The Treatment Perspective in Permanency Decisions for Substance Abusing Parents

by Vostina DiNovo

How do you make fair permanency decisions for families in the child welfare system when parental substance abuse is involved? This is arguably one of the most controversial subjects the legal system faces, and often engenders contention among all parties involved.

Making these decisions demands a practical understanding of the recovery process, and the multiple obstacles this population often faces. This understanding is vital to ensure parents have a fair opportunity to preserve their families, and protect the interests of their children. As a clinician working with mothers who are substance abusers, I have witnessed firsthand the miracles that can and do happen when people fully commit themselves to recovery. I have had the pleasure of observing the metamorphosis of women who overcame turbulent histories and lifelong dysfunction to become nurturing parents, and self-sufficient, self-respecting adults.

On the other hand, I am a firm advocate for children; on a daily basis, my work reinforces my awareness of the devastating impact of addiction upon families. Many of the mothers I treat were themselves children of alcoholics and addicts; children who experienced chaos as a normal way of life; children who grew up to become their parents. It is a sad and chilling recapitulation of pathology. Given a stable home earlier in their childhoods, these women could likely have been spared the neglect and abuse that destroyed their self-esteem, and impaired them as adults.

These issues have plagued families as long as alcohol and other mood altering drugs have existed. With passage in 1997 of the Adoption and Safe Families Act (ASFA), however, the crucible now comes to a boil with unprecedented quickness. This federal law mandates permanency hearings in child protection cases at one year. The strict timelines imposed by ASFA have exacerbated preexisting conflicts of interest among the child welfare, treatment, and legal professions representing different perspectives: the judge, case-worker, and attorneys for the parent and child. The choices are never easy, as the responses show, but they are always better informed when the treatment view is considered.

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Examining these complex issues will enhance your ability to work effectively with these perplexing, frustrating, and occasionally inspiring people.

The Wide-Angle Lens: The Individual Within the System

Although substance-abusing parents are responsible for their behavior and decisions, they have little to no control over the operation of the systems involved in their lives, and the interplay between these systems. The efficiency and comprehensiveness of the child welfare, treatment, and legal systems varies considerably from state to state and jurisdiction to jurisdiction. How these agencies and the individuals within them perform directly and profoundly impacts the parent’s success or failure in recovery. When the machine is well oiled, the parent’s accountability becomes much clearer. Sound infrastructure within systems, and effective collaboration between them, can significantly enhance parents’ likelihood of success in reuniting with their families. On the other hand, for a population notorious for externalizing responsibility for their lives, efficient functioning within and between systems ensures that parents are afforded sufficient opportunity to remedy their issues, and limits parents from shifting the blame for failure. Reasonable efforts to support reunification can be thwarted by conflicts of interests between agents involved in these cases, and by service gaps resulting in treatment failures (See Practice Tips and Case 1.)

From the time parents are first identified as having substance abuse issues that jeopardize the stability of their families, thorough and accurate assessment helps to establish appropriate intervention strategies. Child welfare caseworkers must know about treatment resources, and effectively address issues other than substance abuse, such as domestic violence and homelessness. It is a tall order, as these cases are often already unwieldy by the time the workers become involved. Moreover, some parents may be very invested in their children, but unprepared to address their substance abuse issues. Recovery involves stages of acceptance and moving towards change, and substance abuse treatment may not be the most effective initial approach for parents who remain ambivalent about their addiction. The more appropriate goal in these cases may be to utilize the parents’ investment in their children to motivate readiness to change their substance-abusing behaviors. For example, a parenting psycho-educational intervention targeting substance abusers may achieve the dual purpose of improving parenting skills, while helping the parent recognize the destructive impact of her substance abuse on the family.

Within the treatment arena, availability of services is critical, particularly for women. The timeliness and appropriateness of placement depend upon the efficiency of the assessment and referral process, as well as the comprehensiveness and accessibility of treatment options. Waiting lists are frequently unavoidable. While parents in need of services are awaiting placement, caseworkers, lawyers, judges and others involved can reinforce the parents’ accountability for their recovery by requiring attendance at local 12-step programs such as Alcoholics Anonymous and Narcotics Anonymous. Parents’ compliance with this expectation can provide an early indicator of their motivation level. One way to gauge compliance is to require the parent to obtain and produce a “Where and When” booklet that lists times and locations of meetings. However, recall that investment in family is related to but not dependent upon investment in sobriety, and some parents who are
Felicia's children were placed in foster care as a result of her incarceration for prescription fraud and violation of probation. She had no history of involvement with the state child welfare agency before their removal, and her children had always been in her care. At the time of her incarceration, she and her boyfriend, the father of both children, had been separated for one year due to domestic violence. Before the birth of their first child, Felicia and her boyfriend drank routinely, although both were employed and generally stable. Felicia stopped drinking during her pregnancies, but resumed shortly after the birth of each child.

After the birth of her second child by Cesarean section, Felicia was prescribed Tylenol-3 with codeine, and began to develop an addiction to prescription drugs and alcohol. Within one year, her addiction had become serious, and her relationship with her boyfriend deteriorated. She was employed as a nursing assistant at a senior citizens' home, but was fired for stealing medication. She began drug-seeking behavior, such as using multiple medical providers to obtain drugs, and forging prescriptions, ultimately resulting in her first arrest for prescription fraud.

After her first arrest, Felicia was placed on probation for one year and was ordered to outpatient treatment. Felicia recognized she had a serious problem, was fearful of going to jail, and was invested in keeping her family together. She completed the outpatient program and remained abstinent for five months, but then relapsed. She evaded detection by the regular urine screens required by her probation, but she was eventually caught again for prescription fraud. Felicia's children were placed in foster care, and Felicia was sentenced to serve three months in jail. The balance of her sentence was suspended, and she was ordered to residential treatment on probation.

Felicia, a former foster child, experienced multiple placements until age 15, and then lived in a group home until age 18. She has no family support and has had little involvement with her boyfriend’s family, who live in a distant state. Felicia’s former boyfriend has had no involvement with his children, and his family declined involvement as well.

Both children were placed with the Smiths, first-time foster care providers. The Smiths’ only child was killed at age five by a drunk driver in a car accident, and infertility issues prevented them from having other children. The Smiths are very nurturing foster parents, and have agreed to keep both children while Felicia completes the residential program.

