

Joseph P. Ryan and Hui Huang

Substance Abuse Issues

Findings from developmental studies are consistent and convincing: Family stability and family cohesion are important protective factors for the healthy development of children and adolescents. Family stability is associated with a broad range of outcomes including higher cognitive scores, fewer child behavioral problems, improved health, and a sense of security (Craigie, Brooks-Gunn & Waldfogel 2010). Similarly, family cohesion is associated with the emergence of fewer internalizing (e.g. emotionally reactive, depressive, withdrawn) and externalizing (attention deficits, aggressive) problems (Buehler, Anthony, Krishnakumar, Stone, Gerard & Pemberton 1997). Unfortunately, parental substance abuse disrupts family stability and family cohesion and jeopardizes the safety and well being of children. Moreover, substance abuse is frequently one of the causes for children's out-of-home placement and must be addressed before family reunification can safely occur. For these reasons, parental substance abuse is a major concern for all those involved in serving children, youth, and families.

In this chapter we focus specifically on parental substance abuse and substance dependence in the context of the child welfare system. We discuss how substance abuse is defined and measured in the literature, provide estimates of substance abuse in child welfare populations, and identify critical child and adolescent outcomes affected by substance abuse. This chapter also includes a discussion of recent innovations with regards to service options and clinical developments in the field. This chapter does not include a discussion of adolescent substance abuse in child welfare. Although the use of illicit drugs and consumption of alcohol

are important issues for youth in substitute care settings, that literature is beyond the scope of this chapter.

DEFINITIONS AND MEASUREMENT STRATEGIES

Substance abuse is defined as the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs (World Health Organization 2011). Illicit drugs may include marijuana, cocaine, heroin, hallucinogens, inhalants, and the nonmedical use of prescription-type drugs, of which there are four categories: pain relievers, tranquilizers, stimulants, and sedatives. Prescription-type drugs include some substances that are manufactured and distributed illegally, such as the stimulant methamphetamine (SAMHSA 2010). Hashish is considered marijuana, and crack is considered cocaine. Peyote, LSD, PCP, mescaline, psilocybin mushrooms, and “Ecstasy” (MDMA) comprise the hallucinogens. Inhalants refer to many substances, including nitrous oxide, amyl nitrite, cleaning fluids, gasoline, spray paint, other aerosol sprays, and glue. Although the effects --both short and long term -- of these substances vary, they share similar diagnostic criteria for determining misuse. In the current chapter we limit our discussion of diagnostic criteria and instruments to those with good reliability and validity. We categorize measurements into three groups: diagnostic instruments, multi-dimensional assessments, and drug testing.

Diagnostic instruments use a categorical approach to differentiate substance abusers from non-abusers. In contrast with a measure of severity, the categorical approach simply indicates the presence or absence of a particular problem. The most commonly used diagnostic instrument is Diagnostic and Statistical Manual of Mental Disorder IV-TR (American Psychiatric Association 2000). In the DSM-IV-TR, substance use disorders include substance dependence and substance abuse. Dependence is considered more severe because it involves the psychological and

physiological effects of tolerance and withdrawal (SAMHSA 2010). Substance dependence (American Psychiatric Association 2000) is defined as a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three or more of the following, occurring at any time in the same 12-month period: (1) tolerance; (2) withdrawal; (3) the use of the substance in larger amounts or over a longer period of time than intended; (4) a persistent desire or unsuccessful efforts to reduce substance use; (5) the devotion of a large portion of time to obtaining, using, or recovering from the use of the substance; (6) the reduction of important social, recreational, or occupational activities due to substance use; and (7) the continuing use of the substance, despite knowing that a persistent or recurrent physical or psychological problem is likely to have been related to substance use.

In contrast, substance abuse is limited to individuals that have never met the criteria for substance dependence (American Psychiatric Association 2000). Substance abuse is manifested by one or more of the following, occurring within a 12-month period: (1) recurrent substance use leading to a failure to fulfill major role obligations at work, school, or home; (2) recurrent substance use in physically hazardous situations (e.g., driving an automobile or operating machinery when impaired); (3) recurrent legal problems caused by substance use (e.g., substance-related disorderly conduct); and (4) the continuing use of substance despite having persistent or recurrent social or interpersonal problems initiated or exacerbated by the effects of the substance (e.g., loss of personal relationships, frequent physical domestic altercations).

