse and addiction and that such cases were usually not demonstrating any change or progress.[86] Judge McGee and Judge Parnham had operating criminal drug courts in their jurisdictions and were intrigued by the possibility of moving the model into the family courts.[87] Later, Judge Pach learned of their innovation. She was increasingly frustrated by seeing parents in need and was intrigued by experimenting with new ways of practice.[88] Their experience, as it relates to CASA's recommended agenda for action, is discussed below.

1. Screening and Assessment

In each of the three family drug courts examined in the CASA study, the availability of a program targeting substance-abusing parents has increased caseworkers' awareness of, and screening for, the problem.[89] This is valuable even if screening is informal. Judge Parnham spoke directly to the frontline caseworkers about his program and highlighted the importance of addressing substance abuse. Judge Pach has worked closely with the Suffolk County Department of Social Services to train caseworkers in substance abuse.[90]

Regarding assessment, the courts direct parents referred to the program to a substance abuse specialist for a professional assessment.[91] This is a key step in the process because matching a parent with appropriate treatment is vital to success.

2. Access to Treatment

In all three family drug court programs, treatment is available on demand.[92] Given the waitlists reported around the country for public treatment, this is an important way that judges can use their standing in the community to compel available services for parents in need. Different courts offer access to different kinds of treatment. In Judge McGee's court, participants have access to both residential and outpatient treatment.[93] Judge Parnham noted that if a client is not suitable for the drug court program, his staff assures that the parent will be

86. *See id.* at 64 (Judge McGee), 68 (Judge Parnham), 71 (Judge Pach).
87. *See id.* at 64 (Judge McGee), 68 (Judge Parnham).
88. *See id.* at 72 (citing Personal Communication with Nicolette Pach, Judge, Suffolk County, N.Y. (June 1997)).
89. *See id.* at 64-65 (Reno), 68 (Pensacola), 72 (Suffolk County).
90. *See id.* at 73.
91. *See id.* at 65 (Reno), 70 (Pensacola), 74 (Suffolk County).
92. *See id.* at 64-65 (Reno), 68 (Pensacola), 72 (Suffolk County).
93. *See id.* at 65.

connected with the appropriate services, whether that be in another type of treatment or other mental health services.[94] It is also important to note that each court can tailor its program to the needs of its client base. Access to treatment has also been improved because in both Reno and Pensacola the local treatment providers tailored treatment toward women participating in the drug court program.[95]

3. Motivation

All three judges convey a sense of sincere interest in each of the parents who appear before them.[96] In a sample exchange from Judge McGee's 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."[97] While each judge does not hesitate to use incarceration when necessary, the judges appear eager to give positive reinforcement to parents, impressing upon them how much, in the words of Judge Pach, she "want[s] them to succeed."[98]

The open forum and presence of all participants in the courtroom 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.

Judge Pach has considered carefully how the system of rewards and sanctions should reflect the values of the family court and the goal of better outcomes for children.[99] 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.[100]

4. Accountability

Accountability of all players in the child welfare system is the companion to parent motivation. Bi-weekly hearings and pre-hearing

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94. *See id.* at 70 (citing Personal Communication with Robin Wright, Deputy Court Administrator, Pensacola, Fla. (Dec. 1998)).

95. *See id.* at 67 (Reno), 71 (Pensacola).

96. *See id.* at 67 (Reno), 70 (Pensacola), 73 (Suffolk County).

97. *Id.* at 67 (quoting Judge McGee, Drug Court Session, Reno, Nev. (Sept. 1997)).

98. *Id.* at 74.

99. *See id.* at 73 (citing Personal Communication with Nicolette Pach, Judge, Suffolk County, N.Y. (June 1997)).

100. *Id.* (quoting Personal Communication with Nicolette Pach, Judge, Suffolk County, N.Y. (June 1997)).

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. The judge serves as a coordinating force and enforcer of the system's commitments and obligations to parents.

5. Prevention and Management of Relapse

Preparing for relapse is a key component to long term success. Judge McGee, with the oldest up-and-running parent drug court,[101] has integrated some elements of aftercare into the program.[102] He has also required that parents check in with him after graduation. In both Reno and Pensacola, the treatment 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.[103] Judge Parnham is also considering making connections for parents to churches and other organized religious groups, since such groups are a vibrant force in the community and spirituality can be a component of treatment.[104]

6. Meeting the Goals of ASFA

The drug court model may facilitate meeting the goals of ASFA by fulfilling the "reasonable efforts" requirement for terminating parental rights. Constant review of cases puts drug court cases on a quicker timeline than other family court cases. In Pensacola, 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 chance for reunification. The caseworkers say if parents cannot become sober, drug-free, and ready for reunification through this program, they are not likely to ever do so.[105]

But speeding up the adoption process is not every judge's immediate goal, and, in practice, family courts rarely terminate parental rights. Judge McGee promises candidates that if they complete the program and work hard they will be reunified with their children—

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101. *See id.* at 64.

