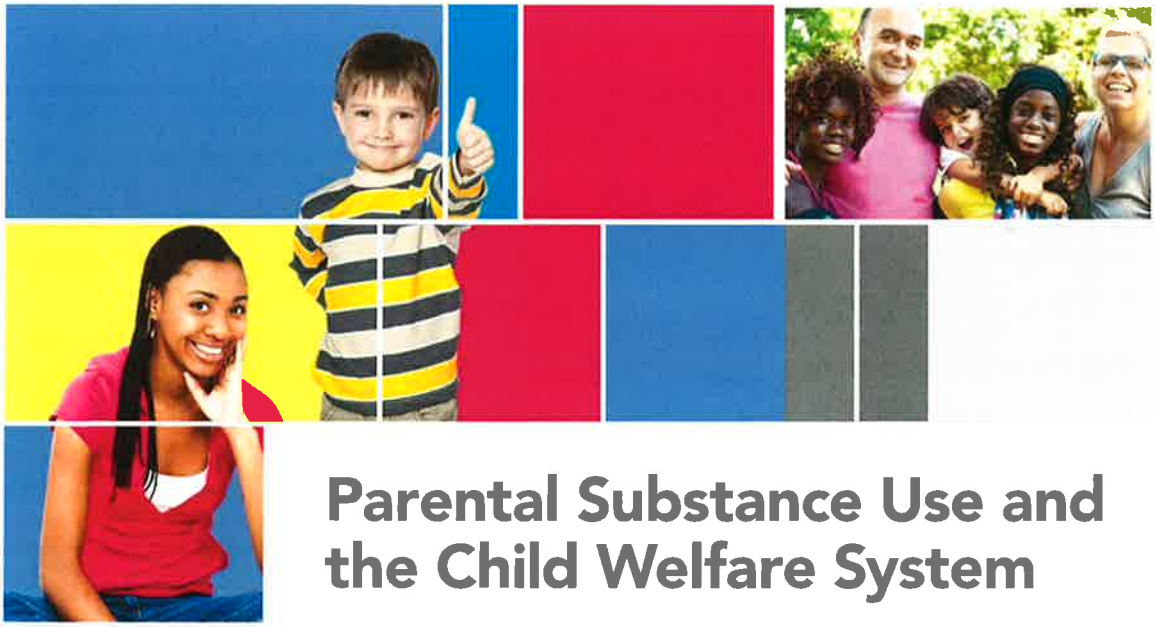

BULLETIN FOR PROFESSIONALS
October 2014

Parental Substance Use and the Child Welfare System

Many families receiving child welfare services are affected by parental substance use. Identifying substance abuse and meeting the complex needs of parents with substance use disorders and those of their children can be challenging. Over the past two decades, innovative approaches coupled with new research and program evaluation have helped point to new directions for more effective, collaborative, and holistic service delivery to support both parents and children. This bulletin provides child welfare workers and related professionals with information on the intersection of substance use disorders and child maltreatment and describes strategies for prevention, intervention, and treatment, including examples of effective programs and practices.

WHAT'S INSIDE

The relationship between substance use disorders and child maltreatment

The impact of parental substance use on children

Child welfare laws related to parental substance use

Service delivery challenges

Innovative prevention and treatment approaches

Promising child welfare casework practices

Systems change and collaboration

Grant programs

Resources for further information

Child Welfare Information Gateway

Children's Bureau/ACYF/ACF/HHS
800.394.3366 | Email: info@childwelfare.gov | https://www.childwelfare.gov

Children's Bureau

The Relationship Between Substance Use Disorders and Child Maltreatment

It is difficult to provide precise, current statistics on the number of families in child welfare affected by parental substance use or dependency since there is no ongoing, standardized, national data collection on the topic. In a 1999 report to Congress, the U.S. Department of Health and Human Services (HHS) reported that studies showed that between one-third and two-thirds of child maltreatment cases were affected by substance use to some degree (HHS, 1999). More recent research reviews suggest that the range may be even wider (Barth, 2009; Traube, 2012). The variation in estimates may be attributable, in part, to differences in the populations studied and the type of child welfare involvement (e.g., reports, substantiation, out-of-home placement); differences in how substance use (or substance abuse or substance use disorder) is defined and measured; and variations in State and local child welfare policies and practices for case documentation of substance abuse.

Children of Parents With Substance Use Disorders

An estimated 12 percent of children in this country live with a parent who is dependent on or abuses alcohol or other drugs (HHS, Substance Abuse and Mental Health Services Administration [SAMHSA], Office of Applied Studies, 2009). Based on data from the period 2002 to 2007, the National Survey on Drug Use and Health (NSDUH) reported that 8.3 million children under 18 years of age lived with at least one substance-dependent or substance-abusing parent.[1] Of these children, approximately 7.3 million lived with a parent who was dependent on or abused alcohol, and about 2.2 million lived with a parent who was dependent on or abused illicit drugs. While many of these children will not experience abuse or neglect, they are at increased risk for maltreatment and entering the child welfare system.

[1] NSDUH is an annual SAMHSA survey of a representative sample of the national population. It defines dependence and abuse using criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, which includes symptoms such as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference in major obligations at work, school, or home over the past year. The most recent data analyzed related to children of substance abusing or dependent parents are from the 2002 to 2007 surveys.