Felicia went from jail to a coed long-term residential program for adults. Although she was motivated about her recovery, she had difficulty focusing on treatment due to inappropriate relationships with male residents, and struggled with the separation from her children. After three months, Felicia’s foster care worker and the treatment providers agreed that Felicia and her family would be better served in a residential program for mothers and children, where her two year old could join her in treatment. The GAL reluctantly agreed with this plan, and the Smiths agreed to keep the older child. Felicia’s six-month case review hearing was held, and the approved plan was for Felicia to transfer to the next program, demonstrate compliance for two months, and then have her two-year-old daughter join her in treatment. The Smiths agreed to be alternative custodians for both children in the event that Felicia failed in treatment.

Felicia transferred to the next program, and did well in treatment. In addition to the program, Felicia was referred for outpatient mental health services to address issues stemming from her own history of abandonment.

Six weeks after Felicia’s admission, her daughter was diagnosed with a hearing impairment. Although the program had previously worked with children who had various special needs, the Smiths believed that the girl should remain in their care, and the GAL agreed. The foster care worker insisted upon following through with the daughter’s admission to the program, stressing that the approved plan was still reunification, and that Felicia would need to learn how to meet her child’s special needs.

The Smiths initially supported the reunification plan, and transported the children for regular visits. However, after the daughter was diagnosed with special needs, the Smiths retained an attorney who filed an emergency petition to prevent the daughter’s admission to the program. At the hearing, the Smiths’ attorney requested a two-month postponement of the daughter’s placement until a psychological evaluation could be completed on both children and Felicia. This request was granted.

After the hearing, the Smiths began a pattern of bringing the children for visitation inconsistently, citing illness, conflicting commitments, and transportation problems. Although the foster care worker was able to arrange transportation to maintain regular visitation, Felicia
became despondent, believing the foster parents were trying to take her children from her, and would succeed. She had several incidents of disruptive behavior, resulting in disciplinary measures within the program. Both the Smiths’ attorney and the children’s GAL cited this regression as further evidence that Felicia would be unable to adequately care for her child. The foster care worker required the foster parents to attend trainings on boundary issues for foster care providers, as well as bereavement counseling, advising them that the loss of their child may be adversely affecting their objectivity. The Smiths attended the trainings, but did not follow through with the bereavement counseling. Due to their noncompliance, the department considered removing the children from the Smiths, but was unable to locate a placement for both children.

The evaluation was completed, and the psychologist recommended against separating the children, introducing an additional obstacle to placement. Felicia’s mental health care providers countered this recommendation with their assessment of Felicia, asserting that she was motivated about her recovery, invested in her children, and stable enough to care for her child in a supportive environment. Based on her previous experience with the program, the foster care worker disagreed with the recommendation against the daughter’s placement in treatment with her mother, and requested a separate parent-child assessment to be conducted by a different psychologist. The findings of this assessment were that both children remained very attached to their mother; the daughter would benefit from being placed in the program; and the son had sufficient resources to tolerate separation from his sibling. The psychologist recommended that the daughter be placed in the program, and that visitation be increased for the son.

When Felicia’s permanency hearing was less than one month away, a case conference was held, attended by the foster care worker, treatment provider, GAL, foster parents, and Felicia. The foster care worker supported reunification, while the GAL opposed it. The Smiths vigorously sought to keep the children, citing Felicia’s history of relapses and regressions, her lack of family support, and her daughter’s special needs. The treatment provider advocated for following through with the daughter’s placement in the program, attesting to Felicia’s investment in her recovery and in her family.

### Professional Perspectives

**As the treatment provider, what treatment goals would you recommend for Felicia?**

Felicia is in a precarious position. While she is motivated about reunification and recovery, she has not had a spotless treatment record, and there are valid concerns about her children’s needs. However, the Smiths are undoubtedly experiencing difficulty with separation due to their own issues, and their unwillingness to follow through with visitation and bereavement counseling suggests that their objectivity is questionable. The conflicting recommendations of the psychological evaluations attest to the complexity of the case, and to the reality that it is impossible to predict outcomes with absolute certainty. A decision to disallow the daughter’s placement in treatment with her mother could result in the complete derailment of family reunification, and undermine Felicia in her recovery.

Given the likelihood that the Smiths’ objectivity is compromised, and furthermore that despite her regressions, Felicia has continually demonstrated investment in her children and in her recovery, I would recommend upholding the reunification plan, placing the daughter in treatment with her mother, and increasing visitation for the son. Additionally, depending upon the availability of this resource, the son’s stability during the separation could be enhanced by the family’s participation in a parenting intervention that includes children. *Vostina DiNovo, Clinical Supervisor, New Generations, Vienna, VA*

**As the judge, consider the treatment provider’s recommendation. What obstacles do you foresee and how might they be addressed?**

Felicia now has the added responsibility of providing direct care to her two-year-old daughter’s special needs, and must demonstrate a higher level of effort to remain sober and available. Felicia needs consistent treatment of both her addiction and abandonment issues. This includes her susceptibility to domestic violence and inability to establish stable relationships, especially considering a lack of relative resources. Felicia’s immediate success in her treatment will be a good indicator to the court of whether reunification is a realistic future goal.

The permanent presence of her special needs daughter so early in the recovery process may impose too great a burden on Felicia. The harm of Felicia’s failures to her daughter may be minimized by the special design of the program. If Felicia fails to show progress, this potential obstacle may be better addressed by placing Felicia in a more restrictive treatment program that excludes her daughter.

The Smith’s heightened resistance to increase visitation with her son may also be an obstacle. When visitation has been disrupted, Felicia’s behavior is directly affected, and has even jeopardized her success in the program, if not her actual placement. The court may address this issue by ordering the foster care worker to assume direct responsibility to ensure those increased visits occur. *Judge Martin P. Welch, Family Division, Circuit Court, Baltimore, MD*
Case 1: Felicia

As the children’s representative, consider the treatment provider’s recommendation. What would you need to see to support reunification? What obstacles do you foresee?

I would be extremely concerned about the foster parents’ behavior. In my experience, their lack of support of the reunification goal is harmful to the children in a way that is hard for adults to appreciate. The lack of visitation is often seen as abandonment by the birth parent, not as protective steps being taken by caretakers. Children who feel abandoned often demonstrate behavioral difficulties later in life.