102. *See id.* at 67.

103. *See id.*

104. *See id.* at 71 (citing Personal Communication with John Parham, Judge, Pensacola, Fla. (Nov. 1997)).

105. *See id.* at 71 (citing Personal Communication with DCF Caseworkers, Pensacola, Fla. (Nov. 1997)).

"guaranteed."[106] Further, most children reside in kinship care, which child welfare agencies do not treat with the same urgency as regular foster care.[107]

Meeting both legal and child developmental time limits is Judge Pach's primary goal for the drug court - whether by reunifying families, freeing children for adoption, or finding another permanent solution. Training in the nature of addiction and recovery, thorough assessments, and ongoing monitoring help Judge Pach make informed decisions regarding children. 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."[108]

7. Collaboration

Collaboration and coordination with other agencies is a significant barrier. Because of the multiple problems these women face, multiple services must be offered in recovery. Judges Parnham and McGee were able to leverage their good standing in the community to gain cooperation from others in the system. To design her program, Judge Pach assembled a steering committee for the project and her own miniature case-management team, with the approval of the local social services agency that acknowledged it was struggling to meet the challenge.[109] The courts can be powerful forces in forging this collaboration by imposing 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. These courts, for example, have negotiated informal agreements from treatment providers to serve drug court participants who otherwise generally have had a difficult time finding treatment.

8. Lack of Resources

All three judges recognize the real barriers to change; the most visible is the lack of resources.[110] Because other criminal courts were

106. *Id.* at 67 (citing Personal Communication with Charles McGee, Judge, Reno, Nev. (Sept. 1997)).

107. *See* Personal Communication with DCF Staff Member (Nov. 1997) (on file with the authors).

108. CASA, NO SAFE HAVEN, *supra* note 3, at 74 (quoting Personal Communication with Charles McGee, Judge, Reno, Nev. (Sept. 1997)).

109. *Id.* at 73 (citing Personal Communication with Nicolette Pach, Judge, Suffolk County, N.Y. (June 1997)).

110. *See id.* at 64 (Reno), 68 (Pensacola), 72 (Suffolk County).

already operating in their area, both Judges McGee and Parnham were able to rely on a sentiment already sympathetic toward drug courts to convince court administrators to fund the program.[111] Judge Pach launched her program with in-kind donations from the court and other agencies; fortunately, funding from a private foundation followed.[112] "My advice," she said, is: "Don't wait for the money."[113] All courts face considerable pressure due to lack of funding for treatment and services for families, and evaluation components for their programs. Each emphasized an interest in outcomes evaluations, but have been unsuccessful in funding any.

E. Promises and Cautions

Early impressions of the family drug court model convey the appearance of 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. Evaluations of outcomes from experiments with family drug courts are necessary to determine whether children benefit and legal protections accorded parents remain inviolate.

The criminal drug court model does not, however, 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 noncompliance with a caseplan. Maintaining appropriate confidentiality and sensitivity to the impact of these programs on women, the poor, and various racial and ethnic groups is also a challenge. 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.

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111. *See id.* at 64 (McGee), 68 (Parnham).

112. *See id.* at 72.

113. *Id.* (quoting Personal Communication with Nicolette Pach, Judge, Suffolk County, N.Y. (June 1997)).

V. CHANGING PRACTICE IN CHILD WELFARE AGENCIES

CASA also studied three child welfare agency-based innovations focused on reaching parents affected by substance abuse: the Alcohol and Other Drug Training Initiative (AODTI) in Sacramento, California;[114] the use of certified addiction counselors by the Division of Youth and Family Services (DYFS) in New Jersey;[115] and Project SAFE, a managed care program, in Connecticut.[116] While these three programs were not designed in conjunction with family court reforms, family courts can encourage and benefit from the use of such innovations.

First, all three programs improve screening and assessment, which may prevent recycling through the family court system and lower caseloads. Second, following improved screening, each innovation has had to struggle and improve the quantity and quality of substance abuse treatment for women. Here, family courts can be instrumental in requiring that parents who appear in their courtroom receive the appropriate services. Third, by addressing substance abuse, the child welfare agency is able to create a clear record that reasonable efforts have been made, which makes decision-making by a family court judge clearer.

