
Substance Abuse–Affected Families in the Child Welfare System: New Challenges, New Alliances

Lenette Azzi-Lessing and Lenore J. Olsen

During the past decade a record number of single-parent families entered the child welfare system because the mother had an identified problem of substance abuse. These trends have forced child welfare agencies and substance abuse treatment providers to take a new look at the needs of mothers with problems of chemical dependency and their children. This article examines the issues that face child welfare and substance abuse treatment professionals as they attempt to address these new challenges and recommends strategies for forging new alliances and closing gaps in service delivery. The article calls for action to end the oppression that hampers efforts to effectively serve these families.

Key words: *child welfare; children; service delivery; substance abuse; women*

During the past decade an unprecedented number of single-parent families entered the child welfare system because the mother had an identified substance abuse problem. Affecting as many as 80 percent of all cases of substantiated abuse and neglect (Child Welfare League of America, 1990), substance abuse is now cited as one of the three most common reasons for children entering care, along with abuse and neglect and economic stress (Children's Defense Fund, 1992). Substance abuse is regarded as a key factor in the recent growth of out-of-home placements (Child Welfare League of America, 1990). These trends have forced the child welfare field and substance abuse treatment providers to take a new look at the needs of parents with problems of chemical dependence and their children. As Halfon so aptly noted, this has meant "treading into an area that has been an incredible morass of con-

flicting policies and inadequate services" (cited in Child Welfare League of America, 1990, p. 24).

This article examines these conflicts and problems in service delivery, looking first at the mandate framing child welfare practice and at issues in substance abuse treatment that affect this population. The article discusses specific practice and policy issues that must be addressed if the problem of chemical dependency is to be dealt with effectively and recommends ways to strengthen the delivery of services to this client population.

Child Welfare Mandate

Current child welfare practice is driven to a large extent by the Adoption Assistance and Child Welfare Act of 1980 (P.L. 98-617), which mandated that families be strengthened through services to prevent placement and, when placement was necessary, reunified as quickly as possible. It required

that child welfare agencies make reasonable efforts to support families and to keep them together. The law builds in timelines for decision making through six-month case reviews and 18-month dispositional reviews.

At the same time, child welfare agencies are also required through federal and state law to protect children from harm and ensure their safety. Thus, child welfare professionals must constantly struggle to find ways to strengthen families while also protecting children. When chemical dependency enters the picture, these mandates become difficult to balance, for the cycle of recovery does not always mesh with the child's needs or the timelines for child welfare decision making. To complicate matters further, these mandates must be met within a service delivery system that is woefully underfunded and where families' needs often extend far beyond the scope of what service providers can offer.

Substance Abuse Treatment

When mothers are referred by the child welfare system for substance abuse treatment, they are referred to a system that has historically focused on treating individual problems and that has been dominated by treatment models favoring the needs of men. Although gains have been made in the availability of services, still less than 1 percent of federal antidrug money is targeted toward drug treatment for women and even less toward pregnant and parenting women (Child Welfare League of America, 1990). The Alcohol, Drug Abuse, and Mental Health Services Block Grant program currently sets aside only 10 percent of its funds for the treatment of women (Child Welfare League of America, 1992). Treatment slots for pregnant women are virtually nonexistent in many communities (Gustavsson, 1991). Residential treatment programs, which are a necessary component of any comprehensive service delivery system (Barth, 1993; Child Welfare League of America, 1992; DeLeon & Jainchill, 1991; Straussner, 1989), pose special challenges for women with primary child care responsibilities and are equally scarce.

To effectively serve chemically dependent women, experts have called for nothing less than a paradigm shift that would refocus services on the needs of the family and on the broader social and economic needs of women in treatment (Child Welfare League of America, 1990, 1992; Daghestani, 1988; Finkelstein, 1994; Reed, 1987; Zimmerman,

1988). Such a family-centered approach would assist women in carrying out their roles as parents and focus on the needs of their children. A service delivery system focused on the needs of women would also consider the fact that they are often socially isolated and frequently do not have good educations or job skills. Such women also have a need for concrete services, including housing assistance, child care, and transportation. Programs that can offer such an ecological approach to treatment are likely to find that their clients will be in a better position to deal with their addiction and, in turn, to parent their children. The challenge, then, is to find a way to tailor these treatment services to the needs of families entering the child welfare system so that the family system can be maintained and children can grow up in a healthy and nurturing environment.

Issues for Practice

To meet this challenge a number of specific issues must be addressed if the child welfare and substance abuse fields are to effectively coordinate their services for this population.