As for the goal of reunification, at the first permanency hearing I would support the goal with very clear guidelines of steps to be complied with no later than six months. For example, notwithstanding the behavior of the foster parents, Felicia needs to understand she cannot allow external setbacks to derail her progress. It is harder to explain to the court why I am supporting reunification if she is not showing progress.

As for the placement of her daughter in the residential program with Felicia, given the second psychological evaluation, I would support the change of placement but would want her to come back to court within three months instead of six. The service providers should report regularly about her treatment progress and her progress in parenting her child. Consistent visitation should also be maintained between Felicia and her son, with the Smiths understanding that their first obligation is to help the family heal, not intercede where they might think it’s appropriate. The Smiths would benefit from bereavement counseling; in the event that Felicia does not succeed in treatment, such counseling would help ensure the children could safely remain with them.

The primary obstacles I foresee are the behaviors of the Smiths and Felicia herself. I also wonder whether the children should engage in play therapy that addresses some of the negative adult interactions they have observed.

Kim-Marie Walker, Attorney, Washington, DC

As Felicia’s attorney, consider the treatment provider’s recommendation. How would you advise your client? What obstacles do you see and how might they be addressed?

I would strongly advise Felicia about the ASFA regulations on mandatory filing of termination petitions if children have been in foster care for 15 out of the last 22 months. I assume the permanency hearing indicates these children have been in the Smith foster home for 12 months. This period may be especially problematic for the two year old since some states impose shorter timeframes for TPRs involving infants.

At the permanency hearing the court will need to be convinced that reunification with Felicia is in the children’s best interest. There are only three months left under ASFA until the state must file a TPR petition unless “compelling reasons” exist or an exception applies. At this late date, Felicia must address the permanency hearing issues and be aware of potential TPR issues.

An important determination is whether both children can safely return to Felicia’s care with proper services and protection orders in place. The service provider’s report reveals Felicia has made progress in her rehabilitation program, and she is addressing the conditions that led to her children’s foster placement. She is motivated about reunification and has visited the children consistently. There are no grounds for a termination petition and it is likely her children will return to her care soon so long as reasonable efforts continue. Services are available at the residential treatment program to allow her daughter to safely return to her care. Therefore, reunification is in the children’s best interest. To help Felicia work towards reunification, I would recommend:

- Placing the second child at the residential program also, or, if impossible, providing extensive visitation, subject to court oversight, that also provides for sibling contact.
- Providing for visitation to counter the foster parents’ efforts to undermine Felicia’s relationship with her children and to facilitate reunification.
- Allowing Felicia to participate in her son’s school, medical care, and counseling.
- Obtaining documentation from the service provider that any problems in progress resulted from a failure to provide appropriate services initially (dual diagnosis of mental health and substance abuse and placement in a women’s program due to prior domestic violence history). This will be important as “compelling reasons” not to file a TPR and eventually whether reasonable efforts were made by the agency in a TPR hearing.

The current services are appropriate.

- Obtaining documentation from the service providers and the caseworker that the current foster home is NOT a proper placement.
- Securing a psychological report addressing the benefits to the child of being removed from the conflict and placed in a home that supports reunification.
- Careful monitoring to prevent parental alienation of the child from his mother or efforts to derail the mother’s recovery.
- A comprehensive plan of services to have Felicia transition out of the residential program into the community where her son can be placed with her.

Pamela Bayer, Attorney, Office of the Public Defender, Monroe County Public Defender’s Office, Rochester, NY
Roberta was identified with serious drug addiction when she gave birth to her second child, who was premature and tested positive for cocaine. She initially denied drug use when confronted by the hospital social worker, but eventually admitted cocaine use. The hospital social worker notified the state child welfare agency, and the agency case-worker initiated charges against Roberta for abuse, as well as proceedings for temporary placement of the infant in foster care. Roberta was discharged from the hospital and returned to her mother’s home, where she lived with her two-year-old son.

The infant remained hospitalized for one week, and was placed directly in foster care upon discharge from the hospital. Roberta became enraged and hysterical when she learned about the placement, and returned to the hospital to retrieve her infant. She was belligerent towards the hospital staff, and was arrested and released on her own recognizance with a charge for assault. After her release, she briefly returned to her mother’s home, and then disappeared for one week on a cocaine binge, leaving her son in the care of her mother, and failing to appear for a scheduled appointment with the agency caseworker. She finally reported to a detoxification center, distraught, depressed, suicidal, and asking for help.

Roberta’s significant other, and the father of both children, was incarcerated for cocaine distribution at the time of these incidents. While Roberta was in detox, the agency caseworker conducted a home visit with her mother, who was cooperative and deeply concerned about her daughter. Roberta’s mother reported that Roberta’s drug use began when she became involved with her boyfriend, who was also physically abusive. The couple and their son had lived at the mother’s home until the mother demanded that the boyfriend leave after a fight with Roberta. The boyfriend left and Roberta took her son and joined him. They stayed in a motel until the boyfriend was arrested.

Roberta returned to her mother’s home, pregnant with her second child. Roberta’s mother demanded that she get help, but was assured by Roberta’s insistence that she could stop on her own since her boyfriend was not around to facilitate her drug use. She remained abstinent from cocaine for two months, and then resumed her drug use. Roberta’s mother threatened to take the two-year-old and put Roberta out of her home, but never followed through, allowing Roberta and her grandson to continue to live with her. Roberta’s mother reported that Roberta had never abused her son, but tended to leave his care to her; she accepted the responsibility, but had frequent conflicts with Roberta about her continued drug use.

After this meeting, the agency caseworker met with Roberta at detox. Roberta insisted that she wanted to get her daughter back, and that she was ready to stop using drugs. Roberta’s mother informed the caseworker that she wanted to obtain temporary custody of her granddaughter.

Key Case Elements:
- Unemployed mother of 2
- Serious drug addiction
- Cocaine-positive baby placed in foster care at birth
- Criminal history (assault)
- Depression and suicidal behavior
- Physically abusive incarcerated boyfriend
- Parenting skills adequate but inconsistent
- Son often cared for by grandmother, who seeks temporary custody
- Shows motivation in treatment

As the treatment provider in this case, what treatment goals are appropriate for Roberta?