In addition to the DSM-IV-TR diagnostic criteria, the World Health Organization developed two instruments; the International Classification of Diseases (ICD) and Composite International Personal Interview (CIDI). The CIDI Short Form (CIDI-SF) is used in child welfare as part of the National Study on Child and Adolescent Well-Being (NSCAW) (National

Center on Substance Abuse and Child Welfare 2009). The CIDI-SF has separate sections for alcohol and drug dependence. Each section opens with screening question(s). In the alcohol section, the screening question is “what is the largest number of drinks you had in any single day during the past 12 months?” If a respondent answers four or more drinks a day, he/she will be asked to complete dependence related questions. In the drug section, the screening questions focus on the use of nine illicit drugs (i.e. marijuana, cocaine, heroin, hallucinogens, inhalants, and the nonmedical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives) during the past 12 months. If a respondent indicated drug use he/she will be asked to complete dependence questions. Each section contains seven dependence questions corresponding to the seven substance dependence criteria noted in the DSM-IV-TR (Gibbons, Barth, & Martin in press).

Multi-dimensional measurement strategies focus on substance use as well as other areas of individual functioning (employment, medical/psychiatric symptoms, family/social relationships). Multi-dimensional assessments are frequently used because individuals with substance problems often report experiencing other health and social difficulties (McLellan, Cacciola, Alterman, Rikkon, & Carise 2006). The designers of multi-dimensional assessments and authors in the larger field of substance abuse and child welfare argue that co-occurring problems increase the risk of substance abuse, and further contribute to the risk of relapse (McLellan et al. 2006; Testa & Smith 2009; Marsh et al 2006). Thus it is important to capture the presence of co-occurring problems.

One of the most commonly used multi-dimensional assessments is the Addiction Severity Index (ASI), developed by researchers from the Treatment Research Institute. The ASI measures seven functional domains: alcohol and drug use, medical and psychiatric health, employment/self

support, family relations, and illegal activity. Information is collected to capture events within two time periods: lifetime and the last 30 days. Information within each time frame is used to evaluate the duration and severity of each problem. Information from the past thirty days is especially useful to monitor change in patient status through subsequent re-administrations (McLellan, et al. 2006). Studies show that the ASI has satisfactory reliability and validity among all adults in most large ethnic groups (Kosten, Rounsaville, & Kleber 1983; McLellan, et al. 1985). The ASI and its training manual are available online (Treatment Research Institute 2009). According to McLellan et al. (2006:113), “the ASI is a standard in virtually all clinical trials of addicted patients, and it is part of the standard clinical assessment of alcohol- and drug-abusing patients in more than twenty states and fifty cities in the United States, as well as the Veterans Administration, the Indian Health Service, and the federal prison system.”

Drug testing is the final method for estimating illicit substance use. Drug testing refers to the use of various biologic sources such as urine, saliva, sweat, hair, breath, blood, and meconium to determine the presence of specific substances and/or their metabolites in an individual’s system (Center for Substance Abuse Treatment 2010). Drug testing can be completed in or out of a laboratory setting. Some child welfare agencies conduct drug tests on all parents under court supervision. The results are used to inform decisions on child placement, family support services, family reunification, and termination of parental rights (Center for Substance Abuse Treatment 2010). The effectiveness and accuracy of drug testing varies by specimen types (Center for Substance Abuse Treatment 2010). The following introduction on various specimen types is based on the drug testing guidelines published by U.S. Department of Health and Human Services (Center for Substance Abuse Treatment 2010).