Parental Substance Abuse in the Assessment of Risk

Practitioners and researchers in the field of child welfare have come to embrace an ecological model for assessing risk and well-being in families. Such a model acknowledges the multicausality of risk, that is, that child abuse and neglect are most often the result of a number of risk factors, not just one.

Commonly identified risk factors include social isolation, poor parenting skills, and high levels of family stress (Belsky, 1980; Garbarino, 1992). Parental substance abuse is an important potential risk factor; drug and alcohol use may cause the parent to be less attentive to children's safety needs and may reduce the parent's ability to control abusive impulses. Procuring illegal drugs may divert household finances from purchasing basic necessities such as food and clothing, or it may cause the parent to leave young children unattended (Child Welfare League of America, 1990; Wightman, 1991).

Although parental substance abuse should be of concern in assessing risk for child abuse or neglect, it is often not viewed within an overall context of risk. Other factors, such as the availability of other caregivers, parenting skills, the parent-

child relationship, and family resources and supports are often discounted because of the hysteria and stereotypes that surround substance-abusing parents, particularly mothers. Thus, child placement and reunification decisions are all too often based on the number of "clean" or "dirty" urine screens reported for a given parent rather than a comprehensive assessment of risk factors, strengths, and supports available for the care and nurturing of children (Child Welfare League of America, 1990, 1992).

Separate and Conflicting Service Delivery Systems

Another major problem in the delivery of services to substance abuse-affected families in the child welfare system is that such families require the convergence of two distinct fields of practice, with separate goals, philosophies, legal mandates, and practice wisdom. The child welfare system seeks to protect children and, whenever possible, to keep families together. When children are removed from their biological parents, federal and state mandates require efforts to reunify such families and, where reunification is not feasible, termination of parental rights so that alternative permanent plans may be made for the children. These efforts are driven by an emphasis on timeliness so that children do not languish in temporary care for indefinite periods of time (Kagan & Schlosberg, 1989; Maluccio, Fein, & Olmstead, 1986). Thus, many family preservation and reunification programs have been created by state and private child welfare agencies to speed the solving of problems contributing to risk through the provision of intensive, home-based services. Such programs are often short term, offering four to 12 weeks of intensive services to alleviate immediate crises and stabilize troubled families (Pecora, Whittaker, & Maluccio, 1992).

Attempts to resolve family problems and risk conditions in a timely manner are seriously hampered, however, when the problems include parental substance abuse. Drug and alcohol addiction is a chronic, relapsing condition that is not quickly or easily overcome. Even those who have been successful in overcoming such addiction commonly recount many failed attempts at recovery. And the "recovered" substance abuser must do battle with the dangers of relapse (Kosten & Kleber, 1992; Marlatt & Gordon, 1985; Wallace, 1992; Washton & Stone-Washton, 1990).

The chronic nature of addiction and the painstakingly slow, erratic nature of recovery are accepted as givens by most substance abuse treatment providers. However, when substance-abusing parents are referred to such providers by child welfare practitioners, a new set of expectations and timelines for the parents' recovery are introduced. Court mandates and case plans often require evidence of abstinence of drug use within a certain time period. These parents, often low-income women, are held to higher standards and are expected to completely overcome their addiction in a relatively brief period of time. Failure to achieve and maintain such abstinence may have severe consequences, such as the removal of children from the home or, when children are already in placement, movement toward termination of parental rights (Child Welfare League of America, 1990, 1992). Thus, the same clinical wisdom that applies to the general population of addicted people often does not apply to substance-abusing parents who find themselves involved with the child welfare system.

Roles of Service Providers

The delivery of effective services to substance abuse-affected families involved with the child welfare system is further hampered by a lack of role clarity among the service providers. Problems are particularly likely to occur when substance abuse treatment providers hold to a traditional view of treatment and recovery, focusing exclusively on individual clients and their addiction (Child Welfare League of America, 1992; Finkelstein, 1994; Wallace, 1992). Such providers may have more difficulty fully collaborating with child welfare workers and other service providers in developing comprehensive, family-oriented service plans. Concerns about the confidentiality of information provided by a parent during the treatment process can also hamper collaboration. In addition, the substance abuse treatment provider may feel the need to protect the parent from the perceived threatening powers of the child welfare system and therefore may be reluctant to share information about parents' treatment and their progress.

Unless such concerns are adequately addressed and the substance abuse treatment provider is able to work collaboratively with child welfare staff, factors critical to a parent's recovery may not receive adequate attention. Certainly interaction

with the child welfare system and courts is a stressor to the parent and is likely to affect the recovery process. On the other hand, parents' attachments to their children and desire to keep the family together are also important motivating factors in recovery. The treatment provider who ignores these critical realities in the parent's life is attempting to intervene in a vacuum, despite the fact that addiction and recovery occur in a complex social context (Wallace, 1992).

