Substance Abuse and Reunification: A Child Welfare Dilemma

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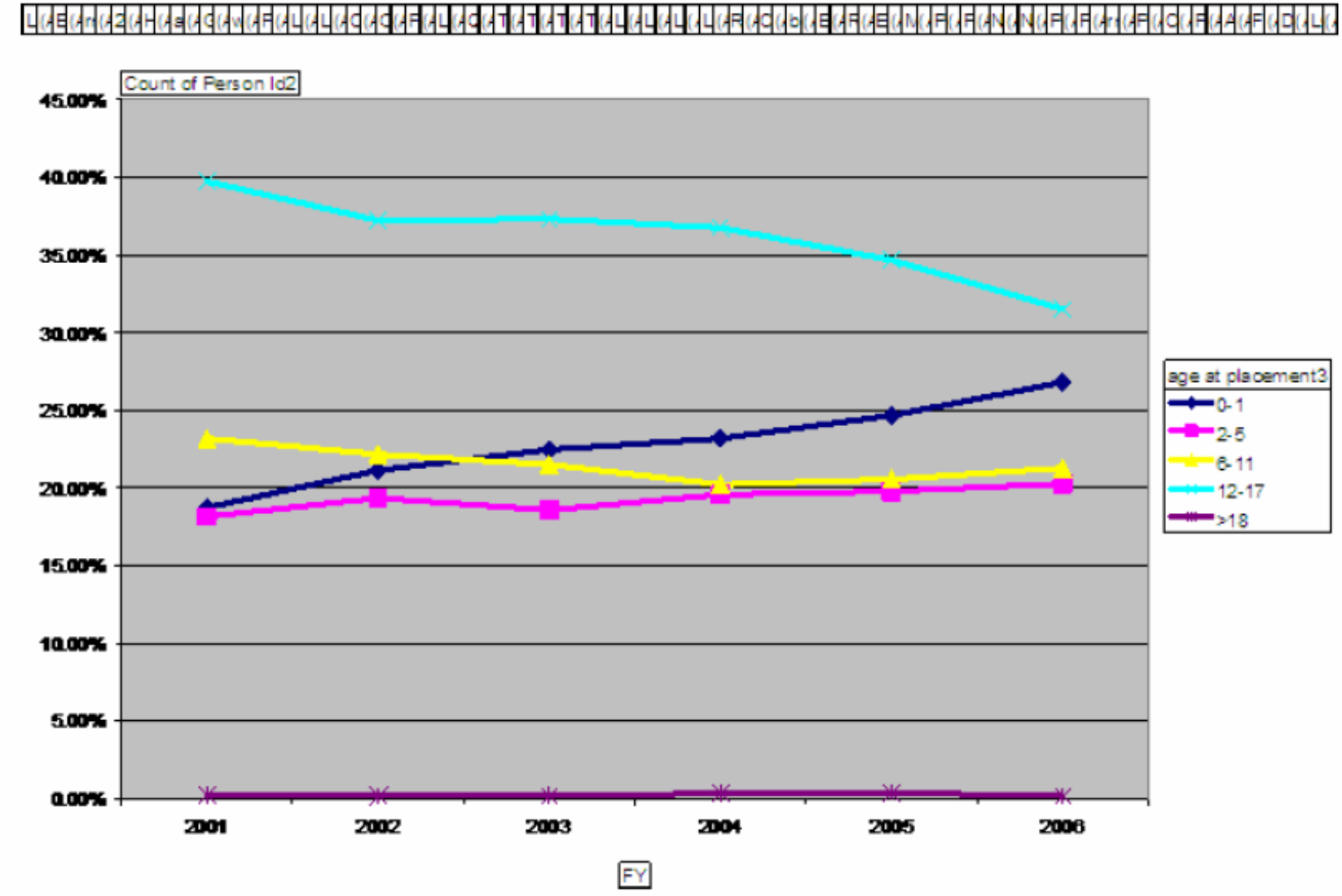
The profile of child welfare families and of children entering the foster care system changed dramatically in the 1980s: Neglect, substance abuse, high rates of infant placements and placements of pre-school children, long length of stay in out-of-home care, reduced rates of reunification, and high rates of re-entry into care resulted in large increases in states' foster care population.