Urine analysis is the most widely used, cost effective, and well-researched approach. A urine specimen is usually collected in a urine specimen cup with a drug test strip, which generally costs less than ten dollars. Five minutes after urine collection, the results can be read from the color change on the drug test strip. Although less effective, oral fluid, or saliva, has gained recent popularity. An oral fluid specimen is collected on a swab placed inside the cheek and is used to estimate drug use within the previous 24 hours. Sweat specimens are collected by applying an adhesive patch to the upper arm or upper back for typically a 7-day period. The patch provides a cumulative record of the individual's drug use when the patch is worn, but the effectiveness depends on the amount of sweat produced by individuals. Hair specimen tests can detect drug use over several months and pinpoint long-term changes in drug use patterns. The greatest limitation of this approach is that hair specimens cannot detect drug use within the last 3 days or discriminate between recent drug use and use that occurred months earlier. For these reasons, it has limited application in child welfare settings. Blood specimens are collected to detect use of both alcohol and drugs, but require analysis by qualified and trained personnel. Meconium (contents of fetal intestines) specimens can be used to identify substance-exposed infants. Meconium specimens indicate the mothers' substance use after 13 weeks of pregnancy.

ESTIMATING SUBSTANCE ABUSE AND DEPENDENCE

According to 2009 National Survey on Drug Use and Health (NSDUH) (SAMHSA 2010), an estimated 22.5 million persons aged 12 or older were classified with substance dependence or abuse in the past year (8.9 percent of the population is aged 12 or older). Of these, 3.2 million were dependent on or abused both alcohol and illicit drugs; 3.9 million were dependent on or abused only illicit drugs; and 15.4 million were dependent on or abused only

alcohol. Estimating the extent of substance abuse by clients served within the child welfare system is more complicated because of variations in definitions across states and measurement strategies between studies (Testa & Smith 2009). Nonetheless, estimates in child welfare populations do exist.

The prevalence of substance abuse among in-home cases ranges from approximately 10% to 68%. The prevalence largely depends on the type of measurement and the sampling pool. Jones (2004) drew a random sample of 443 children from all in-home cases in San Diego County between January 1 and June 30, 1995. The author reported that 68% of the mothers abused alcohol or drugs, and 37% of the mothers abused both alcohol and drugs. The author used a variety of substance abuse measures, including treatment records, history of having substance exposed infants, self-reports, reports from helping professionals, and reports from family members. Mothers were classified as substance abusers if any of the measures yielded a positive indication. This measurement approach tends to provide a high prevalence rate. Estimates from more recent national studies arrive at significantly lower estimates.

Using data from the National Survey of Child and Adolescent Well-being (NSCAW), Gibbons and colleagues (in press) report that 9.6% of caregivers associated with an in-home case have a problem with alcohol or drugs according to the child welfare worker assessment. This estimate is similar to the percentage of children in substance abusing families in the general population (USDHHS 1999). Moreover, the NSCAW estimates indicate that only 3.9% of caregivers were alcohol or drug dependent according to the CIDI-SF. It is worth noting that there is limited overlap between the child welfare worker assessment and the CIDI-SF. That is, the child welfare workers failed to identify a substance abuse problem among 61% of caregivers who met the CIDI-SF criteria for alcohol or drug dependence. Using a different sample from

NSCAW, Libby et al. (2006) reported that 13.2% of Caucasian, 11.3% of African American, 6.1% of Hispanic, and 7.5% of American Indian caregivers have a substance abuse problem. Some argue that the NSCAW estimates are low because the CIDI-SF measures substance dependence rather than substance abuse (Young, Boles & Oteros 2007). For example, a recent study (Marcenko, Lyons, & Courtney 2010) in Washington State reported that 21.8% of 318 mothers with children remaining in her home met the criteria for alcohol or drug abuse/dependence in the past twelve months. These authors used the Mini-International Neuropsychiatric Interview (MINI) to measure substance abuse/dependence.

