Journal of Health Care Law and Policy

Volume 3 | Issue 1 Article 8

Evaluating Histories of Substance Abuse in Cases Involving the Termination of Parental Rights

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EVALUATING HISTORIES OF SUBSTANCE ABUSE IN CASES INVOLVING THE TERMINATION OF PARENTAL RIGHTS

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In recent years, researchers and policymakers have paid increasing attention to the impact that substance abuse[1] on the part of parents is having on the child welfare and family court systems in the United States.[2] In order to assess how courts have been dealing with the intersecting problems of parental substance abuse and child neglect and abuse, I have reviewed a number of judicial opinions in

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1. There is a fair amount of confusion surrounding the related terms "addiction," "chemical dependency," and "substance abuse." *See generally,* MARK KELLER & MAIRI MCCORMACK, A DICTIONARY OF WORDS ABOUT ALCOHOL 6-27 (2d ed. 1982) (setting out terms used to describe types of addiction and alcoholism); Aubrey Lewis, *Introduction: Definitions and Perspectives, in* SCIENTIFIC BASIS OF DRUG DEPENDENCE 5, 5-11 (Hannah Steinberg ed., 1969) (defining "drug dependence"); Steven S. Nemerson, *Alcoholism, Intoxication, and the Criminal Law,* 10 CARDOZO L. REV. 393, 397-99 (describing addiction in terms of "loss of control"); Frank A. Seixas et al., *Definition of Alcoholism,* 85 ANNALS INTERNAL MED. 764 (1976) (setting out definition of "alcoholism"). The use and abuse of both legal drugs (especially alcohol and tobacco) and illegal drugs is widespread in the United States. Three levels of drug involvement are often identified: use, abuse, and dependence. *See* Rosalind E. Griffin, *Assessing the Drug-Involved Client, in* FAMILIES IN SOCIETY: THE JOURNAL OF CONTEMPORARY HUMAN SERVICES (Assessment Series 2, 1991). "'Use' refers to the taking of a drug for pleasure in order to achieve a sense of well-being." *Id.* "Abuse" refers to use of alcohol or other drugs that "interfere[s] with the individual's ability to carry out expected responsibilities." *Id.* "Chemical Dependency" describes the status of an individual who "persists in using drugs, disregarding any negative consequences and exhibiting tolerance to the drug and withdrawal symptoms when he or she cannot have the drug." *Id.* "Addiction" is an umbrella term that includes people who are chemically dependent in the sense that they have developed a tolerance to their substance of abuse and experience withdrawal symptoms when they decrease or cease consumption of that substance. More generally, however, addiction centers on the twin phenomena of loss-of-control and denial. *See Report of the AALS Special Committee on Problems of Substance Abuse in the Law Schools,* 22 J. LEGAL ED. 35, 40 (1994). Depending upon the drug of abuse, a person can experience loss-of-control and/or denial even if he or she is not physically or chemically dependant upon a substance. Thus, addiction subsumes a broad category of substance abusing behaviors. *See* Nemerson, *supra.*

2. *See* DEPARTMENT OF HEALTH AND HUMAN SERVICES, BLENDING PERSPECTIVES AND BUILDING COMMON GROUND: A REPORT TO CONGRESS ON SUBSTANCE ABUSE AND CHILD PROTECTION (1999) [hereinafter REPORT TO CONGRESS]; NATIONAL CENTER ON ADDICTION AND SUBSTANCE ABUSE AT COLUMBIA UNIVERSITY (CASA), NO SAFE HAVEN: CHILDREN OF SUBSTANCE-ABUSING PARENTS (1999) [hereinafter CASA, NO SAFE HAVEN].

cases involving the termination of parental rights.[3] Perhaps the most significant pattern I have discerned in the cases is a marked ambivalence on the part of judges with respect to the behaviors associated with alcoholism and other drug addiction. This ambivalence about whether to regard addiction as a disease or a moral failing is significant, because courts in termination cases often rely upon unexplored assumptions about the nature of addiction and its effective treatment.

This Article will seek to demonstrate that a number of these preconceptions are not in accord with recent scholarship in the fields of clinical social work and psychiatry, especially as this work relates to the treatment needs of women. It will identify some of the chief characteristics that distinguish female addicts from their male counterparts, in order to demonstrate a few of the ways in which traditional treatment often fails these patients. The Article will then summarize some of the work that has been undertaken to develop an alternative model for the treatment of women with substance abuse problems. In the final analysis, good judicial practice in cases involving the parental rights of women addicts must recognize the effects of referring a mother to, and evaluating her within, the prevailing male dominated models of substance abuse treatment.

I. THE PROBLEM OF ASSIGNING RESPONSIBILITY IN CASES INVOLVING SUBSTANCE ABUSE

A good example of the thoroughgoing ambivalence that runs through many of these opinions is found in the 1996 termination of parental rights case, *In re Devon S.*,[4] which was decided by a Connecticut trial court. In concluding that the statutory standard for termination had been met by clear and convincing evidence, the court makes special mention of "[t]he inability or unwillingness of each parent to

3. I obtained these cases by conducting an electronic (text-based) search for opinions available through Westlaw that contained the words "parent," "addiction," and "substance abuse." Some jurisdictions make family law decisions rendered by trial courts and intermediate appellate courts available in this electronic data base, while many do not. As a consequence, I do not claim any scientific validity for my research methodology, as I have no basis to assess whether the group of cases I have collected and evaluated are necessarily representative of termination cases more generally.