All Entries by FY and Age at Placement



This constellation of factors was the child welfare context which led to the passage of the 1997 Adoption and Safe Families Act (AFSA), the most important new child welfare law since 1980.

AFSA set strict timelines for public child welfare agencies to work with birth parents who have had children removed from their custody: Once a child has been in out-of-home care 15 out of 22 months and cannot safely be returned to parents, the child welfare agency is required to file for termination of parent rights, absent compelling reasons to do otherwise.

Washington State law requires that a termination of parental rights petition be filed once a child has been in care 12 out of the past 19 months, again absent compelling reasons to do otherwise, if the child cannot be safely returned to the parent(s).

AFSA also clearly states that child safety is the pre-eminent child welfare goal, so that decision makers will have an explicit guideline if faced with a choice between child safety and supporting and strengthening families.

AFSA also established fiscal incentives for public child welfare systems to increase adoptions; and, nationally adoptions have increased from about 20,000 children per year to more than 50,000 children per year.

The number of adoptions has leveled off in the past two years for which data is available.

In Washington State, adoptions tripled from 400 to 1,200 per year from 1996 to 2004. Washington, like a number of other states, has received several million dollars in adoption incentive funds.

During this same time period (mid-90s to the present), reunifications declined in Washington State for 7 straight years (1997-2004). A Washington State Institute for Public Policy (WSIPP) study (2004) found that most of this decline was due to a reduction in brief placements, while the remainder was due to reduced rates of reunification for neglected children with substance-abusing parents.

Policy makers may have intended to increase adoptions without decreasing reunifications; if so, they miscalculated. A more plausible hypothesis is that public policy aimed at increasing adoptions, regardless of the effect on reunifications, as a means of stopping the growth of out-of-home care by meeting the needs of very young children for permanent families.

It is not a mystery why reunifications have steadily declined:

AFSA timelines for child welfare decision-making are out of sync with substance abuse treatment expectations for the length and difficulty of the recovery process, even if parents enter substance abuse treatment in a timely way, but in fact…

…no more than 20-25% of substance-abusing parents whose children are legally dependent enter and complete court-ordered chemical dependency treatment.

(Famularo, 1989; Gregoire & Schultz, 2001; DHHS, 2005).

There has been very little research regarding why entry into and completion of treatment rates have been so low; and what research there is has some sobering messages.

For example, one Florida study found that treatment motivation for mothers in substance abuse treatment programs who had lost custody of children was lower than for other women, possibly because women whose children had been removed believed that they had little chance of regaining custody.

(Wilke et al, 2005)

It may be that for many parents, removal of children from their care intensifies the demoralization which contributed to the public child welfare agency's decision to place a child in out-of-home care.

Federally-funded projects in several states intended to increase substance-abusing parents' entry into and completion of treatment have met with mixed results.

In a report on substance abuse demonstration projects, the Children's Bureau comments that "no state has been successful to date in promoting significantly greater rates of reunification or other forms of permanency" through increased rates of treatment completion.

(DHHS, 2005)

This same report comments that “the challenges faced by the states with caregiver enrollment highlight the need to test basic assumptions regarding the identification of substance abuse disorders in child welfare populations and caregivers’ availability, motivation, and willingness to participate in treatment.”

(DHHS, 2005)

Both the feds and states have begun to experiment with solutions to parent engagement and motivation without taking another careful look at the characteristics of substance-abusing parents.

First and foremost, there needs to be more child welfare research on co-occurring substance abusing and mental health disorders.

“Between 30-60% of persons in treatment have a co-occurring mental disorder...”

(DHHS, 2004)

A recent California study found that a third of parents with child welfare involvement in substance abuse treatment programs had been on medications for mental health problems; and that rates of mental health outpatient treatment were similar for parents involved with child welfare agencies and non child welfare involved parents (36%).