Child welfare workers also contribute to fragmentation when they fail to communicate clearly with substance-abusing parents and their treatment providers. If child welfare workers do not articulate to their clients the need for substance abuse treatment, expectations about the parent's participation in treatment, and consequences of noncompliance, they are likely to compound the parent's denial and confusion.

Similarly, child welfare workers must also provide adequate information to substance abuse treatment providers when making referrals. Such information should include the reasons for child welfare involvement, reason for referral for treatment, court mandates, and consequences of client noncompliance. The reluctance of child welfare workers to initiate such dialogues with their clients and with substance abuse treatment providers can result from a lack of sufficient training and expertise in the area of addiction, treatment, and recovery (Child Welfare League of America, 1990; Reed, Laird, Hartman, & Harding, 1982; Thompson, 1990; Tracy & Farkas, 1994). Negative attitudes toward people who abuse alcohol and drugs, pessimism concerning treatment, and fear of confrontation also limit staff's ability to respond effectively (Googins, 1984; King & Lorenson, 1989; Tracy & Farkas, 1994).

Responsiveness of Treatment Programs

Unprecedented numbers of parenting women are being referred to substance abuse treatment programs (Child Welfare League of America, 1990; Finkelstein, Duncan, Derman, & Smeltz, 1992). The majority of these programs were developed years ago, when the primary consumers of sub-

stance abuse treatment services were men and treatment strategies as well as program policies were developed in accordance with the needs of men.

The referral of women involved with the child welfare system to traditional substance abuse treatment agencies has presented many challenges to agency administrators and clinicians. There is increasing consensus in the field of substance abuse treatment that intervention models effective in treating men often do not meet the needs of women (Daghestani, 1988; Finkelstein et al., 1992; Reed, 1987). Consequently, there has been a growing movement to develop models of substance abuse treatment congruent with the differing psychological and social needs of women

(Bollerud, 1990; Daghestani, 1988; Finkelstein et al., 1992; Miller, 1991; Wallace, 1992).

However, the barriers encountered by substance-abusing women referred by the child welfare system go well beyond the need for more relevant treatment approaches. Such women are also likely to be poor and to be parents of young children. The low-income status of many of these women often prevents them from owning automobiles or

telephones. They are also unlikely to have access to child care or quality health care for themselves and their children. Failing to keep substance abuse treatment appointments is often interpreted as resistance or a failure to commit to recovery and may result in discharge from the program. But for many women, treatment is interrupted by a lack of basic resources, such as transportation and child care, and the crises that commonly occur in families whose basic needs are unmet. In making such determinations, substance abuse treatment providers may fail to understand not only the obstacles encountered by such clients but also the devastating effects declarations of "failure" may have, particularly on child welfare decisions to remove or reunify children or to move toward termination of parental rights.

The child welfare system compounds this problem when decision making is based solely or largely on the results of drug screens or parents' levels of participation in a given treatment program.

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Because an addicted person may have many unsuccessful attempts at recovery, child protective and court officials need to view the parent's drug use, participation in treatment, and progress in recovery in the broader context of overall family functioning and levels of risk to the children.

These systems issues and problems are particularly acute for families of color, who are overrepresented in the child welfare system (Cohen, 1992; Hogan & Siu, 1988; Olsen, 1982). Child welfare workers, judges, and other professionals are not immune to racism and media stereotyping that suggest that African American and Hispanic parents are more likely to be drug involved than their white counterparts. For instance, a recent study conducted in Pinellas County, Florida, found that despite the fact that African American and white women had similar rates of substance abuse during pregnancy, African American women were reported to legal authorities at approximately 10 times the rate of white women (Chasnoff, Landress, & Barrett, 1990).

In addition to receiving harsher scrutiny, families of color encounter language and cultural barriers that prevent them from receiving adequate services once they are identified as being affected by substance abuse. The traditional substance abuse treatment system often does not take into account the needs of people of color (Child Welfare League of America, 1992). Thus, families of color encounter additional barriers to services from a system in which they are overrepresented and underserved (Billingsley & Giovannoni, 1972; Saunders, Nelson, & Landsman, 1993; Stehno, 1990; Tracy, Green, & Bremseth, 1993).

Recommendations for Practice

To adequately meet the needs of substance abuse-affected families in the child welfare system, it is imperative that the practice issues and problems described in this article be addressed. Fortunately, many efforts to do so are under way on the local, state, and national levels. The North American Commission on Chemical Dependency and Child Welfare was formed by the Child Welfare League of America in 1989 to identify and address both large- and small-system issues relating to families in need of child welfare and substance abuse treatment services. The commission has developed a comprehensive plan of action, much of which is reflected in the recommendations that follow (Child Welfare League of America, 1992).