Despite this methodological shortcoming, I can still report that certain consistent patterns emerged as I went through these cases. Moreover, these recurring features did not appear to be dependent upon the particular legal or factual circumstances of the jurisdictions represented. Thus, notwithstanding the anecdotal nature of this research, I have reason to believe that these patterns in the courts' reasoning and analysis are of general significance to lawyers, judges, social workers, mental health professionals, and others concerned about the interrelated problems of substance abuse and child welfare.

4. 1996 WL 677378 (Conn. Super. Ct. 1996).

deal with their [sic] substance abuse problems and successfully complete drug/alcohol treatment over a 15-month period . . . ."[5]

Now, what I think is most significant about this statement, which is not atypical of the language contained in many of the opinions I have reviewed, is that it contains alternative characterizations of the parents' substance abuse for purposes of assigning them responsibility for their behavior. The court's description of the parents as being "*unwilling*" to abstain from the use of alcohol and other drugs implies an understanding of their conduct that I want to term intentionalist.[6] By contrast, the court's simultaneous characterization of the parents as "*unable*" to achieve abstinence suggests a causal account of the very same behavior.[7] Importantly, this alternative account tends to play out very differently within the context of our conventional blaming practices.[8]

The intentionalist account of conduct, which generally is employed in American law, regards most human activity as having been produced through the agency of an individual's free will.[9] In the substantive criminal law, and in the law of contracts, torts, and elsewhere, this intentionalist account permits the legal system to assign responsibility to people for their behavior, on the ground that each of us generally should be held accountable for the consequences of the choices that we make.[10] Thus, operating within this perspective, a judicial finding that a parent has been *unwilling* to abstain from the abuse of alcohol or other drugs, in a case in which that history of substance abuse has raised concerns about that parent's neglect or abuse of his or her child, permits the court to render a decision with respect to parental rights that holds the parent accountable for his or her conduct without violating basic norms governing responsibility and desert.

On the other hand, the court's recognition of the parents' *inability* to avoid substance abuse generates a different set of inferences

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5. *Id.* at *8. *See also In re* Jasmin J., 1996 WL 518134 at *3 (Conn. Super. Ct. 1996) ("[I]t is very apparent that Carolyn has not personally rehabilitated herself, since she is unwilling or unable to make the necessary sacrifices required for substance abuse treatment . . . ").

6. *See* Richard C. Boldt, *The Construction of Responsibility in the Criminal Law*, 140 U. PA. L. REV. 2245, 2246 (1992) [hereinafter *The Construction of Responsibility*]; MARK KELMAN, A GUIDE TO CRITICAL LEGAL STUDIES 86 (1987).

7. *See* Boldt, *The Construction of Responsibility*, *supra* note 6, at 2264-85.

8. *See id. See also* Michael S. Moore, *Causation and the Excuses*, 73 CAL. L. REV. 1091 (1985); Lloyd L. Weinreb, *Desert, Punishment, and Criminal Responsibility*, 49 LAW & CONTEMP. PROBS. 47 (1986).

9. *See* KELMAN, *supra* note 6, at 86.

10. *See id.*

about the origins of the conduct in question, and about the individual actor's relationship to that conduct. This perspective, which is more characteristic of the helping professions and medicine, views human behavior as the product of a matrix of causal factors—including heredity, early childhood experience, and ongoing environment—that necessarily determines choice.[11] This causal account is well suited to diagnosis and treatment, because it directs helping professionals to evaluate and adjust those features within the causal matrix associated with a client's or patient's conduct that are both amenable to change and productive of a given pathology.[12] It is less well suited, however, to the needs of the legal system in circumstances where the assignment of responsibility is a primary goal, because our blaming conventions tend to recognize an excuse for actors who could not have avoided the conduct that is the subject of the inquiry.[13]

In the past, I have written about how conflict between the intentionalist and causal perspectives is managed within legal institutions.[14] Ordinarily, we know intuitively which of the two should predominate at any given moment, and we therefore experience very little dissonance in evaluating the conduct of others in order either to assign or withhold responsibility.[15] When it comes to alcoholism and other drug addiction, however, many of us experience considerable dissonance, as we attempt to sort through these competing points of view. Stated simply, addiction forces both the intentionalist and causal points of view to the surface.[16]

The profound impact that parental substance abuse is having upon child welfare has been made abundantly clear by researchers and others.[17] But, ambivalence over the moral status of addictive behavior, which I believe characterizes popular conceptions of alcoholism and other drug addiction as well as judicial attitudes in these cases, must be managed by these courts if they are to provide a coherent response to the problem. I have found two strategies consistently employed by judges in order to deal with the simple fact that most of

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11. *See* Boldt, *The Construction of Responsibility*, *supra* note 6, at 2304-06.

12. *See id.* *See also* Seymour Halleck, *Responsibility and Excuse in Medicine and Law: A Utilitarian Perspective*, 49 LAW & CONTEMP. PROBS. 127, 129 (Summer 1986).