(Grella et al, 2006)

This same study found that parents involved with child welfare in substance abuse treatment programs were poorer and more poorly educated than other adults in treatment programs, were more likely to abuse methamphetamines than other persons receiving treatment, but scored lower on the addiction severity scale than non- child welfare involved adults.

(Grella et al, 2006)

- 45% of child welfare involved parents were on probation or parole.

- 43% of child welfare involved and non- child welfare involved adults had been in 2 or more prior treatment episodes.

(Grella et al, 2006)

…we estimate that 50-60% of women who enter treatment for an addictive disorder may have had a co-occurring mental disorder during the prior 12-month period.

…women who enter treatment for a mental disorder are likely to be at much lower risk of a co-occurring addictive disorder, with rates in the 10-20% range.

(Newmann & Sallman, 2004)

In the general population, women have twice the rate of depression as men, and one-third of women who enter substance abuse treatment have experienced clinical depression in the past year.

(DHHS, 2004)

Women in substance abuse treatment had much higher rates of partner violence than women in comparative community samples—often 2, 3, or 4 times higher depending on the specific type of violence. In these women, substance abuse may be related to victimization either because alcohol and drugs are used as a general coping mechanism, or to deal with post traumatic stress disorder resulting from the violence.

(DHHS, 1999)

- Rates of trauma and PTSD are under-diagnosed in clinical settings serving women. Women are often mis-diagnosed as having other severe disorders that result in inappropriate and often ineffective treatment.

- Persons with PTSD have high rates of comorbidity (80 percent) with other disorders, most commonly depression, other anxiety disorders, and substance abuse or dependence.

(Hills, 2004)

It is difficult to imagine two mental disorders that each individually and especially in combination, lead to such demoralization and loss of ideals. In PTSD this loss of ideals has been written about, for example, in work on “shattered assumptions” and the “search for meaning”.

(Ouimette & Brown, 2003)

...women with co-occurring addictive and mental disorders reveal “an emerging profile of vulnerability” linked to poverty and victimization experiences.

(Newmann & Sallman, 2004)

…women who report being victims of childhood abuse are at higher risk for 13 of 16 subsequent lifetime mood, anxiety, and substance disorders in comparison to women who do not have such childhood experiences.

Women with reported childhood sexual abuse histories are at considerably greater risk for posttraumatic stress disorder, manic depressive disorder, drug problems and dependence, major depressive disorder and dysthymia, alcohol problems and other anxiety disorders.

(Newmann & Sallman, 2004)

...almost three-quarters of women with ADM problems (73.8 percent) reported both physical and sexual abuse.

...the vast majority of women who report both a mental health and a substance use problem will also report histories of physical or sexual abuse.

(Newmann & Sallman, 2004)

A related finding, and one that is disturbing in its scope, is the predominant theme of violence in these women's lives. Such violence begins early and, for many women interviewed, continues into adulthood.

...many women who enter the ADM system have been exposed to an epidemic of interpersonal violence across the life course. For many women, this experience is replicated in their contacts with the courts, the child welfare system, the jail and prison system, the welfare system, and within the ADM system itself.

(Newmann & Sallman, 2004)

...women with co-occurring mental health and substance use problems also reported exposure to a range of other life adversities in disproportionate numbers when compared to women with only a mental health or a substance use problem. Close to one fifth of the former group was placed in foster care as children...and of the women who are mothers, over half were separated from their own children against their will. The vast majority of women in the former group and significantly more than the latter report incarceration experiences. Not only are the women with co-occurring mental health and substance use problems more likely than other women to report histories of physical and sexual abuse, they are also more likely to report a number of other life adversities that may be sequelae of earlier abuse experiences.

(Newmann & Sallman, 2004)

Traumatized individuals need to have experiences that directly contradict the emotional helplessness and physical paralysis that accompany traumatic experiences.

...helplessness and paralysis becomes a habitual way of responding to stressful stimuli....