For more than 400,000 infants each year (about 10 percent of all births), substance exposure begins prenatally (Young et al., 2009). State and local surveys have documented prenatal substance use as high as 30 percent in some populations (Chasnoff, 2010). Based on NSDUH data from 2011 and 2012, approximately 5.9 percent of pregnant women aged 15 to 44 were current illicit drug users. Younger pregnant women generally reported the greatest substance use, with rates approaching 18.3 percent among 15- to 17-year-olds. Among pregnant women aged 15 to 44 years old, about 8.5 percent reported current alcohol use, 2.7 percent reported binge drinking, and .3 percent reported heavy drinking (HHS SAMHSA, 2013a).

Parental Substance Abuse as a Risk Factor for Maltreatment and Child Welfare Involvement

Parental substance abuse is recognized as a risk factor for child maltreatment and child welfare involvement (Institute of Medicine and National Research Council, 2013). Research shows that children with parents who abuse alcohol or drugs are more likely to experience abuse or neglect than children in other households (Dube et al., 2001; Hanson et al., 2006). One longitudinal study (Dubowitz et al., 2011) identified parental substance abuse (specifically, maternal drug use) as one of five key factors that predicted a report to child protective services (CPS) for abuse or neglect. Once a report is substantiated, children of parents with substance use issues are more likely to be placed in out-of-home care and more likely to stay in care longer than other children (Barth, Gibbons, & Guo, 2006; HHS, 1999). The National Survey of Child and Adolescent Well-Being (NSCAW) estimates that 61 percent of infants and 41 percent of older children in out-of-home care are from families with active alcohol or drug abuse (Wulczyn, Ernst, & Fisher, 2011).

According to data in the Adoption and Foster Care Analysis and Reporting System (AFCARS), parental substance abuse is frequently reported as a reason for removal, particularly in combination with neglect (Correia, 2013). For almost 31 percent of all children placed in foster care in 2012, parental alcohol or drug use was the documented reason for removal, and in several States

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway.
Available online at https://www.childwelfare.gov/pubs/factsheets/parentalsubabuse.cfm

that percentage surpassed 60 percent (National Data Archive on Child Abuse and Neglect, 2012). Nevertheless, many caregivers whose children remain at home after an investigation also have substance abuse issues. NSCAW found that the need for substance abuse services among in-home caregivers receiving child welfare services was substantially higher than that of adults nationwide (29 percent as compared with 20 percent, respectively, for parents ages 18 to 25, and 29 percent versus 7 percent for parents over age 26) (Wilson, Dolan, Smith, Casanueva, & Ringeisen, 2012).

Role of Co-occurring Issues

While the link between substance abuse and child maltreatment is well documented, it is not clear how much is a direct causal connection and how much can be attributed to other co-occurring issues. National data reveal that slightly more than one-third of adults with substance use disorders have a co-occurring mental illness (HHS SAMHSA, 2013b). Research on women with substance abuse problems shows high rates of posttraumatic stress disorder (PTSD), most commonly stemming from a history of childhood physical and/or sexual assault (Najavits, Weiss, & Shaw, 1997). Many parents with substance abuse problems also experience social isolation, poverty, unstable housing, and domestic violence. These co-occurring issues may contribute to both the substance use and the child maltreatment (Testa & Smith, 2009). Evidence increasingly points to a critical role of stress and reactions within the brain to stress, which can lead to both drug-seeking activity and inappropriate caregiving (Chaplin & Sinha, 2013).

Impact of Parental Substance Use on Children

The way parents with substance use disorders behave and interact with their children can have a multifaceted impact on the children. The effects can be both indirect (e.g., through a chaotic living environment) and direct (e.g., physical or sexual abuse). Parental substance use can affect parenting, prenatal development, and early childhood and adolescent development. It is important to recognize, however, that not all children of parents with substance use issues will suffer abuse, neglect, or other negative outcomes.

Parenting

A parent's substance use disorder may affect his or her ability to function effectively in a parental role. Ineffective or inconsistent parenting can be due to the following:

- Physical or mental impairments caused by alcohol or other drugs
- Reduced capacity to respond to a child's cues and needs
- Difficulties regulating emotions and controlling anger and impulsivity
- Disruptions in healthy parent-child attachment
- Spending limited funds on alcohol and drugs rather than food or other household needs
- Spending time seeking out, manufacturing, or using alcohol or other drugs
- Incarceration, which can result in inadequate or inappropriate supervision for children
- Estrangement from family and other social supports

Family life for children with one or both parents that abuse drugs or alcohol often can be chaotic and unpredictable. Children's basic needs—including nutrition, supervision, and nurturing—may go unmet, which can result in neglect. These families often experience a number of other problems—such as mental illness, domestic violence, unemployment, and housing instability—that also affect parenting and contribute to high levels of stress (National Abandoned Infants Assistance Resource Center [AIA], 2012). A parent with a substance abuse disorder may be unable to regulate stress and other emotions, which can lead to impulsive and reactive behavior that may escalate to physical abuse (Chaplin & Sinha, 2013).