13. *See* Halleck, *supra* note 12, at 128.

14. *See* Boldt, *The Construction of Responsibility*, *supra* note 6, at 2248.

15. *See id.* at 2264, 2279. *See also* P.F. STRAWSON, SKEPTICISM AND NATURALISM: SOME VARIETIES 38 (1986); P.F. Strawson, *Freedom and Resentment*, *in* FREEDOM AND RESENTMENT 1, 6-13 (1974).

16. *See* Boldt, *The Construction of Responsibility*, *supra* note 6, at 2247.

17. *See, e.g.*, CASA, NO SAFE HAVEN, *supra* note 2, at 11-24.

us think of alcoholism and other drug addiction as both intentional conduct and a chronic disease.

The first strategy is centered on the basic legal principle that a child's best interests should govern custody decisions and decisions with respect to parental rights.[18] Invariably (and necessarily), courts in contested cases who rule against the claims of an addicted parent explain that they are doing so to protect the safety and well being of the child, not to punish the parent.[19] Essentially, the strategy here is to avoid having to confront the notion that a person should not be punished for conduct over which he or she had no control (could not have avoided), by characterizing the court's decision as protective of the child's interest and therefore not punitive.

This strategy is inadequate for two reasons. First, I am skeptical that the long-term best interest of many of the children in these cases is better served by their placement in the foster care system or through the termination of their parents' rights than it would be by the provision of intensive and appropriate services designed to maintain the family system and assist its members toward more healthy functioning.[20] But even if I am wrong about this, and even if such an array of potentially effective services is beyond the budgetary means of the relevant agencies, this strategy of focusing on the best interests of the children is still unlikely to ameliorate the underlying difficulty I have identified.

Notwithstanding the stated goal of protecting the best interests of the children, it is clear that parents whose parental rights are terminated as a consequence of their substance abuse experience such a decision as punitive.[21] Indeed, I have been struck as I have read these opinions by how thoroughly this reality pervades both the structure of the courts' analysis and the very language they employ.[22]

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18. *See, e.g.*, CONN. GEN. STAT. § 17a-112(d) (1999); WASH. REV. CODE § 13.34.190(4) (1999). *See generally* JOSEPH GOLDSTEIN, ET AL., BEYOND THE BEST INTERESTS OF THE CHILD (1973).

19. *See, e.g., In re* Luis C., 554 A.2d 722, 727 (Conn. 1989); *In re* T.J.O., 527 N.W.2d 417, 421 (Iowa Ct. App. 1994).

20. *See* CASA, NO SAFE HAVEN, *supra* note 2, at 77-86; Dorothy Roberts, *The Challenge of Substance Abuse for Family Preservation Policy*, 3 J. HEALTH CARE L. & POL'Y 72 (1999).

21. *See In re* Brandon A., 630 N.Y.S.2d 850 (Fam. Ct. Monroe Co. 1995).

22. With respect to the language employed by courts in these cases, *see, e.g., In re* T.J.O., 527 N.W.2d at 421("[P]arents must move quickly to rectify their personal deficiencies."). As to the more general claim that termination of parental rights is, in important respects, understood to be punitive, *see In re* Brandon A., 630 N.Y.S.2d at 852 (describing termination of parental rights as "final and harsh," and recognizing that "a high degree of due process must be afforded to respondent parents in these cases where the government wishes to sever the [parent-child] relationship."). Although not conclusive on this point, it

Given the less than complete success of the first strategy, it should come as little surprise that the great majority of the cases I have evaluated also employ a second rhetorical strategy for harmonizing the intuition that alcoholism and other drug addiction is a disease with the recognition that the involuntary termination of a parent's rights to his or her child is generally experienced as punitive. This second strategy attempts to remove the mitigating effect created by the court's concededly ambivalent understanding of addiction as a disease, by focusing on the parent's receipt of substance abuse treatment and subsequent failure to obtain sobriety.[23] I regard this strategy as rhetorical, because it permits a court to terminate parental rights at least in part on the basis of a parent's refusal of or failure at treatment rather than simply because of his or her addiction.

What generally goes begging in the account offered by these courts is any meaningful information about the kind or kinds of "treatment" that were offered,[24] and whether this "treatment" was appropriate given the particular characteristics of the parent's disease.[25] Instead, "drug treatment," or "substance abuse treatment" is simply employed as a monolith, as if all treatment modalities, and all substance abuse treatment services, were alike. Indeed, it is almost as if the offer of "substance abuse treatment" functions like an inoculation, cleansing the process of any normative dissonance that otherwise might result from a court's assignment of responsibility (and imposi-

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is worth noting the reluctance shown by courts to terminate the parental rights of parents who suffer from other conditions that are as fully disabling as addiction. *See, e.g., In re* Michael G., 194 Cal. Rptr. 745, 748 (Cal. Ct. App. 1983) (finding no termination of parental rights even though parents were developmentally disabled); Leyva v. Brooks, 244 S.E.2d 119, 121 (Ga. Ct. App. 1978) (finding no termination in case involving deaf and mute parent); *In re* McDuel, 369 N.W.2d 912, 916 (Mich. Ct. App. 1985) (finding no severance of parent-child relationship where mother had multiple sclerosis). *But see In re* C.W., 616 So. 2d 127, 128 (Fla. Dist. Ct. App. 1993) (finding that illness beyond parent's control accompanied by neglect can support termination of parental rights).