(Solomon & Siegel, 2003)

Substance Abuse

Mental Health

Poverty

Trauma/Violence

Osher and Drake (1996) summarize research findings gathered during the past decade that conclude that persons with co-occurring disorders, compared to persons with single syndromes:

- have greater vulnerability for rehospitalization;
- experience more psychotic symptoms;
- have more severe depression and suicidality
- have higher rates of violence and incarceration
- have more difficulty with daily living skills
- are more noncompliant with treatment regimens;
- have increased vulnerability to HIV infection; and
- are high service utilizers.

(Hills, 2000)

An ambivalent attitude toward abstinence is the rule and not the exception in persons with co-occurring disorders. Because they are uncertain about the impact of their substance use on their symptom experience, accepting an abstinence orientation can be a difficult task. They may have had this impression implicitly endorsed by service providers who did not address their co-occurring disorders. Recent findings suggest that in early recovery, persons with co-occurring disorders may have difficulty in affiliating with AA groups, even with facilitation.

(Hills, 2000)

…these women clearly indicated that the issue of economic adversity continues to loom large in their lives.

These women face ongoing difficulties in finding and keeping adequate housing, transportation, employment, and child care.

(Newmann & Sallman, 2004)

The association between welfare receipt as a child and greater depressed mood as an adult mirrors the findings of Ensminger (1995) and Elder and Like (1982), who suggested that economic difficulties early in life exert long-lasting deleterious effects, particularly on women.

…these findings do point to the importance of depression in explaining both the persistence and intergenerational trans-mission of poverty.

(Lennon, 2001)

There is a difference between poverty and “deep” poverty, i.e., severe, long term and/or concentrated poverty.

In the early 1990s, 60% of all poor children were white, but 90% of children in long term poverty were African American.

(Corcoran & Chaudry, 1997)

About half of African American children and three quarters of white children who grow up in long term poverty escape poverty as young adults.

Nevertheless, growing up in long term poverty greatly increases the risk of living in long term poverty as an adult.

For example, “long-term poor whites are eight times more likely to live in long-term poverty as adults than non-poor white children.”

(Corcoran & Chaudry, 1997)

- Long term poverty is associated with neighborhood concentrations of poverty, family structure, educational outcomes, parents' work histories and change in labor market conditions

- However, even when these conditions are controlled for there is a 2-1 difference in lifetime earnings between children growing up in middle class families vs. poor families.

(Corcoran & Chaudry, 1997)

Indicators of Demoralization

- Poor self care
- Lack of concern with physical environment
- Apathy in the face of threat
- Cannot “regroup” in the face of adversity
- Accepts demeaning behavior and attributions
- Unresponsive to offers of help
- Hopeless/helpless

Factors Which Sustain Morale in Difficult Circumstances

- Past success with overcoming adversity
- Strong sense of identity
- Good health
- Affiliation with a religious community
- Social support/encouragement
- Hope
- A sense of meaning and purpose
- Taking pleasure in small things
- An ability to ask for help and give help
- Strong self-esteem
- Anger
- Material resources

Given this profile of substance-abusing parents, it's highly unlikely that treatment programs narrowly focused on sobriety and recovery from dependence on drugs/alcohol will be effective with a large percentage of parents whose children have been involuntarily removed from the home.

Nevertheless, there is evidence from both child welfare research and discussions with case reviewers in this state that child welfare case workers utilize treatment completion as a proxy for change.

“Caseworkers indicate that in response to such [workload] pressures, they use service completion as a proxy for client change, include certain requirements in nearly all service plans, and prioritize requirements that can easily be measured and documented.”

(Smith, 2003)

I have occasionally been party to child welfare discussions at both the practice and policy level which attempt to establish guidelines for decision making which bypass caseworker assessment of the effects of substance abuse on parenting and on the risk of child abuse and neglect. This approach will not work except in the most extreme situations.

Possible effects of substance abuse on parenting behaviors

- Unreliable and inconsistent in providing basic care and feeding, hygiene, supervision, protection from danger, medical care, education; increased risk of accidents.
- Physically and/or emotionally unavailable for lengthy periods of time.
- Frequently irritable, cranky, harsh with children.