As compared with in-home cases, the prevalence of substance abuse/dependence associated with parents of children in foster care is significantly higher. Yet variation still exists due to measurement and sampling protocols. Murphy and colleagues (1991) studied a sample of 206 foster care cases in Boston and reported that 43% of the parents had a documented problem with either alcohol or drugs. The General Accounting Office (1994) published a study of 414 foster children from Los Angeles, New York City, and Philadelphia. The authors estimated that 78% of foster children had at least one parent who was abusing alcohol or drugs at the time of temporary custody. Another study published by the GAO (1998) studied a sample of 519 foster children from Los Angeles and Cook County in 1998 and estimated that approximately two-thirds of all foster children in both California and Illinois had at least one parent who abused drugs or alcohol, and most had been doing so for at least five years. Estimates from NSCAW indicate that 28.7% of primary caregivers are abusing alcohol and 37.4% are abusing drugs at time of investigation (USDHHS 2005). Relatively high rates are also reported from the Illinois Alcohol and Drug Abuse Waiver Demonstration (Ryan 2011). Beginning in 2000, parents suspected of alcohol and drug use were screened for substance abuse or dependence at the

temporary custody hearing. As of December 2010, 64% of screened parents were identified as either substance abusing or substance dependent using DSM criteria. This estimate is only for those parents referred for screening. If all parents were included, that is every parent associated with a temporary custody hearing referred for screening or not, approximately 43% would be identified as either substance abusing or substance dependent. In Illinois, these are the most accurate estimates associated with substitute care placements. In addition to the estimates associated with in-home and out of home placements, the number of substance exposed infants represents an important indicator for child welfare systems.

Approximately 440,000 infants (10–11% of all births) are affected by prenatal alcohol or illicit drug exposure (Young et al. 2009). However, there are few up-to-date statewide prevalence estimates of SEI (Young et al. 2009). In Washington, researchers (Washington State Department of Health 2009) estimated that 8,000–10,000 SEI are born each year in Washington. Testa and Smith (2009) provided the SEI rates in Illinois between 1985-2007. They report that the rate peaked at 20 per thousand births in fiscal year 1994 and decreased to 5 per thousand births in fiscal year 2007. Although the rate of SEI reports decreased, the percentage of indicated cases among SEI reports remained at more than 90% throughout the years, which reflected that Illinois legislation considers newborns whose blood, urine, or meconium contains any amount of a controlled substance or its metabolites as abused or neglected minor (Testa & Smith 2009). They also reported that the SEI reports were disproportionately distributed among ethnicity groups. For example, among all infants born in IL 1995, 59% were non-Hispanic White and 20% were African American. In the same year, 12% of SEIs were non-Hispanic White while 83% were African American. The authors suggest that the disproportionate distribution was related to different drug surveillance practices (e.g. publicly funded, inner-city hospitals more likely to test

for substance exposure). This is an important point as perhaps more than other types of maltreatment, the policy context greatly affects the variation of SEIs identified each year and the State's response to those identified.

Although several state statutes (e.g., MN, IA, KY, ND, VA) currently require health practitioners to administer toxicology tests if they suspect prenatal use of illegal substances, health practitioners generally determine their own testing and screening policies and procedures (National Abandoned Infants Assistance Resource Center 2006). Perhaps surprisingly, there exist no federal requirements for drug testing at birth. The only requirement as stipulated by the Child Abuse and Prevention Treatment Act (CAPTA) is that hospitals must have a mechanism in place to connect with child protection when substance exposed infants are identified.

Currently sixteen States consider substance abuse during pregnancy to be child abuse; three consider it grounds for civil commitment (Anthony, Austin, & Cormier 2010). For example, Illinois legislation considers newborns whose blood, urine, or meconium contains any amount of a controlled substance or its metabolites as abused or neglected minors (Testa & Smith 2009).

Yet it is important to note that a single test is often insufficient with regard to the absolute determination of child maltreatment, the extent of potential maltreatment or the extent of substance abuse/dependence. Thus, experts encourage using a combination of random drug tests, self-reports, and observations of behavioral indicators by substance abuse treatment providers or professionals and child welfare workers (Center for Substance Abuse Treatment 2010). Observations include deteriorating hygiene and grooming; impaired functioning in daily life; impaired work behavior; involvement with people, places, and things associated with drug use. Utilizing a combination of drug testing, self report and observational strategies is viewed as

the most reasonable and appropriate response by child welfare professionals. The literature is clear – what happens in the family home is a more accurate predictor of long term child well-being as compared with a single positive drug screen (Lester, Freier & LaGasse 1995). The response from caseworkers and judges should reflect such findings.