23. *See, e.g., In re* J.C., 924 P.2d 21 (Wash. 1966) (reversing the Washington Court of Appeals' decision that the parent's rights could not be terminated on a showing that she had refused to be treated for alcohol abuse or had failed at alcohol abuse treatment but without a showing of "current" use of alcohol); *In re* K.R., 904 P.2d 1132 (Wash. 1995) (affirming the lower courts' termination of parental rights in part on the basis that the parents had "been extremely slow and selective in availing themselves of the court-ordered services and . . . [had] failed to complete the services ordered.").

24. For a good discussion of the different types of substance abuse treatment modalities, and the particular patient characteristics that are relevant in selecting one modality or another, *see* AMERICAN SOCIETY OF ADDICTION MEDICINE, PATIENT PLACEMENT CRITERIA FOR THE TREATMENT OF SUBSTANCE-RELATED DISORDERS (2d ed. 1966). *See also* A. Thomas McLellan et al., *Increased Effectiveness of Substance Abuse Treatment: A Prospective Study of Patient-Treatment "Matching,"* 171 J. NERV. & MENT. DIS. 597 (1983).

25. *See* McLellan et al., *supra* note 24.

tion of a punitive outcome) for conduct that is understood, at least in part, as itself the product of a chronic disease.

The strategic clout derived from this focus on a parent's failure to make "meaningful progress on the path towards rehabilitation"[26] after receiving substance abuse treatment is particularly well illustrated by a 1995 Washington Supreme Court decision, *In re the Dependency of K.R.*,[27] where the majority of the court held that parental rights could be terminated on the basis of a showing by clear and convincing evidence that the parents had failed to avail themselves fully of offered substance abuse treatment services, even in the absence of proof that ongoing conditions of neglect or abuse were present.[28] As Justice Johnson's dissent put it: "The majority today . . . defines unfitness as failure to remedy conditions, and then requires clear and convincing proof only of 'failure to remedy' and no additional proof whatsoever of 'conditions.'"[29]

This shift in focus, from a consideration of the parents' underlying addiction to an examination of their choices with respect to participation in treatment, is extraordinarily powerful. Rarely (at least in the opinions I have reviewed), does a court explore why the treatment failed, or even what constitutes failure.[30] Indeed, in its recent report to Congress on Substance Abuse and Child Protection, the Department of Health and Human Services described as "typical" a

> case in which an addicted mother gives birth to a child who is soon taken into foster care. Handed a list of local treatment agencies (whose programs are likely to be full), the mother is told to 'get clean', if she wants her child back, but is given little or no further assistance in securing treatment. Meanwhile, the child welfare agency places the child in a foster home with adoption potential. If the mother happens to be successful (without help from the child welfare agency), reunification is a possibility. If not, the child may be adopted relatively quickly. Many would consider this a standard practice and adequate performance. Yet, while the child welfare agency may secure a permanent home for the child, the birth mother is likely to have received little or no treatment and thus may be reported again in 12 to 18 months with a new infant. The problem has not been solved, for either the

26. *In re* Devon S., 1996 WL 677378 at *9 (Conn. Super. Ct. 1996).

27. 904 P.2d 1132.

28. *See id.* at 1140.

29. *Id.* at 1142 (Johnson, J., dissenting).

30. *See infra* text accompanying notes 39-42.

mother or her children, *often because inappropriate or very short-term treatment was the woman's only option.*[31]

II. ASSESSING JUDICIAL ASSESSMENTS OF SUBSTANCE ABUSE TREATMENT

If we carefully scrutinize the highly stylized account one regularly encounters in these cases of a parent's failure to successfully avail himself or herself of offered substance abuse treatment, we can see that judges often proceed on the basis of unexplored assumptions regarding the nature of addiction and its effective treatment. To the extent that these preconceptions are not in accord with the best understanding of substance abuse treatment as reflected in recent scholarship in the fields of clinical social work and psychiatry,[32] they may produce unfair or inaccurate results in some number of cases. In general, I have observed two categories of problems.

A.

First, in some of the opinions I have reviewed, while the judges recognize that addiction to alcohol and other drugs is a disease, they fail to acknowledge that this disease can be chronic and progressive.[33] In these cases, parents face the prospect that parental rights may be terminated pursuant to unrealistic criteria. This is particularly true with respect to findings that a parent has "failed" at treatment[34] because he or she has not obtained a stable level of sobriety after the passage of a given period of time—often 12 months.[35] In addition, misapprehensions about the nature of addiction and recovery may

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31. REPORT TO CONGRESS, *supra* note 2, at 7 (emphasis added). The National Center on Addiction and Substance Abuse at Columbia University, in its recent study, reported that "61.3 percent of respondents [to its survey of child welfare agency professionals] say that what treatment is 'available' determines what treatment is 'appropriate' for the parent." CASA, NO SAFE HAVEN, *supra* note 2, at 2. They further reported that "the type of treatment provided to parents through the child welfare system is determined almost exclusively by what is available at the moment, rather than a careful assessment of need." *Id.* at 5.