(Kroll & Taylor, 2003)

Possible effects of substance abuse on parenting behaviors

- Exercises poor judgment (from standpoint of children's needs) in use of resources, choice of friends and associates, exposing children to danger – risk management.
- Exacerbates family conflict and family violence, and may lead to physical abuse and emotional abuse.
- Insistence on secrecy, denial of use of illegal drugs.

(Kroll & Taylor, 2003)

Possible effects of substance abuse on parenting behaviors

- Children may have access to drugs, drug paraphernalia, or meth factory.
- Parental involvement in criminal behavior.
- Social isolation, gradual loss of non-substance-abusing relatives and friends.

(Kroll & Taylor, 2003)

Table 3. Number of Subsequent Reports of Abuse and Neglect for Each Type of Initial Report During the Target Period: July 1997 through June 1998 (33,395 Families Tracked for Five Years)

Initial types of reported child abuse and neglect during the 7/97-6/98 period	*Families by category of initial report*	*Percent of families with new reports*	*Later types of reported child abuse and neglect during the five-year follow-up period*												*5-year Totals of new reports*	*Percent match between later and initial reports*
			1. Sexual abuse	2. Severe physical abuse	3. Less severe physical abuse	4 Com-bined 3 and 5	5. Parent-child relation-ship prob.	6. Com-bined 5 and 10	7. Unmet medical needs	8. Unmet basic needs	9. Com-bined 8 and 10	10. Lack of supervi-sion/pro per care	11. Educa-tional neglect	12. Other combi-nation		
1. Sexual abuse	3,570	49.4	1,015	22	639	249	726	162	166	527	104	777	236	26	4,649	21.8
2. Severe physical abuse	338	41.1	39	28	69	18	60	16	14	50	11	80	13	6	404	6.9
3. Less severe physical abuse	6,245	53.7	917	60	2,135	834	1,843	297	412	924	198	1,490	317	62	9,489	22.5
4. Combined 3 and 5	1,845	54.6	284	21	609	313	656	92	124	237	52	383	110	17	2,898	54.5
5. Parent-child relationship prob.	5,854	51.4	793	44	1,341	590	1,924	350	370	863	196	1,379	332	77	8,259	23.3
6. Combined 5 and 10	1,004	60.8	144	17	269	99	344	86	79	232	73	433	94	16	1,886	41.2
7. Unmet medical needs	1,502	59.3	242	21	351	121	380	101	267	400	89	521	155	15	2,663	10.0
8. Unmet basic needs	4,242	64.9	748	59	1,039	372	1,176	276	444	2,525	372	1,392	498	50	8,951	28.2
9. Combined 8 and 10	909	71.3	146	12	214	77	263	69	101	502	127	472	114	21	2,118	52.0
10. Lack of supervision/proper care	6,048	55.4	839	62	1,313	445	1,456	386	410	1,195	351	2,550	475	76	9,558	26.7
11. Educational neglect	1,834	54.2	190	8	189	93	351	69	124	361	63	439	698	26	2,611	26.7
12. Other combination	4	100.0	1	0	2	0	3	0	1	6	3	5	2	0	23	*Average*
Total	33,395	**55.5**	5,358	354	8,170	3,211	9,182	1,904	2,512	7,822	1,639	9,921	3,044	392	53,509	**28.5**
Percent types of new reports			10.0	0.7	15.3	6.0	17.2	3.6	4.7	14.6	3.1	18.5	5.7	0.7	100.0	
														Number of new reports per family =	**1.60**	

(Loman, 2006)

"There is something all-encompassing about neglect – a qualitative shift in the experience of living – that needs to be considered, independently and coterminously with other types of abuse."

"Neglect is not simply about the physical environment but also includes the totality of the child's experience. It will not necessarily be visible... but it may be palpable in the sense that neglected children can exude a sense of being uncared for on many levels, and this can communicate itself to those around them."

(Kroll & Taylor, 2003)

In addition, children who have been left vulnerable to violence or sexual abuse often have a strong sense of betrayal as regards the non-offending parent. These children may be extremely angry and have a variety of mental health diagnoses.