Different substances may have different effects on parenting and safety (Testa & Smith, 2009). For example, the threats to a child of a parent who becomes sedated and inattentive after drinking excessively differ from the threats posed by a parent who exhibits aggressive

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway. Available online at https://www.childwelfare.gov/pubs/factsheets/parentalsubabuse.cfm

side effects from methamphetamine use. Dangers may be posed not only from use of illegal drugs, but also, and increasingly, from abuse of prescription drugs (pain relievers, anti-anxiety medicines, and sleeping pills). (For more information on effects of various substances, see http://www.drugabuse.gov/drugs-abuse/commonly-abused-drugs/health-effects.) Polysubstance use (multiple drugs) may make it difficult to determine the specific and compounded effects on any individual. Further, risks for the child's safety may differ depending upon the level and severity of parental substance use and associated adverse effects.[2]

Prenatal and Infant Development

The effects of parental substance use disorders on a child can begin before the child is born. Maternal drug and alcohol use during pregnancy have been associated with premature birth, low birth weight, slowed growth, and a variety of physical, emotional, behavioral, and cognitive problems (AIA, 2012; National Institute on Drug Abuse [NIDA], 2011). Research suggests powerful effects of legal drugs, such as tobacco, as well as illegal drugs on prenatal and early childhood development (HHS SAMHSA, 2014).

Fetal alcohol spectrum disorders (FASD) are a set of conditions that affect an estimated 40,000 infants born each year to mothers who drank alcohol during pregnancy (Prevention First, n.d.). Children with FASD may experience mild to severe physical, mental, behavioral, and/or learning disabilities, some of which may have lifelong implications (e.g., brain damage, physical defects, attention deficits) (National Organization on Fetal Alcohol Syndrome, 2012). In addition, increasing numbers of newborns—approximately 3 per 1,000 hospital births each year—are affected by neonatal abstinence syndrome (NAS), a group of problems that occur in a newborn who was exposed prenatally to addictive illegal or prescription drugs (Patrick et al., 2012).

The full impact of prenatal substance exposure depends on a number of factors. These include the frequency, timing, and type of substances used by pregnant women; co-occurring environmental deficiencies; and the extent of prenatal care (AIA, 2012). Research suggests that some of the negative outcomes of prenatal exposure can be improved by supportive home environments and positive parenting practices (NIDA, 2011).

Child and Adolescent Development

Children and youth of parents who use or abuse substances and have parenting difficulties have an increased chance of experiencing a variety of negative outcomes (Felitti et al., 1998; HHS, 1999; Staton-Tindall et al., 2013):

- Poor cognitive, social, and emotional development
- Depression, anxiety, and other trauma and mental health symptoms
- Physical and health issues
- Substance use problems

Parental substance use can affect the well-being of children and youth in complex ways. For example, an infant who receives inconsistent care and nurturing from a parent engaged in addiction-related behaviors may suffer from attachment difficulties that can then interfere with the growing child's emotional development. Adolescent children of parents with substance use disorders, particularly those who have experienced child maltreatment and foster care, may turn to substances themselves as a coping mechanism. In addition, children of parents with substance use issues are more likely to experience trauma and its effects, which include difficulties with concentration and learning, controlling physical and emotional responses to stress, and forming trusting relationships (Staton-Tindall et al., 2013).

Child Welfare Laws Related to Parental Substance Use

In response to concerns over the potential negative impact on children of parental substance abuse and illegal drug-related activities, approximately 47 States and the District of Columbia have child protection laws that address some aspect of parental substance use. Some States have expanded their civil definitions of child abuse

[2] The *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5) states that substance use disorders are measured on a continuum from mild to severe determined by the presence of adverse effects associated with substance use. For more information on the DSM-5 classification of substance-related disorders, see http://www.psychiatry.org/dsm5.

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway. Available online at https://www.childwelfare.gov/pubs/factsheets/parentalsubabuse.cfm

and neglect to include a caregiver's use of a controlled substance that impairs the ability to adequately care for a child and/or exposure of a child to illegal drug activity (e.g., sale or distribution of drugs, home-based meth labs). Exposure of children to illegal drug activity is also addressed in 33 States' criminal statutes (Child Welfare Information Gateway, 2012). (For information on different States' statutes, visit https://www.childwelfare.gov/systemwide/laws_policies/statutes/drugexposed.cfm.)

Federal and State laws also address prenatal drug exposure. The Child Abuse Prevention and Treatment Act (CAPTA) requires States receiving CAPTA funds to have policies and procedures for health-care personnel to notify CPS of substance-exposed newborns and to develop procedures for safe care of affected infants. As yet, there are no national data on CAPTA-related reports for substance-exposed newborns. In some State statutes, substance abuse during pregnancy is considered child abuse and/or grounds for termination of parental rights. State statutes and State and local policies vary widely in their requirements for reporting suspected prenatal drug abuse, testing for drug exposure, CPS response, forced admission to treatment of pregnant women who use drugs, and priority access for pregnant women to State-funded treatment programs (Guttmacher Institute, 2014).

Service Delivery Challenges

Despite the fact that a large percentage of parents who are investigated in child protection cases require treatment for alcohol or drug dependence, the percentage of parents who actually receive services is limited, compared to the need. Also, many parents who begin treatment do not complete it (Traube, 2012). Historically, insufficient collaboration has hindered the ability of child welfare, substance abuse treatment, and family/dependency court systems to support these families.