PROMISING PRACTICE FOR SUBSTANCE ABUSING FAMILIES

Parental substance abuse compromises appropriate parenting practices and creates problems in the parent–child relationship (Famularo, Kincherff, & Fenton 1992; Jaudes, Ekwo, & Van Voorhis 1995; Kelleher, Chaffin, Hollenberg, & Fisher 1994; Nurco, Blatchley, Hanlon, O’Grady, & McCarren 1998). Specifically, substance abuse decreases emotional involvement (Hans, Bernstein & Henson 1999), decreases parental flexibility (Tronick et al 2005), disrupts the interpretation of infant and child cues (Burns, Chethik, Burns & Clark 1991) and helps to create an environment that is often not responsive to the material and emotional needs of children (Magura & Laudet 1996). In a study of parenting practices, Eiden, Chavez, and Leonard (1999) report that substance abusing parents display lower sensitivity and higher negative affect in their interactions with their infants as compared with non substance abusing parents. Measures of sensitivity included visual contact, flexibility, and the ability to read child cues. Measures of negative affect included hostile voice, hostile mood, aggression, and criticism. Escalating periods of drug use further erode the home environment. In a study of recovering heroin addicts, McKeganey, Barnard, and McIntosh (2002) report that during periods of increased drug use, the needs of children become secondary to the needs of the drug user. Thus, it is not surprising that children in substance abusing families are at an increased risk of physical abuse and neglect even after controlling for a wide range of covariates (Chaffin, Kelleher, & Hollenberg 1996).

Once involved in the child welfare system, substance-abusing parents are more likely to

experience subsequent allegations of maltreatment as compared with non-substance-abusing parents (Smith & Testa 2002). In addition to the increased risk of maltreatment, access to and engagement with treatment providers is often limited (Maluccio & Ainsworth 2003). Consequently, children of substance-abusing parents remain in substitute care for significantly longer periods of time and experience significantly lower rates of family reunification relative to almost every other subgroup of families in the child welfare system (GAO 1998). For these reasons, it is important to identify and rigorously evaluate innovative strategies with substance abusing families.

Although somewhat limited, there is a growing literature focused on services for substance abusing parents served by the child welfare system. Marsh, D'Aunno, and Smith (2000) used a non-equivalent control group design to examine the impact of enhanced services for substance-abusing women involved with child protection. The study compared clients who received enhanced services with those who received regular substance use treatment. The use of linkage services (e.g., transportation, child care) increased social service access and decreased subsequent levels of substance use. Smith and Marsh (2002) used the same sample of substance-abusing mothers to examine the impact of matching client-identified needs with services. The authors report that matched counseling services (e.g., domestic violence, family counseling) were associated with reports of reduced substance use, and matched social services (e.g., housing, job training, legal services) were associated with clients' satisfaction with treatment.

Using data from the National Survey of Child and Adolescent Well-being, Barth, Gibbons, and Guo (2006) investigated the association between substance abuse treatment and subsequent reports of child maltreatment for intact family cases. Using propensity score matching (PSM) to approximate random assignment, the authors report that families in the

treatment condition were significantly more likely to experience a new allegation of maltreatment as compared with families in the non-treatment group. The authors present various explanations for this unexpected finding, including potential problems associated with self-reported measures of addiction severity, the inability of services to meet client needs, and the treatment group's involvement with an additional mandated reporter (i.e. substance abuse treatment provider).

In much of the previous work it is often unclear what is meant by “treatment group” and “services.” This problem is not limited to the substance abuse literature, yet the lack of well defined interventions does present challenges when agencies and systems are searching for evidence based programming. In recent years however, several fairly well articulated service models have been developed for and tested with substance abusing parents in child welfare. These models include Motivational Interviewing, the use of Recovery Coaches and Family Dependency Drug Treatment Courts.