(Kroll & Taylor, 2003)

Understanding the child's perspective is important in helping children in foster care or kinship care, and in planning for reunification. Children may reject their parents or identify with them and may have unexpressed fears and fantasies about being reunited with the birth parents. Children who have been raised with secrecy and stigma may be slow to reveal their sense of the world.

(Haight et al, 2007)

Even when children long to be with birth parents, they may have some intensely felt grievances about events prior to their removal from the home and the removal itself.

Parents must be able to cope with their children's feelings, and with their own guilt and shame. Parental remorse does not always lead to reformed behavior; it may lead to more substance abuse.

(Kroll, 2004; Haight et al, 2007)

Babies and toddlers who have spent most of their early childhoods with foster parents or relatives may be far more attached to these individuals than to parents; for parents who had early histories of rejection, children's unhappiness and difficult behavior can set off a dangerous dynamic.

Do we have a concept of "good enough parenting?

- Dependability in providing basic care
- Ensuring safety
- Providing emotional warmth
- Providing stimulation and education adequate to allow normal development
- Providing guidance and boundaries
- Stability of caregiving

(Dept of Health, 2000)

"Children are returned home when they are considered to be safe for the foreseeable future, not simply for the next 24-48 hours."

"A present danger orientation is not sufficient to answer this question."

(Morton & Salovitz, 2006)

"In judging prospective safety, the safety assessment must focus on the extent to which the underlying conditions and contributing factors related to serious threats have been resolved or diminished, the extent to which protective capabilities have been increased, and/or child vulnerability has been reduced.

(Morton & Salovitz, 2006)

Indicators of positive change with young children

- Enjoyment of the infant
- Sensitive and responsible caregiving
- Engagement with the child in mutually satisfying interactions
- Ability to provide appropriate and interesting activities to enhance the child's development

(Howard, 1994)

Indicators of positive change with young children

- Most of all: The child's needs come first in the parent's heart and mind
- Reliable in fulfilling responsibilities and taking care of basic needs
- Makes good use of available resources; asks for help as needed
- Honest and candid regarding one's actions

(Howard, 1994)

Indicators of positive change with school age children

- Can cope with child's negative behavior and emotions
- Enjoys being with child
- Proud of child's achievements and talents
- Increased ability to set limits on child behavior without hitting, yelling, ignoring, or abandoning

(Howard, 1994)

Indicators of positive change with school age children

- Reliability in keeping promises and visiting child
- Increased recognition of past history of CA/N
- Increased contact with persons supportive of positive changes
- Lack of violence in interpersonal relationships

(Wilson, 2000)

Indicators of positive change with school age children

- Increased motivation to change following relapse
- Increased self esteem
- Increased self-efficacy

(Wilson, 2000)

Decision makers should not assume that positive changes in parental behavior and attitude automatically result from the completion of treatment programs; in addition, the possibility that positive changes in parental behavior and attitudes might occur absent completion of treatment programs should not be ruled out.

Treatment completion is a means to an end, not the end itself.

There is a thin body of research on substance abuse treatment outcomes for child welfare involved parents, in part due to low rates of treatment completion, but also for definitional reasons.

Should conclusions regarding treatment effectiveness be based on parents referred to, entering, or completing treatment?

Given the ubiquity of relapse, how should “effectiveness” be defined, and what should the follow-up period for evaluating outcomes be?

Gregoire and Schultz's important study (2001) of treatment outcomes in a Pennsylvania county found that treatment completers had higher rates of sobriety over a 9 month period of time than non-completers; but that almost half (48%) of parents who completed treatment continued to use drugs and/or alcohol after entering treatment; 61% of parents referred to treatment continued to use drugs/alcohol.

Treatment completion rates were greatly influenced by the support or lack of support for treatment by significant others.

Women were less likely to receive support than men.