Child welfare agencies face a number of difficulties in serving children and families affected by parental substance use disorders, including:

- **Insufficient service availability** or scope of services to meet existing needs
- **Inadequate funds** for services and/or dependence on client insurance coverage
- **Difficulties in engaging** and retaining parents in treatment
- **Knowledge gaps** among child welfare workers to meet the comprehensive needs of families with substance use issues
- **Lack of coordination** between the child welfare system and other services and systems, including hospitals that may screen for drug exposure, treatment agencies, mental health services, criminal justice system, and family/dependency courts
- **Differences in perspectives and timeframes,** reflecting different guiding policies, philosophies, and goals in child welfare and substance abuse treatment systems (for example, a focus on the safety and well-being of the child without sufficient focus on parents' recovery)

A critical challenge for child welfare professionals is meeting legislative requirements regarding child permanency while allowing for sufficient progress in substance abuse recovery and development of parenting capacity. The Adoption and Safe Families Act (ASFA) requires that a child welfare agency file a petition for termination of parental rights if a child has been in foster care for 15 of the past 22 months, unless it is not in the best interest of the child. Many agencies struggle with adhering to this timeframe due to problems with accessing substance abuse services in a timely manner. In addition, treatment may take many months (often longer than the ASFA timeline allows), and achieving sufficient stability to care for children may take even longer. Addressing addiction can require extended recovery periods, and relapses can occur.

Innovative Prevention and Treatment Approaches

While parental substance abuse continues to be a major challenge in child welfare, the past two decades have witnessed some new and more effective approaches and innovative programs to address child protection for families where substance abuse is an issue. Some

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway.
Available online at https://www.childwelfare.gov/pubs/factsheets/parentalsubabuse.cfm

examples of promising and innovative prevention and treatment approaches include the following:

Promotion of protective factors, such as social connections, concrete supports, and parenting knowledge, to support families and buffer risks

Early identification of at-risk families in substance abuse treatment programs and through expanded prenatal screening initiatives so that prevention services can be provided to promote child safety and well-being in the home

Priority and timely access to substance abuse treatment slots for mothers involved in the child welfare system

Gender-sensitive treatment and support services that respond to the specific needs, characteristics, and co-occurring issues of women who have substance use disorders

Family-centered treatment services, including inpatient treatment for mothers in facilities where they can have their children with them and programs that provide services to each family member

Recovery coaches or mentoring of parents to support treatment, recovery, and parenting

Shared family care in which a family experiencing parental substance use and child maltreatment is placed with a host family for support and mentoring

Find more information on specific programs and service models:

- National Center on Substance Abuse and Child Welfare (NCSACW), *Regional Partnership Grant (RPG) Program: Overview of Grantees' Services and Interventions* https://www.ncsacw.samhsa.gov/files/RPG_Program_Brief_2_Services_508_reduced.pdf
- NRC for In-Home Services, *In-Home Programs for Drug Affected Families* https://www.nrc-ihs.org/sites/default/files/drugaffectedmemo.pdf
- SAMHSA's National Registry of Evidence-Based Programs and Practices http://www.nrepp.samhsa.gov/

Program Highlight: Illinois Recovery Coaches

As part of Illinois' title IV-E waiver demonstration, recovery coaches provide intensive outreach and engagement services for families whose children have been placed in foster care due to parental substance abuse and maltreatment. Recovery coaches work with parents, child welfare caseworkers, and treatment agencies to remove barriers to treatment, engage parents in treatment, and provide ongoing support following reunification. An experimental evaluation (Ryan and Huang, 2012) found that, compared to families who received standard services, parents working with recovery coaches were more likely to access substance abuse treatment and did so more quickly. In addition, they achieved safe family reunification and reduced the length of time children spent in out-of-home care. Enhanced services to address co-occurring issues were found to be particularly important. (See http://cfrc.illinois.edu/pubs/rp_20120701_IllinoisAODAIV-EWaiverDemonstrationFinalEvaluationReport.pdf.)

Promising Child Welfare Casework Practices

In working with families affected by substance abuse, child welfare workers can use a variety of strategies to help meet parents' needs while also promoting safety, permanency, and well-being of their children. To begin, workers need to build their understanding of parental substance use issues, its signs, the effects on parenting and child safety, and what to expect during a parent's treatment and recovery. Specific casework practice strategies reflect:

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway.
Available online at https://www.childwelfare.gov/pubs/factsheets/parentalsubabuse.cfm

Family engagement. Engagement strategies that help motivate parents to enter and remain in substance abuse services are critical to enhancing treatment outcomes (Wisdom, Pollock, & Hopping-Winn, 2011). An essential part of this process is partnering with parents to develop plans that address individual needs, such as a woman's own trauma history, as well as needs for support services like child care and transportation. Child welfare workers can help create supportive environments, build nonjudgmental relationships, and implement evidence-based motivational approaches, such as motivational interviewing.[3]

Routine screening and assessment. Screening family members for possible substance use disorders with the use of brief, validated, and culturally appropriate tools should be a routine part of child welfare investigation and case monitoring. Once a substance use issue has been identified through screening, alcohol and drug treatment providers can conduct more indepth assessments of its nature and extent, the impact on the child, and recommended treatment. Find more information on screening tools and collaborative strategies:

- *Screening and Assessment for Family Engagement, Retention and Recovery* at http://www.ncsacw.samhsa.gov/files/SAFERR.pdf
- *Protecting Children in Families Affected by Substance Use Disorders* at https://www.childwelfare.gov/pubs/usermanuals/substanceuse/chapterfour.cfm

Individualized treatment and case plans. Caseworkers can help match parents with evidence-based treatment programs and support services that meet their specific needs. Working collaboratively with families, alcohol and drug treatment professionals, and the courts, caseworkers can help develop and coordinate case and treatment plans.