Because Roberta was distraught to the point of suicide, her psychiatric stability is a primary concern. Roberta is probably experiencing postpartum depression, compounded by the effects of her addiction. She requires mental health and substance abuse interventions. Although she is early in her addiction, and has achieved a brief period of abstinence on her own, the extent of her deterioration warrants at least a short-term residential placement, followed by outpatient services. If her depression is found to be longstanding, it will be more difficult to treat than a more transient postpartum depression. Roberta may need a long-term residential treatment program. A program that allows placement of children with their mothers would be an appropriate option only after Roberta’s acute depression is resolved.

Regarding Roberta’s newborn daughter’s placement, the case may best be served by keeping the infant in foster care until Roberta completes the short-term residential program, or until she can be placed with her mother in an appropriate long-term program. The infant has already been placed in foster care, an arrangement that may be more stable for her than being displaced again to the grandmother’s custody until Roberta is able to assume supervised care of her daughter. Continuing the foster placement would also boost Roberta’s investment in her recovery, and give her counselors greater leverage in keeping her motivated.

Finally, the grandmother has not set limits for Roberta’s irresponsible behavior, and has probably been enabling her daughter’s addiction and poor parenting. The grandmother needs to be able to set boundaries with Roberta before gaining custody of her infant granddaughter. Kinship care arrangements with family members who cannot set limits effectively can provide a “safety net” that inadvertently undermines reunification. Roberta may be less likely to follow through with treatment given the false sense of security she may develop if her daughter is placed with the grandmother. Participating in family counseling may improve the grandmother’s ability to serve as a temporary custodian, and her appropriateness as an alternate custodian in the long-term permanency plan.

Vostina DiNovo, Clinical Supervisor, New Generations, Vienna, VA
Case 2: Roberta

As the judge presiding over this case, what is your response to Roberta’s situation? What would you need to see to support a plan for reunification? What obstacles do you foresee and how might they be addressed?

Roberta’s total acceptance of her addiction is the first and foremost factor towards reunification. Therefore, the court must see success in her initial phase of recovery beyond the detoxification. A reemergence of her abusive and enabling boyfriend in her life would be detrimental, so she must receive effective counseling to break this cycle of domestic violence and unhealthy dependence. Also, the grandmother lacks knowledge about drug addiction and how to effectively support Roberta. Therefore, the court should encourage the grandmother to participate in family and drug counseling. Last, Roberta has been charged with assault and faces possible imprisonment, which would disrupt visitation and reasonable efforts for reunification. If Roberta is convicted, her sentence could be mitigated by her success in drug treatment and the sentencing judge’s understanding (hopefully) of the negative emotions that can arise when a parent is initially involved in the child welfare system. Judge Martin P. Welch, Family Division, Circuit Court, Baltimore, MD

As the caseworker, what permanency goal is appropriate in this case, taking the treatment provider’s view into account? What obstacles do you foresee and how might they be addressed.

The most appropriate case plan is reunification with adoption as the concurrent plan. The mother should be fully aware that the reunification plan will be time limited and will depend on her behavior. Ideally, the treatment program would accept the mother and children. The agency should be able to arrange a court order that allows for the children to be with their mother while giving the agency the flexibility to place the children elsewhere if necessary without the stress on the mother, and possibly the two year old, of a court hearing. Of course, the agency would be able to place the children back with their mother as appropriate. It might be possible to arrange for the children’s grandmother to keep the children when necessary.

If a treatment program that accepts mothers and children cannot be located, then the first placement resource for the children is the grandmother. The worker will have to be clear, and get agreement, that the plan is reunification with the mother. Without support for reunification from the grandmother, it might be best to place the children with a foster family that will support the plan. Dennis Thompson, Caseworker, Prince George’s County Department of Social Services, Landover, MD

As Roberta’s attorney, how would you advise your client? What obstacles do you foresee and how might they be addressed?

I would encourage Roberta to grant permanent custody of her son and newborn daughter to her mother. I would help her prepare and file a custody petition to that effect, in which the grandmother is the petitioner and proposed custodian.

If necessary, Roberta could accept a permanent custody order to the grandmother that grants Roberta only supervised visits, arranged between her mother and herself. The order would reflect that Roberta’s drug abstinence and verifiable drug treatment would be sufficient “changed circumstances” to petition the court to modify the custody/visitation aspects of the custody order.

As the custody case moves forward, I would seek dismissal of the abuse case, as there are no longer any agency concerns; the children are in the permanent custody of a fit and willing relative, and there is no need for continued state intervention or monitoring. Thereafter, or simultaneously, Roberta would need to continue pursuing drug and mental health treatment for herself, and may in the future work with her mother to regain unsupervised visits and then custody of the children.

An obstacle will arise if the agency objects to the permanent custody order to the grandmother. I would explain to my client that the “temporary” nature of the present custodial situation for the baby is in name only—that her situation has all the earmarks of a situation wherein mothers permanently lose their children to the foster care/adoptive system. Relying on the grandmother as a resource and source of continuity for the children while she works to address her addiction offers the best hope for reunification. If she cannot recover, at least her children will be with family and she will always have some access to them.

Tamara Guglin, Attorney, Monroe County Public Defender’s Office, Rochester, NY
motivated to keep their children may not be ready initially to embrace twelve-step programs.

**Collaboration**

A good working relationship between the treatment provider and other agents involved in the case depends upon regular communication about the parent’s progress in treatment. This can be achieved by monthly progress reports submitted by the treatment provider to other parties involved, such as caseworkers, probation officers, lawyers, and judges in cases where the parent is court-ordered into treatment. These monthly reports serve several key purposes: they provide ongoing documentation of the parent’s progress in treatment; they reinforce the parent’s awareness of the direct potential consequences for noncompliance; and they facilitate timely intervention, such as case conferences attended by outside agents, when a parent falters in treatment.

Treatment efficacy is significantly enhanced when other parties are directly involved, a unified front that is supportive, yet unflinching in holding the parent accountable, increases the leverage of the treatment provider when working with the parent. Addiction impairs the parents’ capacity to make connections between actions and consequences, so any measures taken to elucidate the role of cause and effect for the parent can positively impact the recovery process. Denial is a powerful thing, and frequent reality checks help parents accept that their addiction is the root of the unmanageability in their lives.