32. *See infra* text accompanying notes 46-73.

33. CASA, NO SAFE HAVEN, *supra* note 2, at 19.

34. Or has failed to accomplish "personal rehabilitation" as the law in some jurisdictions provides. *See, e.g., In re* Migdalia M., 504 A.2d at 537.

35. The Adoption and Safe Families Act of 1997, Pub. L. No.105-89, 111 Stat. 2115, conditions the states' receipt of federal funding upon their adherence to new time-lines that reduce the time allowed to resolve cases of child neglect or abuse from 18 months to 12 months. *See* REPORT TO CONGRESS, *supra* note 2.

lead a court to characterize a relapse or a series of relapses as a failure of treatment rather than as part of the recovery process itself.[36]

While there is a great deal that can be said about the application of rigid time limits for substance abuse treatment, it is worth acknowledging that a parent's time-line for treatment may simply be at odds with his or her child's developmental time-line. Others have written about the difficulty of reconciling these distinct time-lines, and about the importance of acting in children's best interests.[37] I do think, however, that it is dangerous to adopt a practice of concluding automatically that a parent with a substance abuse problem who has not achieved total abstinence within a preset period of time has "failed at treatment."

With respect to relapse generally, it is important that child welfare officials and judges understand that a parent's relapse is not necessarily an indication that treatment has failed, given the chronic nature of addiction. Often relapses, when identified and addressed, represent a phase in the process of recovery, from which a parent can learn and advance toward the ultimate goal of abstinence.[38]

In my review of these cases, I regularly encountered opinions in which this more subtle assessment of relapse was lacking. A representative example of this sort of problem may be found in *In re Devon S.* mentioned above.[39] In this case, the court noted that the mother had been referred to a number of substance abuse treatment programs, and that "[h]er 'off-again, on-again' attempts at treatment were marked by spotty attendance, non-compliance with program rules and periodic relapses."[40] Based upon this record, the *Devon* Court concluded that the mother had failed at treatment, and on that basis proceeded to terminate her parental rights.[41] What goes unacknowledged in this case, however, is evidence that the mother had continued to return to treatment following each relapse, and had continued to search for interventions that would assist her in keeping her "promises to [the child welfare agency] and the court that she would cooperate with substance abuse therapy and remain drug-free."[42]

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36. *See* CASA, NO SAFE HAVEN, *supra* note 2, at 81.

37. *See* CASA, NO SAFE HAVEN, *supra* note 2, at 6.

38. *Id.* at 81.

39. *See In re* Devon S., 1996 WL 677378, at *8 (Conn. Super. Ct. Nov. 6, 1996).

40. *Id.* at *8.

41. *See id.* at *10.

42. *Id.* at *8. *See also In re* Jasmin J., where the court implies that the mother's repeated pattern of starting one treatment regime after another and then leaving each shortly thereafter demonstrated that she was not trying to achieve recovery. 1996 WL 518134, at *3

The reluctance of some courts to scrutinize relapses with sufficient care to distinguish between those parents who have failed at treatment and those who have not yet succeeded, works a hardship on both mothers and fathers. In addition, a second related shortcoming in the way that many courts evaluate instances of relapse impacts women in particular. As the recent U.S. Department of Health and Human Services Report to Congress points out, a pattern of relapse on the part of some women:

> may point to a more serious disorder that was not initially diagnosed, such as post traumatic stress syndrome resulting from past sexual or physical abuse or current abuse. In order to address these issues in women's lives, such as stress connected with being a single parent, low income, being identified as a maltreating parent, and having few social resources, any or all of which may bring about relapse, . . . [f]ormal relapse prevention components that offer means for early detection of relapse and tools for intervention should be included in every treatment program.[43]

Clearly, a woman whose treatment needs include attention to these sorts of issues, who has not received appropriate services or aftercare,[44] should not be penalized for an "unwillingness" to undertake a process of recovery. All too rarely, however, in my review of cases, did I find judges who carefully considered the specific elements of the treatment offered to the women before them in order to make a determination about whether their individual psycho-social characteristics had been met with truly appropriate interventions.

B.

The last point directs attention to a second category of problems relating to courts' assessments of the adequacy of the substance abuse treatment that parents receive. Here I want to focus almost exclusively on the treatment needs of women.

In the past few years, researchers have begun studying some of the ways in which women who suffer from alcoholism or other drug addictions differ from their male counterparts.[45] In light of these dif-

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(Conn. Super. Ct. Aug. 28, 1996). Here again, the court fails to consider that this parent continued to enter treatment after each relapse, and that other factors, including a poor fit between the treatment she was offered and her individual needs, could have accounted for, or contributed to, her inability to complete a program.

43. REPORT TO CONGRESS, *supra* note 2, at 18.

44. *See* CASA, NO SAFE HAVEN, *supra* note 2, at 6.