Support of parents in treatment and recovery. Child welfare workers can support parents in their efforts to build coping and parenting skills, help them pay attention to triggers for substance-using behaviors, and work collaboratively on safety plans to protect children during a potential relapse (Breshears, Yeh, & Young, 2009). Workers also can help coordinate services, make formal and informal connections, and encourage parents in looking forward to their role as caregivers (DiLorenzo, 2013).

Providing services for children of parents with substance use issues. Given the developmental and emotional effects of parental substance abuse on children and youth in child welfare, it is important that child welfare workers collaborate with behavioral/mental health professionals to conduct screenings and assessments and link children and youth to appropriate, evidence-based services that promote wellness. Individualized services should address the child or youth's strengths and needs, trauma symptoms, effects associated with prenatal or postnatal exposure to parental substance use, and risk for developing substance use disorders themselves.

Permanency planning. ASFA and treatment timeframes become significant considerations in permanency plans and reunification goals in families affected by substance abuse. Concurrent planning, in which an alternative permanency plan is pursued at the same time as the reunification plan, can play an important part in ensuring that children achieve permanency in a timely manner. For instance, guardianship by a relative or adoption by foster parents might be the concurrent goal if family reunification is not viable. (For more information, read Information Gateway's *Concurrent Planning: What the Evidence Shows* at https://www.childwelfare.gov/pubs/issue_briefs/concurrent_evidence/.)

For child welfare training and other resources related to improving the safety, permanency, well-being, and recovery outcomes for children and families, visit the NCSACW website at https://www.ncsacw.samhsa.gov.

Systems Change and Collaboration

Since the late 1990s, systems-level collaboration and service integration strategies have been increasingly implemented to coordinate services from child welfare, treatment, dependency courts, and other service systems for families affected by substance use. Communication

[3] For general information about motivational interviewing, visit http://motivationalinterview.org/; see also the *Rocky Mountain Quality Improvement Center's Pre-Treatment Program Curriculum Guide: Motivational Interviewing* at http://www.americanhumane.org/assets/pdfs/children/pc-rmqic-ptp-guide.pdf.

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway.
Available online at https://www.childwelfare.gov/pubs/factsheets/parentalsubabuse.cfm

and active collaboration across systems help ensure that parents in need of substance abuse treatment are identified and receive appropriate treatment in a timely manner, while children's intervention needs are also addressed. To meet complex needs, collaborative practice provides access to a wider array of resources than is traditionally available from an individual system (Children and Family Futures, 2011). Collaborative and integrated strategies have shown promising results—women remain in treatment longer, are more likely to reduce substance use, and are more likely to remain or reunite with their children (HHS, 2014; Marsh & Smith, 2011).

Family treatment drug courts (also known as family drug courts and dependency drug courts) represent a cross-system approach with demonstrated success. These courts use judicial system authority and collaborative partnerships to support timely substance abuse treatment for parents, provision of a wide range of services for families, and monitoring of recovery components. Evaluations have linked these courts with improvements in treatment enrollment, treatment completion, and family reunification (Marlowe & Carey, 2012). The following websites provide additional information:

- Learn more about existing family treatment drug court programs at https://www.ncsacw.samhsa.gov/resources/resources-drug-courts.aspx.
- Find guidelines to develop or enhance drug court programs in *Guidance to States: Recommendations for Developing Family Drug Court Guidelines*, available from http://www.cffutures.org/files/publications/FDC-Guidelines.pdf.

Examples of other cross-systems changes to overcome traditional "siloed" approaches include:

Cross-training of child welfare and substance abuse treatment professionals to build an understanding of each other's systems, legal requirements (e.g., ASFA), goals, approaches, and shared interests

Collocation of substance abuse specialists in child welfare offices to assess and engage parents, provide services to families, and offer training and consultation services to child welfare workers (see *Substance Abuse Specialists in Child Welfare Agencies and Dependency Courts Considerations for Program Designers and Evaluators*, http://www.ncsacw.samhsa.gov/resources/resources-Substance-Abuse-Specialists.aspx)

Cross-system partnerships, based on shared principles that ensure coordinated services through formal linkages (such as interagency agreements) between child welfare, treatment, and other community agencies

Cross-system information sharing related to screening and assessment results, case plans, treatment plans, and progress toward goals, which can support professionals in each system to make informed decisions, while still adhering to confidentiality parameters (see https://www.ncsacw.samhsa.gov/resources/information-sharing.aspx)

Program Highlight: King County Family Treatment Court

Begun in 2004, Washington State's King County Family Treatment Court was designed to improve the safety and well-being of children in child welfare by providing parents with access to drug and alcohol treatment, judicial monitoring, and individualized services. Program components include early intervention, comprehensive services for the entire family, and a holistic approach to strengthening family functioning. A quasi-experimental evaluation found that, compared to parents served by a regular dependency court, family treatment court parents entered treatment sooner and were more likely to successfully complete treatment. In addition, children in the family treatment court group spent less time in out-of-home care and were more likely to permanently reunite with their parents (Bruns, Pullman, Weathers, Wirschem, & Murphy, 2012). For more information, visit http://www.kingcounty.gov/courts/JuvenileCourt/famtreat.aspx.