**Working towards reunification**

Since the initial permanency goal in these cases is generally family reunification, effective collaboration between the treatment provider and the child welfare caseworker in matters involving the children is critical. This becomes especially important in cases where children from one family are in different placements, or in multiple jurisdictions. In such cases, basic logistics like transportation for visitation can become obstacles to progress. A strong alliance between the treatment provider and the caseworker can circumvent these obstacles, and bolster parents’ confidence that their providers support them in the goal of reunification. (See Practice Tips and Case 1.)

Forging this alliance begins by establishing a clear agreement between the service providers about goals and expectations for parents at the outset of treatment. Differing agendas between the service providers can undermine parents’ ability to achieve reunification, and create loopholes for parents to attribute blame for noncompliance. The best outcomes in treatment are attained when parents have opportunities to regularly visit with and gradually increase involvement in their children’s lives. Parents’ level of investment in reunifying with their families can be evaluated by their consistency in following through responsibly with visitation, and other matters involving their children such as court appearances, school-based services for their children, and participation in concurrent permanency planning. However, these parents require emotional support, practical guidance, and often assistance with planning and transportation to fulfill these obligations.

**The Starting Point**

In reviewing a case, consider when the first point of intervention actually took place. How long has the parent had to come to terms with the addiction, and to follow through with appropriate measures to keep the family intact? For most substance abusing parents, the first point of child welfare intervention occurs well before removal takes place, meaning these parents have had some opportunity before the permanency timeline begins to struggle through denial, and realize the need to invest in recovery. However, in cases where the removal of custody is the first point of systems intervention, the parent experiences a much more tumultuous entry into facing their addiction. For these parents, the clock starts ticking much sooner; this rapid-fire chain of events may jump-start motivation, but also calls for more intensive intervention and support services. For example, if a pregnant woman with no treatment history delivers an infant who tests positive for drugs (see Case 2), in one fell swoop she has provided irrefutable evidence of her addiction that may result in removal of custody. The more catastrophic nature of this entry into the system demands intensive support.

Mothers in these circumstances are more likely to encounter the powerful stigma attributed to addicts. They are often perceived and treated as deplorable, an experience that makes it hard for them to trust their service providers. For these mothers, this is an overwhelming combination of stressors: sudden family disintegration; entanglement with the child welfare system; strident confrontation of the addiction; punitive measures such as criminal charges, and demoralizing value judgments. In cases in which the mother loses custody at birth, first-time mothers and mothers with little to no previous exposure to treatment may reasonably require more time
to stabilize after removal than those who have had longer histories of involvement in services.

Most parents are more gradually introduced to the child welfare system. Many parents enter service because their children’s behavior signals dysfunction in the family (see Case 3). Children of substance-abusing parents begin to display warning signs that are recognized by their teachers, such as absenteeism; indicators of neglect such as poor health and hygiene; and evidence of emotional, physical, or sexual abuse, and behavior problems in school. Evaluating parents’ motivation for reunification includes noting their response to these initial interventions, which generally begin well before removal of custody. At the first point of intervention, it is essential for the parent to be made fully aware of the potential consequences of noncompliance, and to have clear goals and expectations.

For Women Only
Since these cases most commonly involve the mother as the primary caregiver, it is extremely important to know about issues that uniquely affect women who are substance abusers and parents. For women, alcoholism generally follows a more insidious progression, as women are more likely to be solitary drinkers who drink at home, and go to great lengths to conceal their alcoholism. They tend to progress further in their alcoholism before they begin to exhibit overt manifestations of their impairment, such as driving violations, which more commonly result in earlier interventions for men (See Case 3.) For this reason, women are often initially identified with alcohol-related problems at later stages of their alcoholism than men, and may require more intensive interventions.

Involvement in abusive and dysfunctional relationships with men who are also substance abusers is a core issue for women, further complicated by the fact that these men are often the fathers of their children. The course of treatment and recovery heavily centers upon the development of healthier boundaries in relationships. For women in early recovery, difficulty disengaging from partners who do not support their recovery poses a serious risk factor for relapse. (See Case 4.) When these men are also the fathers of their children, the relationship becomes a tie that binds. Even if the mother reaches the point of making a healthy decision to end the relationship as a couple, she faces the difficult task of maintaining a functional relationship as parents only, without simultaneously jeopardizing her recovery. This area represents a tremendous pitfall for substance-abusing mothers.

Women commonly have serious clinical issues other than substance abuse that more fully emerge after they achieve sobriety, such as histories of sexual abuse, dual diagnosis with mental illnesses such as depression, and extremely low self-esteem. Additionally, the responsibility of being a single parent is daunting even for women who are not impaired, and overwhelming for women in early recovery who are in the beginning stages of establishing self-sufficiency. Economic hardships and the shortage of affordable housing further hinder these women in their journey towards stability as working single parents; for those

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### Practice Tips

**Promoting Collaboration Between Service Providers**
- Establish clear expectations and goals at the outset of treatment.
- Minimize or eliminate conflicting agendas between the parties involved.
- Ensure a comprehensive approach that addresses obstacles such as transportation, housing, and domestic violence.
- Maintain regular communication about the parent’s progress in treatment, such as monthly progress reports.
- Provide visible support for treatment, such as attending regular case conferences.
- Participate in interventions when needed; recognize and reward progress, and enforce appropriate consequences for noncompliance, in a timely fashion.

**Enhancing Treatment Success**
- Become more knowledgeable about recovery and treatment; seek appropriate interventions based upon an accurate assessment of the parent’s stage of recovery.
- Become more familiar with community resources such as twelve-step programs that are essential for maintaining long-term sobriety, and advise the parent to pursue these resources.
- Become more familiar with issues that uniquely affect women in recovery, such as dysfunctional relationships, and clinical issues other than substance abuse.
- Ensure appropriate follow-through with services, such as continuing outpatient services after completion of residential programs.
- Ensure that treatment services include, or are combined with interventions targeting parenting skills, stress management, healthy relationships, and relapse prevention.
with limited educations and poor employment histories, the challenge of supporting a family on a minimum wage job is burdensome.