Linking the Child Welfare and Substance Abuse Treatment Systems

The problems faced by families in need of both child welfare and substance abuse treatment services are complex and often overwhelming. Therefore, it is critical that the services provided to these families be comprehensive and well coordinated (Barth, Ramler, & Pietrzak, 1993; Finkelstein, 1994; Gustavsson, 1991; Thompson, 1993; Tracy & Farkas, 1994). The various systems must work together closely and cooperatively to achieve this goal. Both child welfare and substance abuse treatment programs must broaden their orientation and improve their communication with one another.

Staff Training. A first step toward better service coordination and collaboration is staff training. Substance abuse treatment providers should be provided with opportunities to learn about the child welfare system, including the dynamics of abuse and neglect, the concept of permanency planning, and legal issues such as reporting laws and mandates for reasonable efforts to maintain and reunite families. Such training should also include content on the interrelatedness of substance abuse, child abuse and neglect, and other forms of family violence (Child Welfare League of America, 1992; Straussner, 1989; Tracy & Farkas, 1994). Emphasis should be placed on the role of substance abuse treatment within the context of delivering an array of services to families, each of whom has unique risk factors, needs, problems and strengths.

Professionals working in the child welfare system must develop greater expertise in the area of substance abuse and its treatment (Curtis & McCullough, 1993; Thompson, 1990; Tracy & Farkas, 1994). Training should go beyond helping workers identify substance abuse among their clients and making appropriate referrals. Child welfare staff must also develop a good understanding of addiction and the recovery process, including the nature and meaning of relapse. Such training should help child welfare professionals base decisions on a variety of factors, such as social supports and parenting ability, which are likely to exacerbate or ameliorate risk in a substance abuse-affected family. Training should be extended to all who work in the field of child welfare, including judges, attorneys, and children's advocates.

Empowerment-Based Practice. Because substance abuse-affected families involved with the child welfare system often come from disempowered groups, it is important that professionals working with these clients engage in empowerment-based practice. Such an approach takes into account the ecological nature of the client's problems and works toward solving environmental problems in addition to building self-efficacy and helping the client assume personal responsibility for change (Dunst, Trivette, & Deal, 1988; Gutiérrez, 1990; Hegar & Hunzeker, 1988; Solomon, 1976). As Hegar and Hunzeker noted, use of empowerment strategies may help prevent placement and "enable parents and children to reunify more quickly" (p. 501).

Culturally Competent Service Delivery. As child welfare and substance-abuse treatment professionals join together to serve this population, it is imperative that they learn the importance of delivering services to families in a culturally competent and respectful manner that identifies and builds on existing strengths. With such training, they will be better prepared to offer treatment approaches that are geared to the specific needs of a diverse client population (Cohen, 1992; Comas-Díaz, 1986; Harris-Offutt, 1992; Ziter, 1987). To ensure a culturally competent approach to service, staff recruitment should reflect the racial and cultural diversity of the client population and have sufficient bilingual staff to serve parents who speak little or no English.

Interagency Communication. In addition, representatives of substance abuse treatment and child welfare systems must improve interagency communication and collaboration. They should develop policies and procedures and interagency agreements that facilitate the sharing of information and address concerns about client confidentiality. Case conferences that include all service providers who are working with a given family should be encouraged and should occur regularly.

Finally, committees or task forces should be developed at the local and state levels to identify system barriers and to create strategies to overcome such barriers. Such a task force, consisting of representatives of the child welfare and substance abuse treatment systems as well as other service providers, could be very useful in developing procedures for interagency collaboration and in developing plans for staff training and joint programming. These task forces would also pro-

vide a forum for openly discussing and resolving the philosophical differences that often underlie service barriers.

Continuum of Services

Family-Centered Home-Based Services. In addition to strengthening the links between these systems, there is a need to address the gaps that exist in services. As social workers plan for permanency with families who have been affected by parental substance abuse, they are likely to find that these families will need more support than the current service delivery system is able to provide. Many of these families can continue to nurture and care for their children but only with adequate treatment resources and ongoing supportive services that remain in place over an extended period of time.