Joint planning and case management to help safeguard against parents becoming overwhelmed by multiple and potentially conflicting requirements of different systems

Wraparound and comprehensive community services that address multiple service needs of parents and children, including those related to parenting skills, mental health, health, domestic violence, housing, employment, income support, education, and child care

Flexible financing strategies that leverage or combine various funding streams to address the needs of substance abuse treatment for families involved in child welfare

Linked data systems that track progress toward shared system objectives and achievement of desired outcomes while also promoting shared accountability

For more information on collaborative practices and tools, see these NCSACW resources:

- *The Collaborative Practice Model for Family Recovery, Safety and Stability*, at http://www.cffutures.org/files/PracticeModel.pdf
- Webpages related to In-Depth Technical Assistance (IDTA), at https://www.ncsacw.samhsa.gov/technical/idta.aspx

Grant Programs

The Children's Bureau has funded several discretionary grant programs that support demonstration projects with the goal of improving outcomes for children and families in which one or more parents have a substance use problem. Recent grant programs include:

Regional Partnership Grants (RPGs) to Increase the Well-Being of, and to Improve the Permanency Outcomes for, Children Affected by Substance Abuse. Since 2012, 70 grants[4] have been awarded to regional partnerships nationwide to foster cross-system collaboration and service integration for families with children who are in or at risk of entering foster care as a result of a parent's substance abuse. The grants address common challenges, such as engagement and retention of parents in treatment, service shortages, and conflicting approaches and timeframes across systems. Evaluation findings show evidence of enhanced collaboration and changed practice models, improvements in parental capacity to care for children, and promising results for safety, permanency, and child and family well-being (DeCerchio, Rodi, & Stedt, 2014). (For more information, visit https://www.ncsacw.samhsa.gov/technical/rpg-i.aspx.)

Comprehensive Support Services for Families Affected by Substance Abuse and/or HIV/AIDS. Authorized by the Abandoned Infants Assistance Act, these grants offer services to support infants and young children who have been exposed to a dangerous drug or HIV/AIDS and are at risk of out-of-home placement. Services provided to children and their caregivers include prevention and early intervention services, family-based substance abuse treatment, child and family counseling, referrals to mental health services, and parenting skills training. (For more information, visit http://aia.berkeley.edu/aia-projects/general-information/.)

Family Connection Grants: Comprehensive Residential Family Treatment Projects. Part of a larger cluster of demonstration grants to help reconnect family members with children in or at risk of entering foster care, these projects provide services for chemically dependent women, their children, extended family members, and partners. Services include intensive substance abuse treatment, mental health and health services, parenting skills, employment support, child care, and other services that support comprehensive family needs.

In addition, a few Children's Bureau **title IV-E child welfare waiver demonstration projects** have provided opportunities to develop and test innovative substance abuse interventions. For example, Illinois and Oregon have implemented mentoring and coaching programs for parents in child welfare in need of substance abuse treatment. Previous projects in Delaware and New Hampshire collocated substance abuse counselors within child welfare agencies. (For information on child welfare

[4] Authorized by the Child and Family Services Improvement Act of 2006, the Children's Bureau awarded 53 first round RPGs. The Child and Family Services Improvement and Innovation Act of 2011 reauthorized the program (dropping the earlier focus on methamphetamine abuse) and enabled the funding of 17 new second round RPGs and 2-year extensions for 8 first round grants.

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway.
Available online at https://www.childwelfare.gov/pubs/factsheets/parentalsubabuse.cfm

waivers, see http://www.acf.hhs.gov/sites/default/files/cb/waiver_profiles_vol1.pdf.)

SAMHSA also funds grant programs with the goal of enhancing services and improving outcomes for families affected by parental substance abuse. Recent programs include **Services Grant Program for Residential Treatment for Pregnant and Postpartum Women** and **Grants to Expand Services to Children Affected by Methamphetamine in Families Participating in Family Treatment Drug Court** (see https://www.ncsacw.samhsa.gov/technical/cam.aspx).

Conclusion

As new demonstration and innovation projects continue to be implemented, expanded, and evaluated, the field continues to learn more about promising and effective approaches to holistically address the complex needs of families with substance use issues. In particular, there is a continuing call for and movement toward enhanced collaboration among child welfare, substance abuse treatment, courts, and other systems to provide coordinated and comprehensive services to both children and their parents. Further, the use of enhanced and linked information systems will improve the collective ability to track and share the results of collaborative efforts to achieve better outcomes for these families and children.