Richard Barth has recently published a study based on data from the National Survey of Child and Adolescent Well-Being which found that parents receiving in-home services from public child welfare agencies who reported participating in substance abuse treatment were reported for abuse or neglect twice as often as parents with in-home service cases who reported no involvement in substance abuse treatment.

(Barth, 2006)

Clearly, the positive benefits to parents resulting from substance abuse treatment may not be immediate; substance abuse treatment and recovery is a long-term process, even when successful.

Treatment is not protection.

Children and parents will often need continued support and services for long periods of time.

"Recovery is a process of making lifestyle changes to support healing and to regain control of one's life. Recovery involves being accountable and accepting responsibility for one's behavior. It is the process of establishing and re-establishing patterns of healthy living..."

(DHHS, 2005)

“Parenting stress may continue to pose a significant threat to maintaining sobriety even after initial reunification.”

Stressors include:

- Coping with children’s feelings and behaviors
- Feeling overwhelmed by demands and needs
- Inadequate emotional support
- Lack of adequate support services
- Substance use by other family members
- Abusive relationships
- Contentious relationship with CPS/CWS
- Threat of possible removal
- Social stigma directed to parents who have lost custody of children
- Financial strains / housing

(Carlson et al, 2006)

Factors which influence the likelihood of timely and successful reunification

- Parental income; “Children whose mothers lost a significant amount of cash assistance after their children’s placements were reunified more slowly than were children whose mothers did not, underscoring the centrality of a consistent source of income to reunification speed.”

(Wells & Guo, 2004)

Factors which influence the likelihood of timely and successful reunification

- "For impoverished single parent mothers with children in foster care, the characterization [of poverty as a state of crisis] also points to the difficulties involved in managing work, meeting agency requirements, and experiencing fear, grief, or paralysis over the possible loss of their children."

(Wells & Guo, 2004)

Factors which influence the likelihood of timely and successful reunification

- Family preservation services can be utilized to reduce parental stress during reunification and prevent re-entry into care. These services must be delivered for extended periods of time and take on a child development focus.

(Wells & Tracy, 1996; Barth, 1994)

Factors which influence the likelihood of timely and successful reunification

- Transitional housing programs should be available to parents completing substance abuse treatment programs. These programs allow parents in recovery to develop new support systems.

(Metsch et al, 2001)

Factors which influence the likelihood of timely and successful reunification

- The use of family treatment drug courts can be expanded; and, just as importantly, the practices which make drug courts successful can be utilized in other settings, especially the practice of giving parents frequent and regular feedback on their progress in treatment and recovery. Frequent and well-deserved praise has a powerful influence on adult behavior.

(Green et al, 2007)

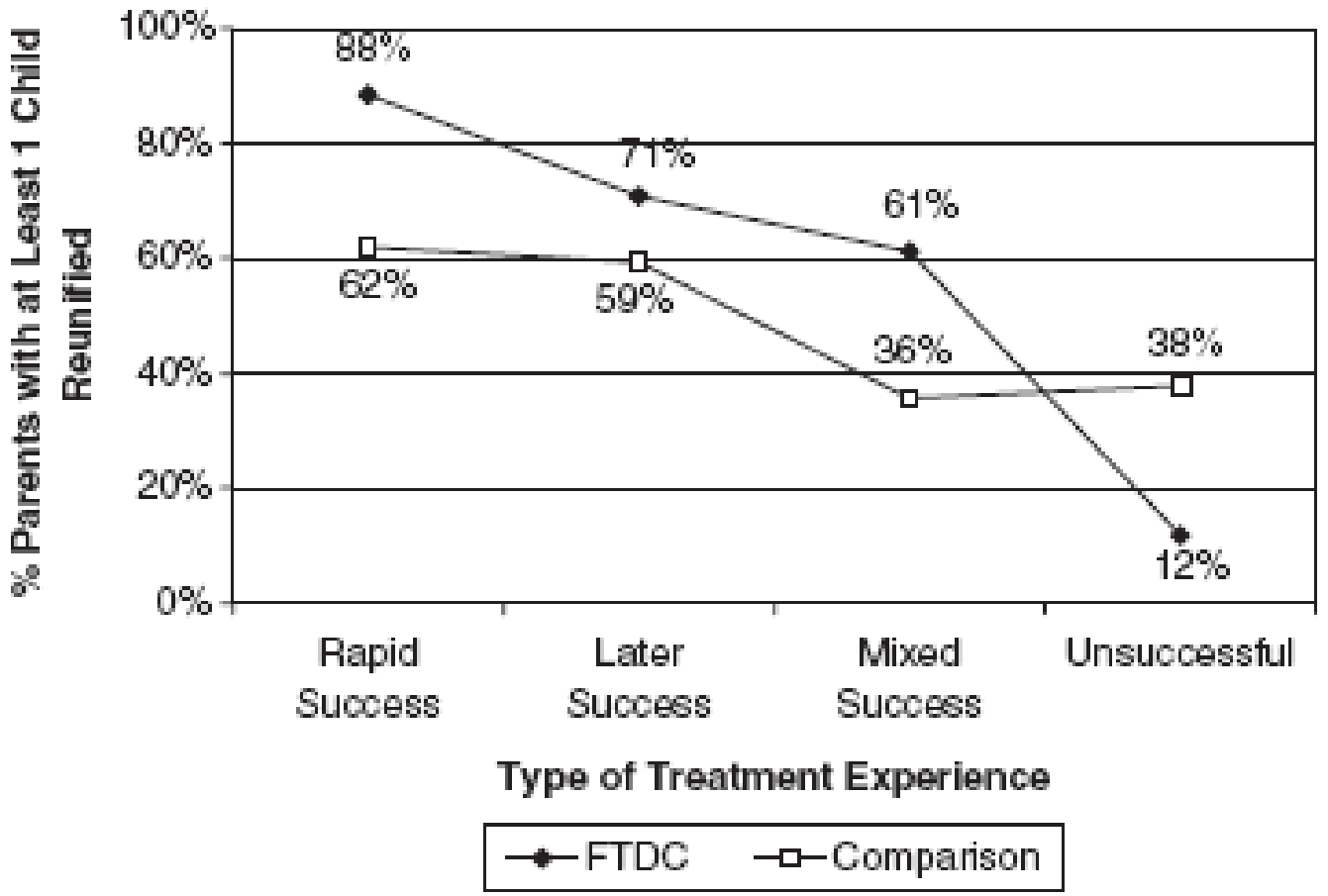


FIGURE 2: Interaction Between Type of Treatment Experience and FTDC Versus Comparison Predicting Whether Parent Was Reunified With at Least One Child

(Green et al, 2007)

Re-entry into care rates are 10-15% in the first year following reunification and 25-30% over 3-5 years.

At any one time in Washington State, approximately one-third of children in care are in their second, third, even fourth placement episodes. Re-entry is related to relapse and children's behavioral problems.

(Frame et al, 2000)

Given the difficulties which substance-abusing families present, why is there a renewed interest in reunification?

There is a greatly-increased understanding that low rates of reunification for substance-abusing parents are due in part to the inadequacies of child welfare interventions and available treatment programs.

“Existing data regarding the probability of successful reunification may be misleading. They likely reflect the inadequacy of existing treatment efforts or programs, rather than the true potential for reunification.”

(Wald, 1994)

There is also an increased awareness that some groups of children, especially behaviorally troubled school-aged children, are not faring well in the foster care system; and that permanent planning “casualty rates” are unacceptably high for this age group.

It is not unusual for child welfare staff to consider returning older children/ youth to parents who are drug-dependent because of the harm these children are experiencing from placement disruptions.

It is extremely distressing for child welfare decision makers to seriously consider whether placement in foster care has done a child more harm than good.

It has become increasingly obvious that adoption is not a cure-all for the permanency needs of children in out-of-home care; adoption rates are low for behaviorally trouble school age children.

(Schofield et al, 2005)

Low rates of reunification are a major factor in racial disproportionality, especially for African American and Native American families.

A more just, humane, and effective child welfare system will have a greater investment in reunification services.