Motivational Interviewing: Motivational interviewing is a brief client-centered approach to increasing intrinsic motivation so that parents can explore and reduce ambivalence (Miller & Rollnick 2002). Clients are believed to approach behavioral changes with varying levels of readiness. Engaging in motivational interviewing is intended to assist the client in becoming more aware of the consequences associated with maintaining the behavioral status quo. The clinician remains nonjudgmental throughout the sessions. The basic components of this approach are expressing empathy, developing discrepancies (between problem behavior and personal views), rolling with resistance (in contrast with challenging resistance), and supporting self efficacy (capacity to cope with obstacles) (Burke, Arkowitz & Menchola 2003; Lundahl, Kunz, Brownell, Tollefson, & Burke 2010).

In a meta-analysis of thirty controlled clinical trials, Burke et al (2003: 856) report that motivational interviewing is “equivalent to other active treatments and superior to no-treatment or placebo controls for problems involving alcohol, drugs, and diet and exercise” (p.). The effects noted in the meta-analysis are not limited or specific to child welfare populations, but given the findings, motivational interviewing and adaptations of motivational interviewing (AMI) are now commonly utilized as part of treatment planning for substance abusing parents in child welfare. The results are mixed. Chaffin and colleagues (2009) tested motivational interviewing in combination with parent-child interaction therapy (PCIT). The authors report that the combination of pretreatment motivation interviewing and PCIT improved program retention for individual parents with low to moderate motivation. Negative effects were reported for parent with high initial motivation. The authors note that improvements in retention cannot be attributed to motivational interviewing alone. Similarly, Mullins et al (2004) tested motivational interviewing with a randomized control trial of women involved with child welfare. The authors focused on session attendance, group attendance, and urine screenings. In contrast with studies in the general population, Mullins et al (2004) report no differences between the motivational interviewing and educational control condition. The authors speculate that perhaps motivational interviewing is less effective with coerced populations. In short, motivational interviewing is seen as an effective tool in substance abuse settings. Yet additional studies with child welfare populations are necessary to determine (a) why similar effects in retention are not observed and (2) whether motivational interviewing can improve rates of reunification; because although all professionals are generally supportive of increasing rates of treatment access and program retention, the future of motivational interviewing in child welfare will be limited if this clinical approach has no significant affect on reuniting children with their biological parents.

Recovery Coaches: Since 2000, Illinois and in particular Cook County, has been engaged in a concerted effort to address the problem of substance abuse in child welfare. Specifically the county developed and implemented an integrated model for substance abusing caregivers. This integrated model emerged out of an existing service partnership between the Division of Alcoholism and Substance Abuse (DASA) and the Illinois Department of Children and Family Services (IDCFS), and represents one of three ongoing Title IV-E waiver demonstrations in the State of Illinois. Title IV-E waivers permit States to bypass federal regulations related to the financing of foster care services in order to develop and test innovative strategies for serving children and families. Waiver demonstrations are approved by the Children's Bureau and require cost neutrality.

The Illinois AODA Waiver Demonstration Project tested a model of intensive case management using recovery coaches. The use of recovery coaches is intended to increase access to substance abuse services, improve substance use disorder treatment outcomes, shorten length of time in substitute care placement, and affect child welfare outcomes, including increasing rates of family reunification. To achieve these stated goals, recovery coaches engage in a variety of activities, including comprehensive clinical assessments, advocacy, service planning, outreach, and case management. The clinical assessments focus on a variety of problem areas, such as housing, domestic violence, parenting, mental health, and family support needs. Recovery coaches visit the family home and the AODA treatment provider agencies. Recovery coaches also make joint home visits with child welfare caseworkers, AODA agency staff, or both. Recovery coach services are provided for the duration of the case, and such services may also be continued for a period of time subsequent to case's closing. The empirical evidence supports the recovery coach efforts in Illinois. The families assigned to the recovery coach group

are significantly more likely to achieve reunification (27% vs. 20%) and significantly more likely to achieve adoption as a secondary option for permanency (38% vs. 33%) five years post assignment. Moreover, the parents associated with recovery coach services are significantly less likely to be associated with a subsequent substance exposed infant. (Ryan, Choi, Hong, Hernandez, & Larrison 2008; Marsh, Ryan, Choi & Testa 2006; Ryan, Marsh, Testa & Louderman 2006; Ryan 2011). The recovery coach model provides services at the individual client level. In contrast, the Family Dependency Drug Treatment Courts¹ represent a macro level intervention; changing the context within which substance abusing parents are processed and monitored in child welfare.