Child care is a prominent issue for most parents, and even more so for substance-abusing moms whose families of origin are dysfunctional, and therefore inappropriate as care providers. Their cases are compounded by the fact that their children generally have significant needs such as health, behavioral, and emotional problems, further taxing their already limited resources as parents. The realization that the problems experienced by their children frequently result from their addiction deepens the shame and guilt experienced by these women. These potent stress factors culminate in rendering these women more vulnerable to relapse.

For a new mother, postpartum depression is a real and potentially devastating condition that further compromises the woman's ability to manage the stress of struggling through early recovery. Additionally, pregnant women who are dually diagnosed with mental illness have fewer options for psychoactive medications due to the risks of birth defects, and may decompensate as a result of necessary changes in their psychiatric medication regimen. These women require more intensive support in attaining emotional stability.

In residential treatment, women tend to have poorer outcomes than men in coed settings. Women often require a more nurturing approach than is usually provided in traditional programs designed for men. Additionally, there are few residential treatment programs that admit mothers with a child, or retain a pregnant woman after she delivers her infant. This becomes a serious obstacle to treatment for women who lack appropriate kinship care options for their children while they participate in residential treatment, and refuse to consider placing their children in foster care for fear of losing custody. The "fear factor" also inhibits some women from seeking services in the first place due to the viable concern that disclosing their substance abuse will result in losing their children. These women may be aware of their need for services, but persist in attempting to manage on their own until they are in crisis, or become so conspicuously impaired that they demand intervention.

Mothers in early recovery face multiple issues that can hinder their progress and undermine their recovery. They require a comprehensive assessment of their needs, and a well-integrated approach that adequately addresses these issues. To be effective for these women, treatment interventions must incorporate stress management, relapse prevention, parenting education, and intensive work on developing healthy relationships, as these elements are fundamental for success.

Managing Relapse and Noncompliance
The dilemma for professionals working with these cases is that they are rarely clear-cut. Cases in which the parent shows little to no motivation or possesses no redeeming qualities spark relatively little controversy in deciding whether to terminate parental rights, and are also relatively uncommon. Most cases are not black and white, and almost always involve shades of gray. Despite efforts to intervene effectively and appropriately, few cases are free from regression and relapse. The natural progression of recovery is two steps forward, and inevitably one step back. This population is maddeningly inconsistent, characterized by sporadic compliance and emotionality, and fraught with complicating factors. It is vitally important to recognize, however, that alcoholics and addicts are often capable of overcoming relapse and successfully achieving sobriety. Maintaining long-term sobriety depends upon the parent’s ability to recognize relapse warning signs, and develop effective strategies for protecting their recovery. Regressions and episodes of relapse that occur in treatment should not necessarily be viewed as a total disaster; to the contrary, encountering these setbacks in a supportive environment can be an invaluable learning experience for the parent.

The progression towards relapse is usually behaviorally apparent to the treatment provider before the actual physical relapse, and requires swift and decisive intervention. Blunt restatement of the potential consequences for noncompliance, particularly when provided directly by the agents responsible for enforcing them, such as caseworkers and probation officers, may restore the parent’s investment in their recovery. When all else fails, and resistant parents relapse repeatedly, the most appropriate treatment goal may become helping them come to terms with the reality that adoption may, indeed, be in the best interest of their children.

Conclusion
The challenge of making permanency decisions when the parent is a substance abuser can be surmounted by attaining a balanced and well-informed perspective of the multiple factors that determine success. A comprehensive and objective understanding of the individual, in the context of systems, can maximize the likelihood of rendering a fair and impartial decision.

Vostina DiNovo, PhD, is an assistant director and clinical supervisor at New Generations, Fairfax County Alcohol and Drug Services, Vienna, VA.
Case 3: Diana

Diana B., a 32-year-old mother of 4 children, ages 3, 6, 10, and 14.

PART I:

Diana’s case was opened with the state child welfare agency after her six-year-old son began to seriously act out at school. The school counselor had notified Diana about her son’s behavior, and Diana agreed to meet to discuss the problem, but did not appear for the appointment.

After Diana failed to respond to the counselor’s repeat phone messages, the school counselor notified the state child welfare agency. Diana finally called the school counselor, who referred her to the agency caseworker assigned to her case. Diana called the caseworker and scheduled an appointment. Although she appeared for the meeting appropriately groomed and dressed, the caseworker detected the odor of alcohol. The caseworker confronted her about alcohol use, and Diana promptly denied drinking. When the worker requested a breathalyzer from her, Diana admitted to drinking the day before, but insisted that she had not been drinking that day. She refused to take the breathalyzer, and the worker informed her that she would be referred to outpatient counseling. Diana accepted the referral, acknowledging that her life was becoming unmanageable. She expressed concern about her son’s acting-out behavior, and attributed the behavior to his difficulty adjusting to the separation from his father. Regarding her own issues, she became upset when the caseworker confronted her about her alcohol abuse, but insisted that she would go to counseling.

Diana scheduled an appointment with the outpatient treatment provider, and followed through with her first session for assessment. She acknowledged that she had a drinking problem, and disclosed that she had been charged with a DWI one year ago, but attributed her excessive drinking at that time to stress from serious marital conflicts. Diana failed to appear for her next appointment, rescheduled twice, and failed to show up twice.

The outpatient treatment provider sent Diana a letter informing her that her case would be closed due to her failure to complete the assessment, and that she would notify the caseworker. Diana did not respond to the caseworker’s repeated attempts to contact her until one month later. She called the worker, disclosed that she had been charged with a second DWI, and that she wanted help with her drinking.

Key Case Elements:
- Recently divorced
- Alcoholic
- History of DWIs
- Daughter sexually abused by ex-husband, now lives with maternal grandmother
- Daughter displays risk-taking behavior
- Son has serious behavior problems
- 3 children in foster family placements
- Frequent relapses
- Lack of commitment to treatment
- Intergenerational substance abuse and child abuse in father’s family
- Daughter’s at-risk behavior is a source of aggravation for mother
- Unstable job and housing

What treatment goals are appropriate in this case?

Although she has been able to maintain a fairly high level of functioning, Diana’s second DWI confirms that her alcoholism is serious. Furthermore, she is invested in her family, but still very ambivalent about her alcoholism. She could benefit from an intensive outpatient intervention, preferably one that also addresses parenting issues. If such a resource is not available, substance abuse treatment may be combined with a parenting psycho-educational intervention. Working specifically on her parenting issues may enhance Diana’s motivation to change her substance-abusing behavior.