The family-centered home-based approach used in family preservation services offers particular promise for those parents who can continue to care for their children in their own homes. Offering services in the home eliminates many of the obstacles that families without transportation and child care resources encounter. Moreover, staff can more fully assess the family's living situation as well as potential risks to the children (Hodges & Blythe, 1992). Such home-based services should include a strong case management component, along with counseling, parent education, skills-building, advocacy, and concrete services (Barth et al., 1993; Cole & Duva, 1990; Sullivan, Wolk, & Hartman, 1992). It is important that these services include links with appropriate and relevant substance abuse treatment, housing, health care, child care, education, and transportation. As the North American Commission on Chemical Dependency and Child Welfare noted, however, such programs must be realistic about parental capacity and the parent's readiness to make a commitment to change (Child Welfare League of America, 1992).

Women-Centered Services. To adequately respond to mothers' addictions, a full range of treatment options designed for the specific needs of women must be available. These options should include outpatient services as well as day treatment programs, residential treatment, and ongoing peer support groups (Child Welfare League of America, 1992; Straussner, 1989). Substance abuse treatment providers working with a mother involved with the child welfare system in any one of these settings must be aware of the multiple demands on her. In particular, providers need to be

aware of the role that past physical abuse and sexual abuse may have had in her chemical dependency (Bollerud, 1990; Miller, 1991; Rohsenow, Corbett, & Devine, 1988). Programs should also be as comprehensive as possible, offering case management services as well as medical and practical supports (Child Welfare League of America, 1990).

Mothers who enter residential treatment are likely to be separated from their children. There is debate about the desirability of allowing parents and children to remain together while the parent struggles with the demands of recovery, but programs that have done so report remarkable success (Child Welfare League of America, 1990). Providers choosing to treat mothers and children together need to be careful that their services for children are not merely added on but that they are developmentally appropriate and staffed by fully qualified child care professionals. In addition to addressing addiction and parenting issues, such programs should also be prepared to help a substance-abusing mother with the educational and job skills she will need to successfully support herself and her children once she completes treatment.

For families who must be separated while the mother is in treatment, social workers must become creative about the ways they approach reunification. Recovery is likely to extend beyond the timelines of a parent's case plan. As Warsh (1993) observed, it is simplistic to think that either a mother will have fully recovered from her addiction within those timelines or her child should be placed permanently elsewhere. A more flexible and supportive approach would recognize that the mother will need a great deal of support while she is in recovery and that this can be provided in a way that maintains and strengthens child-parent bonds. Frequent visitation is critical during periods of separation to maintain these bonds and to enhance the parent's motivation to do the hard work of recovery.

Following discharge from treatment, transitional housing that allows parents and children to live together in a supervised setting would give the parent the additional time she may need to solidify the progress she has made (Wallace, 1992). It would also give her additional support while she completes her education or job training and would address her needs for safe housing. At the same time, staff would be available to help the

parent with recovery issues and with negotiating the maze of social services she is likely to need.

Individualized Services. Once a parent and her children are ready to live together independently, it is likely that she will continue to need support to maintain the gains she has made in treatment. For these families, individualized services tailored to the needs of that family are critical; for example, parent aides who can work with a parent who is feeling overwhelmed and respite care to provide a break from the demands of parenting may be needed to help a parent maintain the progress she has made and to avert the need for another separation from her children. Neighborhood-based family resource centers can offer accessible services in times of crisis as well as provide a single point of entry for ongoing assistance with basic needs. Ongoing self-help and support groups specifically aimed toward the needs of recovering parents are an important resource as well. Ideally such programs should include transportation and child care. This continuum would allow practitioners to put into practice the values of family preservation for those families affected by parental substance abuse.

Conclusion

As important as individual services are, their effectiveness will ultimately be limited if society does not also address the underlying problems of poverty and oppression that are inherent in so many of these families' chemical dependence. Such oppression exacerbates the conditions of these families' daily lives, making the struggle against chemical dependence that much harder (Weiner, Wallen, & Zankowski, 1990).

As Kamerman and Kahn (1983) noted, a full continuum of services includes not only case services for individual families but also basic social provisions for all families, including adequate income, employment opportunities, housing, and education. Without these basic supports, both child welfare staff and substance abuse treatment providers will continue to be hampered in their ability to respond to the pressing needs of their clients. Without also working to correct the racism and sexism that feed stereotypes about substance-abusing parents, it will be difficult to develop the base of support necessary to put in place the services these families so desperately need. Thus, the profession needs to work on several levels, strengthening alliances between child

welfare and substance abuse treatment providers, closing gaps in service, and addressing the oppression that limits options for families. ■

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Lenette Azzi-Lessing, MSW, ACSW, is executive director, *Children's Friend and Service*, 153 Summer Street, Providence, RI 02908. **Lenore J. Olsen, PhD**, is professor, School of Social Work, Rhode Island College, Providence.

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