Drug Courts: Family Dependency Drug Treatment Courts are part of a larger category of problem solving courts that include adult drug court (for non violent adult offenders), community courts (offender expected to give back to community as compensation), domestic violence court, gambling court, DWI court, mental health court (diverts defendants with mental illness to community based treatments), and truancy court (school based court focused on education). The purpose of the family drug court is to help states meeting the permanency requirements associated with the Adoption and Safe Families Act and improve the level of functioning for substance abusing families (Boles, Young, Moore & DiPirro-Beard 2007). Family drug courts differ from traditional child protection courts in that the frequency of judicial monitoring is increased, the provision of substance abuse treatment for parents in the child welfare system is prioritized, parents are subjected to regular drug tests and judges issues sanctions (e.g. incarceration) and rewards (e.g. progress/graduation ceremonies often associated with token gifts) for service compliance (Edwards & Ray 2005). The increase and popularity of these

¹ These courts are also referred to throughout the literature as Dependency Drug Courts and Family Drug Courts

courts is stunning. The number of drug courts (of any kind) in the United States increased from 230 in 1997 to 2,147 in 2007. Similarly, Family Dependency Drug Treatment Courts (which were essentially nonexistent in 1997) have doubled in recent years (153 in 2004 to 301 in 2007) (Huddleston, Marlowe & Casebolt 2008). Although caution is generally viewed as good advice with the exponential replication of any service model, there is some evidence to warrant the family drug courts' growth.

Green and colleagues (2007) evaluated the effectiveness of family treatment drug courts in four geographically diverse locations. The evaluation focused on a range of important outcomes (short and long term) including treatment access, treatment retention, treatment completion, family reunification and maltreatment recurrence. The authors used a quasi-experimental nonequivalent control group design. Each site identified 50 family drug court cases and 50 comparison cases. The authors report that parents in the family drug court group entered treatment more quickly (73 vs. 182 days), spent more time in treatment (303 vs. 185 days), completed treatment at a higher rate (45% vs. 34%), were more likely to achieve family reunification (57% vs. 44%) and were no more likely to experience a subsequent substantiated report of maltreatment (23% vs. 15%). Similar results are reported for an evaluation of a family drug court in Sacramento, California (Boles, Young, Moore & DiPirro-Beard 2007). Such evidence is encouraging. Yet to fully understand the true value added by family drug courts, court personnel, researchers and funding agencies need to invest in more rigorous designs. Currently, family drug courts are voluntary. At the time of temporary custody, parents are given the option to participate in family drug court (perhaps a dedicated calendar/docket within the larger family court). This creates problems in the identification of equivalent comparison groups – as volunteers are undoubtedly different from those declining participation. Although propensity

score matching and other statistical adjustments can help correct for selection bias (i.e. removing the volunteer effect), given the widespread use and rapid growth of family drug courts, an evaluation utilizing an experimental design is necessary. The lack of experimental designs is not limited to family drug courts or even child welfare more broadly. In fact the general lack of rigorous experimental designs has given rise to a surge of concerns about the quality of empirical evidence in all of the applied social sciences (Boruch, Snyder, & DeMoya 2000). Such concerns will only limit the identification and replication of “best practices” or “evidence-based practices” in child welfare.