Vostina Di Novo, Clinical Supervisor, New Generations, Vienna, VA

As the caseworker, what case goals would you recommend for Diana? What would you want to see to avoid further CPS intervention (i.e., removal of the children)?

At this point, intensive family services would be involved. The worker and aide would be able to help Diana locate an appropriate program(s), help arrange transportation and child care, and monitor the children. The workers would be in the house two to four times a week. Goals would be to locate and attend the programs, and to maintain appropriate care of the children.

Dennis Thompson, Caseworker, Prince George’s County Department of Social Services, Landover, MD
PART II:
Diana was referred to an intensive outpatient treatment program. However, her attendance was poor, and she was unable to get her drinking under control. She was charged with another DWI, wrecking her car and losing her driver’s license in the process. The outpatient treatment provider recommended to the agency caseworker that Diana be referred to a short-term residential program. This plan would require temporary placement of Diana’s three younger children with another custodian.

The caseworker scheduled a meeting with Diana to discuss this plan, and Diana became outraged. She said she would not accept placing the children in their father’s care due to safety concerns. Diana disclosed that her ex-husband had sexually abused the oldest daughter when she was 10, a crisis that resulted in the daughter moving to Diana’s mother’s home, and ultimately led to the couple’s divorce. Furthermore, Diana said she did not trust her children’s paternal grandparents due to the grandfather’s alcoholism and abusiveness. Finally, Diana’s mother was already caring for two other grandchildren and could not take Diana’s three younger children. The caseworker advised Diana to consider placing her children in foster care if no appropriate family arrangements could be found. Diana agreed to do so, with the understanding that the caseworker would need to verify Diana’s concerns about her husband and his family.

The caseworker contacted the children’s father to discuss the problem. He initially denied abusing his stepdaughter, but admitted it when confronted with details. Additionally, he confirmed Diana’s concerns about his parents, and reluctantly agreed with the temporary placement of his children in foster care. The three younger children were placed with the Jacksons, while the oldest daughter remained with Diana’s mother.

Diana went to detox, followed by a 30-day residential program. Additionally, she began exploring bringing criminal charges against her ex-husband for sexual abuse. Diana did well in the program initially. However, soon after her admission, her mother sought help from the caseworker with the oldest daughter, whose behavior had been deteriorating at school and home and she had recently been caught drinking, smoking pot, and having sex. The grandmother had kept this information from Diana for fear that she would become unstable, but she recognized that she could no longer manage her granddaughter’s behavior alone. The caseworker contacted the treatment provider about the problem, and they agreed to hold a family conference. When the treatment provider told Diana about her daughter’s situation, Diana became agitated and left the program against staff advice. She appeared at her ex-husband’s apartment, intoxicated and armed with a handgun. She called the police when she started shooting out the windows. She was arrested and charged on several counts. Her mother posted her bail, and she was released.

Diana was fired from her job after this incident, and soon after was evicted from her apartment. She went to live with her mother, and her three younger children remained in foster care while Diana went through her trial. She was sentenced to three years in jail, all suspended except for four months, and was ordered to long-term treatment as a condition of her probation after she did her time.

Diana completed her four months in jail, and was awaiting placement in a residential facility. By this time, her children had been in care for six months. The children’s paternal grandparents made repeated attempts to obtain custody of the children during Diana’s incarceration, but the caseworker found their home unsuitable due to the grandfather’s overt alcoholism. Diana was motivated for treatment, and although she was concerned about her children remaining in care, she recognized her alcoholism was serious and she needed help. Her six-month permanency review was approaching.

From a treatment perspective, what permanency plan is most appropriate?
Diana’s personal disintegration is undeniable, yet she finally appears motivated for treatment. However, the turbulence in her course of treatment thus far, compounded by the lack of appropriate kinship care, warrants identifying alternative custodians. The permanency plan should establish very clear goals for Diana’s first six months in treatment, since she will be unable to resume caring for her children within one year of their placement in foster care. She will need to meet these goals to seek an extension at her one-year permanency review. In the meantime, the caseworker may be able to assist the grandmother with services for the oldest daughter, who is obviously at risk. The caseworker will also need to coordinate visitation to ensure all three children have ongoing contact with their mother. The caseworker should also consult with the treatment provider about initiating parenting services. Vostina DiNovo, Clinical Supervisor, New Generations, Vienna VA

As the caseworker, consider the treatment provider’s recommendation. What case goals would you set for Diana? What obstacles do you foresee and how can they be addressed?
The sex abuse allegation involving Diana’s oldest daughter and the father must be investigated. Assuming that the finding is indicated, the oldest daughter will need specialized therapy, which the worker can arrange. She is already showing behaviors that are typical for sex abuse victims. The family will need support and help to deal with the mother’s incarceration, subsequent treatment, and the sex abuse issues. At some point, family therapy will be appropriate. In the meantime, frequent visits should be set up.
Case 3:
Diana

The main permanency goal will still be reunification if the mother works on the issues underlying the addiction. The time issues can be managed if the treatment programs regularly inform all parties of Diana’s progress. It would not hurt for the programs to include in the reports more context than usual (e.g., given that Diana has just been told of her daughter’s acting-out behavior, some regression is expected). This may explain some of Diana’s behaviors and help show they are temporary and not indicative of progress. Such statements also give the caseworker and client something concrete to take to court and provide a basis to argue for more time. Dennis Thompson, Caseworker, Prince George’s County Department of Social Services, Landover, MD

As the judge in this case, what questions will you have at the six-month permanency review?

At the sixth-month permanency review, the Court should ask what services have been and will be in place to address Diana’s needs. Diana, having completed four months of incarceration, is in the early stages of her second inpatient treatment program. The court will want to know whether the her program includes strategies to help Diana care for her three children who are in foster care (including her six year old who is acting out in school) as well as strategies to address the special needs of her 14-year-old daughter (not in foster care) who was sexually abused and not treated.

Diana’s actions of confronting her abusive former husband indicates her willingness to risk gains made in treatment to protect her daughter. A concern is what counseling programs are in place to allow her to act more suitably in caring for her children.