Resources for Further Information

- Child Welfare Information Gateway
  https://www.childwelfare.gov/systemwide/substance/
- Children and Family Futures
  http://www.cffutures.org/
- National Abandoned Infants Assistance Resource Center
  http://aia.berkeley.edu
- National Center on Substance Abuse and Child Welfare
  https://www.ncsacw.samhsa.gov/
- National Institute on Drug Abuse
  http://www.nida.nih.gov
- National Registry of Evidenced-Based Programs and Practices
  http://www.nrepp.samhsa.gov/
- Substance Abuse and Mental Health Services Administration
  http://www.samhsa.gov/

References

Barth, R., Gibbons, C., & Guo, S. (2006). Substance abuse treatment and the recurrence of maltreatment among caregivers with children living at home: A propensity score analysis. *Journal of Substance Abuse Treatment, 30*(2), 93-104.

Barth, R. (2009). Preventing child abuse and neglect with parent training: Evidence and opportunities. *Future of Children, 19*(2), 95-118. Retrieved from http://futureofchildren.org/publications/journals/journal_details/index.xml?journalid=71

Breshears, E. M., Yeh, S., & Young, N. K. (2009). *Understanding substance abuse and facilitating recovery: A guide for child welfare workers.* Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from http://www.ncsacw.samhsa.gov/files/UnderstandingSAGuide.pdf

Bruns, E. J., Pullmann, M. D., Weathers, E. S., Wirschem, M. L., & Murphy, J. K. (2012). Effects of a multidisciplinary family treatment drug court on child and family outcomes: Results of a quasi-experimental study. *Child Maltreatment, 17*(3), 218-230.

Chaplin, T. M., & Sinha, R. (2013). Stress and parental addiction. In N. E. Suchman, M. Pajulo, & L. C. Mayes (Eds.), *Parenting and substance abuse: Developmental approaches to intervention* (pp. 3–23). NY: Oxford University Press.

Chasnoff, I. (2010). *The mystery of risk: Drugs, alcohol, pregnancy, and the vulnerable child.* Chicago, IL: NTI Upstream.

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway.
Available online at https://www.childwelfare.gov/pubs/factsheets/parentalsubabuse.cfm

Child Welfare Information Gateway. (2012). *Parental drug use as child abuse.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/systemwide/laws_policies/statutes/drugexposed.cfm

Children and Family Futures. (2011). *The collaborative practice model for family recovery, safety and stability.* Irvine, CA: Author. Retrieved from http://www.cffutures.org/files/PracticeModel.pdf

Correia, M. (2013). Substance abuse data in child welfare. *Casey Practice Digest: Substance Use Disorders in Families With Young Children.* Casey Family Programs, Issue 5.

DeCerchio, K., Rodi, C., & Stedt, E. (2014). *Regional Partnership Grants: Enhanced collaboration, promising results.* Children and Family Futures, Webinar, April 16, 2014. http://www.cffutures.org/presentations/webinars/regional-partnership-grant-enhanced-collaboration-promising-results

DiLorenzo, P. (2013). Caregivers with substance use disorders: The caseworker's role in supporting recovery and preventing relapse. *Casey Practice Digest: Substance Use Disorders in Families With Young Children.* Casey Family Programs, Issue 5.

Dube, S. R., Anda, R. F., Felitti, V. J., Croft, J. B., Edwards, V. J., & Giles, W. H. (2001). Growing up with parental alcohol abuse: Exposure to childhood abuse, neglect, and household dysfunction. *Child Abuse & Neglect, 25*, 1627-1640.

Dubowitz, H., Kim, J., Black, M., Weisbart, C., Semiatin, J., & Magder, L. (2011). Identifying children at high risk for a child maltreatment report. *Child Abuse & Neglect, 35*(2), 96-104.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A .M., Edwards, V., . . . Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine,14*, 245-258.

Guttmacher Institute. (2014). *State policies in brief: Substance abuse during pregnancy.* Retrieved from https://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf

Hanson, R. F., Self-Brown, S., Fricker-Elhai, A. E., Kilpatrick, D. G., Saunders, B. E., & Resnick, H. S. (2006). The relations between family environment and violence exposure among youth: Findings from the National Survey of Adolescents. *Child Maltreatment 11*(1), 3-15.

Institute of Medicine and National Research Council. (2013). *New directions in child abuse and neglect research.* Washington, DC: The National Academies Press. Retrieved from http://www.iom.edu/Reports/2013/New-Directions-in-Child-Abuse-and-Neglect-Research.aspx

Marlowe, D. B., & Carey. S. (2012). *Research update on family drug courts.* Alexandria, VA: National Association of Family Drug Court Professionals. Retrieved from http://www.nadcp.org/sites/default/files/nadcp/Reseach%20Update%20on%20Family%20Drug%20Courts%20-%20NADCP.pdf

Marsh, J., & Smith, B. (2011). Integrated substance abuse and child welfare services for women: A progress review. *Children and Youth Services Review, 33*(3): 466-72.