From a practice perspective, it is important to recognize that problems with substance abuse rarely occur in isolation. The comorbidity rates with other health and social problems for substance abusing adults is high. In part, the problem of comorbidity makes working with substance abusing clients in child welfare particularly challenging. The National Institute of Mental Health Epidemiological Catchment Area Program reports 37% of adults with an alcohol disorder and 53% of adults with a drug disorder also report a comorbid mental disorder. These estimates represent the general population. Significantly higher rates of comorbidity are reported in prison and other high risk populations (Regier, et al. 1990). Within the child welfare system, co-occurring mental health, domestic violence and inadequate housing are frequently documented. In a study of substance abuse and co-occurring problems in the Illinois child welfare system, Marsh et al (2006) found that 92% of substance abusing families report simultaneously struggling with mental health, domestic violence and/or housing problems. Specifically, in Illinois between 2000 and 2010, substance abusing families involved with the child welfare system in Cook County report high rates of domestic violence (43%), mental health diagnoses (61%), unemployment (72%), and homelessness (8%). These estimates have

important implications for practice and policy, as the presence of such problems increases the risk of continued maltreatment and decreases the likelihood of achieving family reunification (Hess, Folaron, & Jefferson 1992; Aron & Olson 1997; Park, Metraux, Brodbar, & Culhane 2004; Jones 1998; Hoffman & Rosenheck 2001; Newton, Litrownik & Landsverk 2000; Landsverk, Davis, Ganger, Newton, & Hohanson 1996; Faller & Bellamy 2000; Marsh et al 2006). Given high rates of co-occurring problems and the consequences associated with such problems, many of the innovations in child welfare practice for substance abusing parents involves specialized, shared, or integrated service models.

Conclusions and Future Directions

Substance abuse and substance dependence complicate and interfere with the healthy development of children. Moreover, parents struggling with substances are likely to encounter great difficulties and perhaps insurmountable obstacles on the road to achieving family reunification. There is some evidence to suggest that both individual level (e.g. recovery coaches) and organizational level (e.g. family drug courts) interventions work in terms of improving treatment access and family reunification. We believe and argue that parents will achieve the greatest level of success when child welfare service delivery systems embrace changes at both the individual and organizational level. Interventions are required at both micro and macro levels because this is where the critical decision makers reside. If we focus only on the caseworkers and parents (individual level), we fail to account for the judges' authority and final decision concerning reunification.

The experiment with recovery coaches in Illinois highlights the limitations of an intervention delivered only at the individual level. The recovery coach model is based on the assumption that if substance abusers can be identified and connected with treatment providers,

progress toward recovery could be accomplished more quickly and in turn family reunification could be achieved. Some of these assumptions are supported with the data. Families did access services and achieve reunification at significantly higher rates. Yet, the level of success was less than anticipated; data from Illinois indicate that even when families complete all the mandated substance abuse treatments required by caseworkers, a fairly large proportion is still unable to achieve reunification and experience case closure. Why is that? What would prevent reunification subsequent to the completion of substance abuse treatment – especially when the problem of substance abuse was a primary reason for placement? Several authors argue, and there is evidence to support, that co-occurring problems help explain such a finding (Testa & Smith 2009; Marsh et al 2006). That is, despite progress in the domain of substance abuse, the presence of domestic violence in the home remains a primary obstacle. An alternative explanation is that many judges lack the sufficient knowledge base and understanding of substance abuse in general and the recovery process more specifically. A limited knowledge base in turn helps to create a risk averse atmosphere and consequently contributes to reunification delays. For example, judges that perceive relapse as a certainty in the recovery process might be less inclined to return children from foster care, regardless of service compliance. Intervention at the court level (e.g. judicial trainings), even in the absence of an established family drug court, might help to address such problems. Such an intervention would not ignore or deny the fact that relapse occurs, but rather recognizes the idea that reunification can often be achieved as parents make significant progress toward sobriety. To date, little research focuses on the judges' perceptions of substance abusing parents and the association between these perceptions and case dispositions. Studies in this area would make a significant

contribution to the literature and help inform practice innovations and partnerships with the courts.

“One day at a time for the rest of my life” is an adage commonly repeated in recovery groups. This statement indicates that the work of recovery is never complete. Substance abusing parents will always be striving to achieve and maintain sobriety. Our policies and practices in child welfare ought to reflect this reality. In working with substance abusing parents, progress and not perfection should be the primary objective and benchmarks of success in the child welfare system.

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