A. Alcohol and Other Drug Treatment Initiatives in Sacramento, California

In 1995, the Sacramento County Department of Health and Human Services implemented the Alcohol and Other Drug Treatment Initiative (AODTI).[117] AODTI is a training program that strives 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.[118]

The program has directly confronted the need for screening and assessment of substance-abusing parents. Caseworkers have learned new skills and specifically how to use a formal assessment questionnaire to identify the severity and nature of substance abuse problems. Parents may see this tool as an independent, unbiased test, which adds

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114. *See id.* at 44-50.

115. *See id.* at 50-55.

116. *See id.* at 55-60.

117. *See id.* at 45.

118. *See id.* (citing Interview with Pam Smithstan, Consultant, Alcohol and Other Drug Training Initiative Trainer, in Sacramento, Cal. (June 1997)).

credibility to caseworkers' recommendations for treatment.[119] When caseworkers use these skills and this tool, they usually appear to be effective at screening and assessment. 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. Caseworker-run support groups for parents appear to help motivate parents to address their substance abuse problems or at least remain interested in treatment until a treatment slot becomes available.

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. 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 family courts to faster resolution of cases for children in foster care.

B. Certified Addiction Counselors in New Jersey

Rather than investing resources in re-training its caseworkers, the New Jersey Division of Youth and Family Services (DYFS) decided to purchase substance abuse guidance from outside experts.[120] Beginning in 1995, DYFS contracted with two local agencies to provide certified alcohol and drug counselors (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.[121] The program and the surge in treatment refer-

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119. *See id.* at 48 (citing Personal Communication with Department Employee at AODTI Training Level Three Session, in Sacramento, Cal. (June 1997)).

120. *See generally id.* at 50-55.

121. *See id.* at 51 (citing Personal Communication, Memo from Alison Recca-Ryan, Easter Seals, to Gretchen Higgins, Contract Administrator, DYFS (Mar. 6, 1996)).

rals 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.[122] For example, DYFS and Addiction Services realized that more ninety-day treatment slots were needed in place of twenty-eight-day treatment slots.[123] When they demanded longer slots, some treatment facilities responded accordingly.[124]

Although nobody in the program wants to break up families, if a parent does not follow treatment requirements, 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.[125] As a result, the program contributes to the task of determining when "reasonable efforts" have been made to keep the family together.

C. 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. DCF contracted a managed care company to conduct substance abuse assessments, drug testing, and substance abuse treatment for DCF parents at the company's network of providers. Although DCF has not negotiated prospective payment nor specific outcome measures 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.[126] This program is called Project SAFE.

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

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122. *See id.* at 54 (citing Interview with Division of Youth and Family Services Staff, in Trenton, N.J. (June 1997)).

123. *See id.*

124. *See id.*

125. *See id.*

126. *See id.* at 57 (citing Connecticut Department of Children and Families, A Report to the General Assembly: Child Protective Services and Adult Substance Abuse Treatment (1997)).

state-funded services.[127] By providing immediate access to treatment, Project SAFE capitalizes on the motivation that can arise in moments of crisis.

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.[128] This project provides supportive housing and intensive case-management to Project SAFE's target population who are engaged in treatment and are ready to be reunited with their children in the community.[129] 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.

D. Movement in the Right Direction

Through innovations such as these, child welfare agencies 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 when to return children home. Efforts to prevent and prepare for relapse and to move more expeditiously to terminate parental rights when appropriate are lower priorities. If these experiments survive and thrive, child welfare agencies may gain the confidence and resources to address these last concerns.

Family courts can recognize and encourage such programs in their courtrooms. The courts can emphasize to agency staff and advocates the court's expectation that substance abuse assessment and treatment become automatic elements of good practice.

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 pre-

127. *See id.* at 59 (citing Connecticut Department of Children and Families, A Report to the General Assembly: Child Protective Services and Adult Substance Abuse Treatment (1997)).

128. *See id.* (citing Personal Communication with DCF Staff, in Trenton, N.J. (Dec. 1998)).

129. *See id.* at 59-60 (citing Personal Communication with DCF Staff (Dec. 1998)).

vented is an option no one supports. Family court judges and staff are uniquely positioned to help bring about system-wide change. They can adopt the guiding principles for managing substance abuse related cases of child abuse and neglect, and require substance abuse screening and assessment and timely, appropriate, comprehensive treatment for parents. They can use the power of the court to help motivate parents and facilitate adoption whenever appropriate. They can emphasize prevention, assure training of all court professionals, and require planning for relapse prevention and management. They can improve information systems and arrange for program evaluations. Finally, they can help overcome structural and cultural barriers to integrating services and change the way the courts and child welfare agencies do business. By assuming leadership in these ways, family courts can help transform the chaos of the current child welfare system and provide a true safe haven for children who are victims of neglect and abuse by substance-abusing parents.