45. *See* Sheila B. Blume, *Alcohol and Drug Problems in Women: Old Attitudes, New Knowledge, in* TREATMENT CHOICES FOR ALCOHOLISM & SUBSTANCE ABUSE 183 (H.B. Milkman &

ferences, clinicians have reported that a number of elements characteristic of traditional substance abuse treatment may be poorly suited to the needs of many women patients.[46] In my review of cases, I saw substantial evidence of many of the features that the treatment literature identifies as characteristic of women patients, but I rarely encountered an assessment of whether the treatment offered to women facing the termination of their parental rights had been responsive to these needs.[47] In the absence of any explicit discussion of this matter, and given the nature of most treatment resources that are in place in the community, it is fair to assume that the treatment made available to a great many women is based upon therapeutic models developed for men.[48]

There is a vast literature on the nature of addiction and on the variety of models of treatment that have been employed.[49] To date, there remains considerable controversy regarding the elements that go to make up the disease and the measures thought most likely to provide effective treatment.[50] Moreover, until fairly recently, most of the available research involved male addicts and treatment modalities

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L.I. Sederer eds., 1990); Peter G. Fellios, *Alcoholism in Women: Causes, Treatment, and Prevention, in* ALCOHOLISM AND SUBSTANCE ABUSE IN SPECIAL POPULATIONS 11 (Gary W. Lawson & Ann W. Lawson eds., 1989); Helen E. Ross, *Alcohol and Drug Abuse in Treated Alcoholics: A Comparison of Men and Women*, 13 ALCOHOLISM: CLINICAL & EXPERIMENTAL RES. 810 (1989).

46. *See* Lani Nelson-Zlupko et al., *Gender Differences in Drug Addiction and Treatment: Implications for Social Work Intervention with Substance-Abusing Women*, 40 SOC. WORK 45, 48-49 (1995); Brenda V. Smith, *Improving Substance Abuse Treatment for Women*, 24 CLEARINGHOUSE REV. 490 (1990).

47. *See, e.g., In re* Devon S., 1996 WL 677378 (Conn. Super. Ct. Nov. 6, 1996); *In re* Jasmin J., 1996 WL 518134 (Conn. Super. Ct. Aug. 28, 1996).

48. *See* Nelson-Zlupko et al., *supra* note 46, at 48-50. *See also* REPORT TO CONGRESS, *supra* note 2, at 5.

49. On the nature of addiction, *see generally* AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 1994); WORLD HEALTH ORGANIZATION EXPERT COMMITTEE ON DRUG DEPENDENCE, WORLD HEALTH ORGANIZATION TECHNICAL REPORT SERIES No. 775, TWENTY-FIFTH REPORT (1989); WORLD HEALTH ORGANIZATION EXPERT COMMITTEE ON ADDICTION-PRODUCING DRUGS, WORLD HEALTH ORGANIZATION TECHNICAL REPORT SERIES No. 273, THIRTEENTH REPORT (1964); Bruce K. Alexander, *The Disease and Adaptive Models of Addiction: A Framework Evaluation, in* VISIONS OF ADDICTION: MAJOR CONTEMPORARY PERSPECTIVES ON ADDICTION AND ALCOHOLISM 45 (Stanton Peele ed., 1988); Ralph E. Tarter & Kathleen L. Edwards, *Vulnerability to Alcohol and Drug Abuse: A Behavior-Genetic View, in* VISIONS OF ADDICTION: MAJOR CONTEMPORARY PERSPECTIVES ON ADDICTION AND ALCOHOLISM 67 (Stanton Peele ed., 1988). For a good discussion of the various treatment models, *see* AMERICAN SOCIETY OF ADDICTION MEDICINE, PATIENT PLACEMENT CRITERIA FOR THE TREATMENT OF SUBSTANCE-RELATED DISORDERS, *supra* note 24.

50. *See, e.g.,* HERBERT FINGARETTE, HEAVY DRINKING: THE MYTH OF ALCOHOLISM AS A DISEASE (1988); Stanton Peele, *Introduction: The Nature of the Beast, in* VISIONS OF ADDICTION: MAJOR CONTEMPORARY PERSPECTIVES ON ADDICTION AND ALCOHOLISM, *supra* note 49, at xi.

designed for men.[51] All the same, certain points of agreement with respect to the treatment needs of women have begun to emerge.

Addicted women are more likely than men to report that they began using drugs in response to a specific traumatic event, including incest and rape, or other instances of sexual and physical abuse.[52] As noted earlier, relapse among women receiving substance abuse treatment is also highly correlated with posttraumatic stress resulting from past or ongoing physical or sexual assaults.[53]

Relationships figure more heavily in the substance abusing behavior of women, and in their success or failure at treatment.[54] Addicted women are "more likely than not to come from families in which drugs were used as a primary coping strategy by one or more family members,"[55] and are more likely than men to have substance-abusing partners.[56] Addicted women tend to be assigned primary responsibility for childcare in their families, and generally receive less encouragement and support from family members than do male recipients of substance abuse treatment.[57] In fact, many women are discouraged from entering treatment by other family members who perceive the woman's participation "as a threat to her ability to care for the family,"[58] and many leave treatment prematurely in order to take care of dependent children.[59] Not surprisingly, given these characteristics, outcome studies have shown that men's ability to succeed in treatment is much less heavily dependent upon the behavior of their significant others than is the case with women in treatment.[60]

Women with alcohol and other drug addictions are more likely to experience feelings of guilt, shame, and anxiety than are their male counterparts, and have dramatically higher rates of depression than

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51. *See* Edle Ravndal & Per Vaglum, *Treatment of Female Addicts: The Importance of Relationships to Parents, Partners, and Peers for the Outcome*, 29 INT'L J. ADDICTIONS 115, 116 (1994).