Najavits, L. M., Weiss, R. D., & Shaw, S. R. (1997). The link between substance abuse and posttraumatic stress disorder in women. *The American Journal on Addictions, 6*(4), 273-283. doi: 10.1111/j.1521-0391.1997.tb00408.x

National Abandoned Infants Assistance Resource Center (AIA). (2012). *Research to practice brief: Supporting children of parents with co-occurring mental illness and*

substance abuse. Retrieved from http://aia.berkeley.edu/media/pdf/brief_supporting_children.pdf

National Data Archive on Child Abuse and Neglect. (2012). Adoption and Foster Care Analysis Reporting System. [Data file]. Ithaca, NY: Author.

National Institute on Drug Abuse. (2011). *Prenatal exposure to drugs of abuse.* Retrieved from http://www.drugabuse.gov/sites/default/files/prenatal.pdf

National Organization on Fetal Alcohol Syndrome. (2012). *FASD: What everyone should know.* Retrieved from http://www.nofas.org/wp-content/uploads/2012/10/NOFAS-FASD-What-Everyone-Should-Know-2012.pdf

Patrick, S. W., Schumacher, R. E., Benneyworth, B. D., Krans, E. E., McAllister, J. M., & Davis, M. M. (2012). Neonatal abstinence syndrome and associated health care expenditures: United States, 2000-2009. *Journal of the American Medical Association (JAMA), 307*(18), 1934-1940.

Prevention First. (n.d.). Fetal alcohol spectrum disorder [website]. Retrieved from https://www.prevention.org/Resources/FASD.aspx

Ryan, J. P., & Huang, H. (2012). *Illinois alcohol and other drug abuse (AODA) IV-E waiver demonstration. Final evaluation report.* Urbana-Champaign, IL: Children and Families Research Center. Retrieved from http://cfrc.illinois.edu/pubs/rp_20060101_IllinoisAODAWaiverDemonstrationFinalEvaluationReport.pdf

Staton-Tindall, M., Sprang, G., Clark, J., Walker, R., & Craig, C. (2013) Caregiver substance use and child outcomes: A systematic review. *Journal of Social Work Practice in the Addictions, 13*(1), 6-31. doi:10.1080/1533256X.2013.752272

Testa, M., & Smith, B. (2009). Prevention and drug treatment. *Future of Children, 19*(2), 147-168.

Traube, D. (2012). The missing link to child safety, permanency, and well-being: Addressing substance misuse in child welfare. *Social Work Research, 36*(2), 83-87.

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

U.S. Department of Health and Human Services, Children's Bureau. (2014). *Targeted grants to increase the well-being of, and to improve the permanency outcomes for, children affected by methamphetamine or other substance abuse: Third annual report to Congress.* Retrieved from http://www.cffutures.org/files/RPG%20Program_Third%20Report%20to%20Congress.pdf

U.S. Department of Health and Human Services, SAMHSA, Office of Applied Studies. (2009). *The NSDUH Report: Children living with substance-depending or substance-abusing parents: 2002-2007.* Rockville, MD: Author.

U.S. Department of Health and Human Services, SAMHSA. (2013a). *The NSDUH report, Data spotlight: 6.8 million adults had both mental illness and substance use disorder in 2011.* Rockville, MD: Author. Retrieved from http://www.samhsa.gov/data/sites/default/files/spot111-adults-mental-illness-substance-use-disorder/spot111-adults-mental-illness-substance-use-disorder.pdf

U.S. Department of Health and Human Services, SAMHSA. (2013b). *Results from the 2012 National Survey on Drug Use and Health: Summary of national findings.* Rockville, MD: Author. Retrieved from http://media.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/NationalFindings/NSDUHresults2012.pdf

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway. Available online at https://www.childwelfare.gov/pubs/factsheets/parentalsubabuse.cfm

U.S. Department of Health and Human Services, SAMHSA. (2014). *Addressing fetal alcohol spectrum disorders (FASD).* Treatment Improvement Protocol (TIP) Series 58. Rockville, MD: Author. Retrieved from: http://store.samhsa.gov/product/TIP-58-Addressing-Fetal-Alcohol-Spectrum-Disorders-FASD-/SMA13-4803

Wisdom, J., Pollock, M. N., & Hopping-Winn, A. (2011). *Service engagement and retention for women with substance use disorders.* Berkeley, CA: National Abandoned Infants Assistance Resource Center.

Wilson, E., Dolan, M., Smith, K., Casanueva, C., & Ringeisen, H. (2012). *NSCAW child well-being spotlight: Caregivers of children who remain in-home after maltreatment need services.* Washington, DC: Office of Planning, Research and Evaluation, U.S. Department of Health and Human Services. Retrieved from http://www.acf.hhs.gov/programs/opre/resource/nscaw-ii-child-well-being-spotlight-caregivers-of-children-who-remain-in

Wulczyn, F., Ernst, M., & Fisher, P. (2011). *Who are the infants in out-of-home care? An epidemiological and developmental snapshot.* Chicago: Chapin Hall at the University of Chicago. Retrieved from http://www.chapinhall.org/sites/default/files/publications/06_08_11_Issue%20Brief_F_1.pdf

Young, N. K., Gardner, S., Otero, C., Dennis, K., Chang, R., Earle, K., & Amatetti, S. (2009). *Substance-exposed infants: State responses to the problem.* Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://www.ncsacw.samhsa.gov/files/Substance-Exposed-Infants.pdf

Suggested citation:

Child Welfare Information Gateway. (2014). *Parental substance use and the child welfare system.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau