How many times have we heard these statements about parents involved in the child welfare system struggling with substance use disorders (SUD)? The majority of child welfare cases involve families impacted by SUDs. The reality is that addiction is a disease and we must treat it like one in the child welfare system. The good news is that like other chronic, primary diseases, such as diabetes or asthma, it is treatable and can be managed successfully.

This article highlights research on the seven common ingredients to heal families impacted by SUDs and discusses Family Treatment Courts (FTC) as one solution to help parents receive quality treatment and reunify with their children. It offers questions for child welfare and court professionals to ask to effectively advocate for reasonable services in SUD cases. Questions can be directed to the judge/court to advocate for reasonable services and/or the legal and child welfare systems to make systemic changes.

1. Identifying families in need of SUD treatment should begin early.

Given the often conflicting timelines between the Adoption and Safe Families Act (AFSA) and the time it takes to effectively treat a person with SUDs, identifying substance abuse early is critical to the success of reunification and long-term recovery. ASFA requires the state to move for termination of parental rights if a child is in foster care for 15 out of 22 months. Depending on the frequency and duration of abusing substances, recovery from SUDs can take much longer.

Questions to ask:
2. There must be timely access to assessment and treatment services.

SUD assessments should be consistent with Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-V) criteria defining SUDs. Further, assessors should use standardized, valid tools to assess for treatment. A continuum of care, based on the assessment, should be made available to parents since treatment is not one size fits all. Also, because of AFSA timelines, child welfare families need to be able to access treatment quickly once assessed.

Questions to ask:
- Does the treatment program use a standardized, valid, and reliable substance use tool?
- How are clients matched to the appropriate level of care?
- How often are clients reassessed to meet their changing treatment needs?

3. Increased management of recovery services and treatment compliance are key.

The single strongest predictor of reunification is completing treatment. One strategy to maximize treatment compliance uses a peer mentor/specialist/recovery specialist model. Mentors have been through the system themselves because of addiction, have successfully reunified, had their legal cases dismissed, continue to be in recovery, and may have specialized training. Programs that use peer mentors to engage parents in treatment have higher treatment completion rates than those not using mentors.

Questions to ask:
- What strategies are used to engage and retain clients in treatment, including those who drop out of treatment or miss appointments?
- Does this program use peer mentors to engage and retain clients?

Treatment should be evidence-based, trauma-informed, and address the client’s multiple needs. Often, co-occurring disorders exist in this population. The best treatment program provides a combination of therapies and other services to meet the needs of the individual patient, such as housing, transportation, child care, vocational training, medical care, and educational services. Treatment should offer behavioral therapy and counseling as well as clinical and care management, trauma-informed services, self-
help peer support groups, substance use monitoring and when appropriate, Medication Assisted Treatment (MAT).

Recent medical and scientific research have led to major developments in using MAT and deserve special attention. A variety of medications can be used to complement substance use treatment for different SUDs including tobacco, alcohol, and opioids. A medical doctor determines the appropriate medication, dosage, and duration. MAT is shown to increase retention in treatment, decrease illicit opiate use, decrease pregnancy-related complications, and reduce maternal craving and fetal exposure to illicit drugs. Professional organizations such as the World Health Organization and the American Academy of Pediatrics have set clinical standards of care that include using MAT, such as methadone or buprenorphine, for pregnant women with opioid use disorder.

Questions to ask:

- What evidence-based trauma-specific services are provided?
- Are services designed to meet the client’s co-occurring disorders?
- Is the treatment provider and all its staff members trauma-informed?
- Are there policies or practices in place that are barriers to accessing MAT?
- Is MAT available to an expectant mother?

4. Improved family-centered treatment services and parent-child relationships help families heal from addiction.

When parents involved in the child welfare system are engaged in treatment, they are first and foremost parents who are attempting to reunify with their children or maintain the children in their care. Treatment must take that into consideration and serve three subgroups: parent, children, and family.

Parents have their own needs (parenting skills, mental health, medication management, domestic violence), children have their own needs (developmental, health, school readiness, trauma, mental health), and families have their own needs (basic necessities, employment, housing, child care, transportation, counseling to improve parent-child relationship).

Services must be accessible and focus on the parent-child relationship. Quality and frequent family time, evidence-based parenting programs (e.g., Celebrating Families, Strengthening Families) to address the unique issues of family recovery, parent-child relationship based interventions (e.g., Child Parent Psychotherapy), early and ongoing peer recovery support, and
trauma-informed services are key service components to support and strengthen the parent-child relationship.

Questions to ask:

- What services are provided to address the specific needs of children and other family members?
- Can children accompany their parent to treatment and if so, are there any restrictions on age and number of children?
- What evidence-based parenting or family strengthening programs are provided?

5. Frequent judge contact with clients promotes treatment effectiveness.

Judges serve important roles in child welfare cases involving SUDs because they can motivate parents to pursue their treatment objectives and monitor progress toward those objectives. Studies of traditional drug courts have found the judge to be the single biggest influence on the success of participants. These studies have also shown that spending an average of three minutes or greater produce much higher program completion rates and significantly less future drug behavior.

The positive effects are amplified in FTCs. In a FTC, the parent appears before the judge and treatment team every one-to-two weeks for the first few months of treatment, and at least once a month in later phases. FTCs are effective in helping parents with SUDs seek treatment. One national study found that parents in these specialized courts entered treatment faster, stayed in treatment longer, and completed more treatment sessions compared to parents seeking treatment in a traditional court.

In addition to the quantity of contact, participants are better able to achieve their treatment goals when they are treated with respect and empowered by the judge to engage actively in their own recoveries.

Questions to ask:

- Has the judge received specific training on substance use disorder and mental health?
- How often will the judge review my client’s progress?

6. Responses to treatment behavior should be systematic and allow the parent to manage contingencies that naturally arise within treatment.

The treatment team and judge must remember that parents in child welfare cases are dealing with addiction, a brain disorder that influences the parent’s thinking and actions. Responses to their behavior should be therapeutic and motivational instead of punitive...
and coercive. Drug treatment experts recommend that treatment works better when sanctions and incentives are written and delivered in advance, gradually scaled, and applied consistently and appropriately.\textsuperscript{12} A range of appropriate responses should be developed by the team before treatment begins and consistently applied to individuals based on the phase of the program and their length of sobriety. The aim for these responses should be “flexible certainty” where the client knows that a certain response is forthcoming but that allows the team to be flexible enough to address individual needs of that client.

Questions to ask:

- Is there a handbook available for my client that clearly sets out the system of incentives and sanctions for certain behavior?
- Does this sanction serve a purpose that is related to the safety of the child, the therapeutic treatment goal of the program, or motivation of the client to finish treatment?

7. Effective treatment uses a collaborative, nonadversarial approach grounded in efficient communication between service systems and the court.

Working with parents with SUDs requires collaboration across different sectors, including treatment providers and family services that often deal with a parent in isolation. The FTC model promotes communication by bringing together a treatment team to discuss the parent’s progress and which team members are best equipped to address specific treatment challenges. This collaborative approach presents challenges for protecting the parent’s confidential information, so it is important that all parties are equally represented in the staffings. Parent attorneys, guardians ad litem, and state agency attorneys all have important roles to play in this nonadversarial process. When all parties communicate and work together, studies have shown that treatment works better, faster, and produces stronger families in the long run.

Questions to ask:

- Have my client and all parties come to an agreement about how to protect confidential information?
- Have all the members of the treatment team been trained to understand the ethical duties of every person on the team?

As Nancy Young, Director of Children and Family Futures reminds us, “We can no longer say that we do not know what to do to obtain better outcomes with this critical set of families.”\textsuperscript{13} Let us keep on working to help heal families in the child welfare system who are impacted by SUD by asking the right questions and implementing the answers to those questions in our communities.
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**Terminology Matters**

Professionals in child welfare, substance use disorder treatment, and courts may use many terms to refer to substance use concepts: addiction, substance use disorders, substance use, substance abuse, substance dependence. Other common terms are alcohol and other drug use, alcohol and other drug abuse, and alcohol and other drug dependence.

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V)(2013), provides guidance. The DSM-V no longer uses substance abuse and substance dependence, rather it refers to substance use disorders, defined as mild, moderate, or severe to indicate the level of severity as determined by the number of diagnostic criteria met by an individual. The term addiction was also omitted from the DSM-V diagnostic terminology. Due to this change, the field is shifting toward using substance use disorders (SUDs).

According to the DSM-V, substance use disorders occur when the recurrent use of alcohol and or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. A diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. Alcohol and other drug use exists on a continuum, however. Not everyone who uses substances develops a clinical substance use disorder. There are cases in which the term substance use is justified. Any pattern of substance use by a parent can present risks for children in the absence of protective factors, whether there is a diagnosed substance use disorder or not.

While the DSM-V changes the classification of substance use disorders, many child welfare, treatment and court systems still refer to these disorders generally as substance abuse. Depending upon the context, terms may vary. In some cases, substance abuse is used to indicate when an individual’s substance use interferes with areas of life functioning, yet there may not be a
clinically diagnosed substance use disorder. In other cases, the term addiction is used to refer to individuals who have a substance use disorder. Readers should be aware of these variations in terminology and the ubiquitous use of the term substance abuse.

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Endnotes

1. The 7 strategies are adapted from the work of the Children Family Futures and the National Center on Substance Abuse and Child Welfare’s 2017 paper ”Understanding Substance Use Disorder Treatment in Your Community: A Draft Discussion Guide for Child Welfare and Court Professionals to Identify the Best Treatment Fit for Families,” which lists guiding questions relating to quality treatment. The 7 ingredients were identified through CFF’s work on the Children Affected by Methamphetamine (CAM) grant program 2010-2014, which included 12 Family Treatment Drug Courts supported by SAMHSA to expand and/or enhance services to children and improve parent-child relationships and on the Regional Partnership Grant Program (RPG) Round I, 2007-2012, administered by the Children’s Bureau, which funded 53 grantees, including 12 RPG grantees who implemented a Family Drug Court and submitted comparison group data. Marlowe, D. B., & S.M. Carey. "Research Update on Family Drug Courts." National Association of Drug Court Professionals, Need to Know, May 2012.


3. E.g., One study showed neuronal recovery in some brain regions following 14 months of abstinence from methamphetamine abuse but function in other brain regions did not recover even after this period of abstinence, indicating that some methamphetamine-induced changes are long lasting. See National Institute on Drug Abuse. "What are the Long-Term Effects of Methamphetamine Abuse?" September 2013.


6. SAMHSA estimates up to two-thirds of men and women in substance use disorder treatment have a history of childhood abuse and neglect. See Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. *Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues. Treatment Improvement Protocol (TIP) Series*, No. 36. DHHS Publication No. (SMA) 00-3357.


11. Ibid.