52. *See* Richard C. Boldt, *A Study In Regulatory Method, Local Political Cultures, and Jurisprudential Voice: The Application of Federal Confidentiality Law to Project Head Start*, 93 MICH. L. REV. 2325, 2369 (1995) [hereinafter *Head Start*]; Nelson-Zlupko et al., *supra* note 46, at 46.

53. *See* REPORT TO CONGRESS, *supra* note 2, at 18.

54. *See* Boldt, *Head Start*, *supra* note 52, at 2369-71; J. Grant Macdonald, *Predictors of Treatment Outcome for Alcoholic Women*, 22 INT'L J. ADDICTIONS 235 (1987); Ravndal & Vaglum, *supra* note 51, at 116.

55. Nelson-Zlupko et al., *supra* note 46, at 46.

56. *See id.*

57. *See id.*

58. *Id.*

59. *See id.* at 48.

60. *See* Macdonald, *supra* note 54, at 244. *See also* Sheila B. Blume, *Alcohol and Other Drug Problems in Women*, *in* SUBSTANCE ABUSE: A COMPREHENSIVE TEXTBOOK 794, 802 (Joyce H. Lowinson et al. eds., 2d ed. 1992).

do male addicts.[61] As a group, substance abusing women "have lower expectations for their lives than male addicts, and they express greater preoccupation with simply surviving and minimizing discomfort than getting ahead in life."[62]

As a general matter, women suffering from addiction to alcohol or other drugs are likely to be in positions of relative powerlessness, are likely to have low self-esteem, little control over their environments, and to feel hopeless.[63] In light of these characteristics, it only stands to reason that women have had less success in substance abuse treatment programs than have their male counterparts.[64] In the first place, traditional treatment programs often provide little or no assistance in the way of child care.[65] Moreover, the use of confrontational therapeutic approaches designed to overcome a patient's denial, which have been shown to be effective with many men, may have disabling effects with those women patients who respond with increased feelings of shame, guilt, or depression.[66] Similarly, treatment programs that include elements of the twelve-step model developed by Alcoholics Anonymous may not be effective for women whose response to instructions to give one's self up to a "higher power" is to feel even more dependent and less in control of their lives.[67]

Given the strong links between substance abuse and sexual assault among female addicts, the practice in many traditional treatment settings of engaging patients in group sessions with a strong emphasis upon public confession may be counter-productive. While the conventional view is that such "cathartic" sessions can have a "cleansing" effect for addicts, many women may experience the pres-

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61. In one reported study, 19% of the alcoholic women interviewed also fulfilled the diagnostic criteria for major depression, as compared to only 5% of the men under study. *See* Blume, *supra* note 60, at 798 (describing Michie N. Hesselbrock et al., *Psychopathology in Hospitalized Alcoholics*, 42 ARCHIVES GEN. PSYCHIATRY 1050 (1985)). *See also* Linda J. Beckman, *Self-Esteem of Women Alcoholics*, 39 J. STUD. ON ALCOHOL 491 (1978).

62. Nelson-Zlupko et al., *supra* note 46, at 47.

63. *See id.* at 48. *See also* Boldt, *Head Start*, *supra* note 52, at 2371.

64. *See* Nelson-Zlupko et al., *supra* note 46, at 48.

65. *See id.*

66. *See* Jan Copeland et al., *A Comparison of a Specialist Women's Alcohol and Other Drug Treatment Service With Two Traditional Mixed-Sex Services: Client Characteristics and Treatment Outcome*, 32 DRUG & ALCOHOL DEPENDENCE 81, 82 (1993). *See also In re* R.B., 696 N.E.2d 1259, 1261 (Ill. App. Ct. 1998) (quoting trial court as suggesting that "[t]he first ray of hope . . . would be a genuine admission by Mrs. Smith she's got a drug problem.").

67. *See* David Berenson, *Powerlessness—Liberating or Enslaving? Responding to the Feminist Critique of the Twelve Steps*, *in* FEMINISM AND ADDICTION 67 (Claudia Bepko ed. 1991); Nelson-Zlupko et al., *supra* note 46, at 49.

sure to engage in such discussions as a kind of re-violation, especially if they occur in mixed-gender groups.[68]

Finally, the dominant view in many traditional treatment settings is that a person suffering from alcohol or other drug addiction must deal with his or her substance abuse before addressing other psychological or social issues. Some commentators have gone so far as to describe this as identifying the addict with his or her addiction.[69] Some recent work has shown, however, that many women respond better to substance abuse treatment when their addiction is viewed as one of a number of interrelated issues to be confronted together. Often, women who are told to put aside a disabling depression, a continuing sense of grief over a past instance of rape or incest, or ongoing concerns regarding continuing domestic violence, in order to focus on their problems with alcohol or other drugs, feel as if the treatment providers have simply missed the point.[70] Thus, an evidentiary record indicating that a mother has attempted treatment in a variety of settings and has left treatment after each attempt, could be an indicator to a court that this woman has not received appropriate treatment.[71] Particularly if the record also contains evidence of intimate violence, anxiety caused by extreme poverty, social isolation, or depression,[72] courts should look closely at the treatment plan made available to this parent in order to determine whether the therapeutic pieces were in place, in an integrated fashion, necessary to insure that she had at least a fighting chance at overcoming her addiction.

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68. *See* Blume, *supra* note 60, at 801-02; Nelson-Zlupko et al., *supra* note 46, at 49.

69. *See* Nelson-Zlupko et al., *supra* note 46, at 50. *See also In re* Jasmin J., 1996 WL 518134, at *2 (Conn. Super. Ct. Aug. 28, 1996) (reporting expert testimony that "addiction is . . . the most important issue to be addressed. Parenting training is an important goal, but is subsumed by the need to address the addiction problem.").

70. *See* Nelson-Zlupko et al., *supra* note 46, at 48.

71. *See, e.g., In re* Devon S., 1996 WL 677378 (Conn. Super. Ct. Nov. 6, 1996) (failing to give weight to evidence that mother continued to return to treatment following each relapse); *In re* Jasmin J., 1996 WL 518134, at *2 (reporting that mother "did what she has repeatedly done in the past: She was admitted to the [treatment] Program and thereafter, quit the program," but failing to consider either her willingness repeatedly to attempt treatment or the suitability of the programs to which she was referred).

72. *See, e.g., In re* Natashia D., 1997 WL 345327, at *2 (Conn. Super. Ct. June 17, 1997) (record contained evidence of domestic violence and other "long-standing and severe mental health problems"); *In re* T.J.O., 527 N.W.2d 417, 422 (Iowa Ct. App. 1994) (record contained evidence of domestic violence and a psychological evaluation indicating that the mother "has often seen things as beyond her control"); *In re* Dependency of J.C., 924 P.2d 21, 24 (Wash. 1996) (record contained evidence that mother's boyfriend had been "physically abusive" to mother).

C.

The question, then, is what such a plan would look like. At a minimum, it would provide mothers with nonconfrontational and empathic counseling directed to exploring the "components of the[ir] environment that are unhealthy and oppressive and that trigger the use of drugs. Having identified these sources of struggle and stress, women can then be helped to develop and use effective, safe, and nondestructive alternative coping strategies."[73]

This integrated plan would also include provisions for child care, referrals for medical services, parenting classes, and gender-specific counseling groups. All-female groups are especially important not only to create an environment in which women can share experiences of past victimization without feeling re-violated, but also to foster the development of positive, healthy relationships with other women, to "build support networks and . . . shared experiences. . . ."[74]

One particularly compelling example of the kind of integrated treatment services I have in mind, which I suspect are all too rare, is detailed in a 1995 article in the journal, *Social Work.*[75] The author, Beatrice Rogoff Plasse, describes parenting groups that were conducted at a day treatment center in New York City over a three-year period.[76] Plasse reports that sixty of the sixty-eight recovering addicts who participated were successful at staying drug free for the period of their day treatment program, which averaged two years.[77] This is a very positive set of results.

What is significant about this experiment is that many of the issues relating to child development that were raised in the parenting groups were linked to ongoing work taking place in individual counseling sessions.[78] Through the use of journal writing, role playing, and other techniques, participants engaged in a kind of learning that assisted them in their transition from addiction to recovery.[79] As Plasse describes it:

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73. Nelson-Zlupko et al., *supra* note 46, at 50.

74. *Id.* "Recognition of women's ability to survive horrific experiences gives them the ability to move beyond the abuse and create environments in which they are not revictimized." *Id. See also* Boldt, *Head Start, supra* note 52, at 2370.

75. *See* Beatrice Rogoff Plasse, *Parenting Groups for Recovering Addicts in a Day Treatment Center*, 40 SOC. WORK 65 (1995).

76. *See id.* at 66-67.

77. *See id.* at 66.

78. *See id.*

79. *See id.* at 68-71.

> Central to the model . . . is the idea that the childhood and adult history of each individual becomes the focal point for integration and synthesis of the ideas about child development. Introducing the notion that one's life, no matter how damaged or filled with pain, has vital things to teach can take the client from a state of despair and passivity to one of curiosity and hope. Parenting can in this way be seen as a second chance for healing oneself and one's children.[80]

I cannot help but contrast this approach to the one I observed repeatedly in the cases I read. In opinion after opinion, the court reported that the parent (usually a mother) had been referred to substance abuse treatment, and occasionally to anger management classes, parenting classes, or other similar activities. In every case in which the mother had failed to obtain sobriety within the mandated time period, the court's account was that she had failed at drug or alcohol treatment, and independently, that she had either attended or failed to complete the other designated activities. In no cases that I reviewed, did the judge think about or discuss the provision of these services as interrelated and interdependent. For many addicts, and for most women who are addicted to alcohol and other drugs, their addiction is not their identity. Treatment must reach more broadly if it is to assist as many parents as possible, and judges hearing these cases must insist that the adequacy of the treatment offered be a factor in any consideration of the parent's efforts at recovery.

80. *Id.* at 67.