Finally, the court would ask whether the treatment program will prepare Diana for the possibility that, in spite of her best efforts over the next 10 months, reunification may not be in any of the children’s best interests. Specifically, the court would ask whether Diana understands that while in treatment her three children (especially the youngest) may progress developmentally in their nonrelative foster care placement and establish bonds with the caretaker. Judge Martin P. Welch, Family Division, Circuit Court, Baltimore, MD

As the representative for the children, what services and interventions would you request for the children? What would you need to support a permanency plan for reunification?

All of the children should be assessed for therapy services. It is unclear how much direct knowledge the children have of the problems that the adults in their lives are facing, but it is clear that after having their removal and placement with non-kinship resources (the younger three), the dysfunction of the family has touched their lives. They will likely need therapy as a safe space in which to talk about their feelings and their fears.

As for the oldest daughter, her behaviors indicate that the behaviors of the adults around her are affecting her and the choices she is making. She clearly should receive therapeutic and drug intervention services. I would also like to see family therapy in place that includes the father; keeping secrets or dealing with each issue in a vacuum simply sets the family up for failure later. I would need to see regular visitation, and engagement in individual and family therapy before recommending reunification.

As for Diana, I would need to see continued motivation in treatment and a commitment to maintain sobriety by participating in a 12-step program. I also would want to see her establish a support network to help sustain the family once court involvement ends. Kim-Marie Walker, Attorney, Washington, DC

As Diana’s lawyer, how will you advise your client? What obstacles do you foresee and how can they be addressed?

Diana needs to be counseled about ASFA’s mandatory filing of a termination petition once the children are in care for 15 of the most recent 22 months. Her current service plan of residential treatment will place the children beyond that limit. Additionally, there has been little progress during the first six months of placement and prior failures before placement. The court may well consider changing the permanency goal from reunification to adoption at this point.

I would emphasize that the prior services were not appropriate to address the family’s issues. Given the seriousness of Diana’s abuse, outpatient treatment was not realistic. The children’s needs were not assessed and the grandmother did not receive proper services. As a result, Diana’s recovery was compromised when confronted with her daughter’s deterioration. (Under ASFA, a compelling reason for not filing a termination petition is when appropriate services have not been provided.) A report from the current program about its appropriateness to meet her needs and likelihood of success should be provided to the court. If a program is available that accepts women with children, efforts should be made to require this service given Diana’s history of concern about foster care placements and her ability to stay focused in treatment.

I would also consider a family session with the grandmother and client to see if it is possible to place the children with the grandmother. It would be important to consider services available to assist the grandmother with care, such as day care, respite care, financial aid, etc. It may be more appropriate to consider placing the older daughter in a therapeutic setting to address her serious needs and free the grandmother to care for the younger children. At both the six-month reviews and the permanency hearing, the court can consider whether there are appropriate relative resources available for the children. Placement with the grandmother could give the agency a reason not to file for TPR.

If there is no relative placement, it will be key to have a thorough visitation plan that involves the mother in all aspects of these children’s lives. Pamela Bayer, Attorney, Monroe County Public Defender’s Office, Rochester, NY

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Courtney has a 10-year history of polysubstance dependence, and was admitted to a residential treatment facility with her one-year-old daughter. She was recently released from jail after serving six months for several charges including possessing and distributing narcotics. She was admitted to the program on probation, and faced a five-year sentence if she violated her probation by not complying with treatment.

Courtney’s daughter was removed from her care and placed in a foster home when she was in jail. Her service plan required her to comply with treatment to regain custody of her daughter. She was previously incarcerated at age 23; at that time, her parental rights were terminated to her then two-year-old son. Because her family of origin is extremely dysfunctional, she was unable to identify an appropriate custodian for her son; therefore, he was adopted. Her five-year-old daughter has been in her paternal grandmother’s care.

Courtney has a history of abusive relationships with men who are substance abusers; they typically are drug dealers who support her habit. Her criminal involvement has been directly linked with the men in her life, as time and again she finds herself in trouble due to entanglements with her boyfriend’s crimes. She is estranged from the fathers of her two older children, and the father of her one-year-old daughter was incarcerated at the time of her admission to treatment.

Plagued by guilt over the loss of her oldest child, Courtney became invested in her newborn. Not wanting to lose another child, she decided after her newborn’s father was incarcerated that it was time for her to get her life together. She sought and followed through with an outpatient treatment program, and maintained her sobriety for six months. However, her boyfriend was released. Although they were both on probation for drug-related charges, they were soon using and dealing again. They were caught and reincarcerated for distribution, and violating probation.

Courtney participated in jail-based substance abuse treatment and did well. She was beginning to feel more stable in her sobriety, and upon her release, the goal of regaining custody of her daughter inspired her. Courtney was very motivated for treatment, and demonstrated surprisingly good parenting skills. Although she struggled with serious issues such as a history of sexual abuse, extremely low self-esteem, and a turbulent relationship with her mother, she was consistently willing to face her pain. She recognized the destructiveness of her addiction, and her relationships, and made progress recognizing the connections between the two. Courtney also gradually reestablished her relationship with her five-year-old daughter, and began to connect with healthier family members whom she had previously avoided due to their disapproval of her lifestyle. She aspired to develop sufficient clerical skills to work as a receptionist, and completed her GED.

Courtney was about to advance to the next level of treatment, and move towards semi-independent living, when her child’s father was released from prison. His release was destabilizing and caused her to regress in treatment. He also went to a residential program, but no contact was allowed between the two, except for matters involving their child.

Courtney became withdrawn, and while she was still conscientious about following program rules, she was not as actively working on her issues. She was caught sneaking phone calls to her boyfriend, and was put on restriction in the treatment program. Although she briefly showed some improvement, she was soon caught in another incident of dishonest and manipulative behavior. She deviated from an off-site pass with her daughter to sneak a visit with her boyfriend, a decision that not only violated program rules, but also violated her probation, and her child welfare service plan to regain custody. She was again placed on restriction, and an intervention case conference was called. Her probation officer, her caseworker, and her child’s GAL all attended the conference. By the time this incident took place, Courtney had been in treatment for six months, and her case review hearing for her daughter was coming up soon. Courtney acknowledged that her behavior was self-destructive, but she was defensive, detached, and flat in affect. However, she stated that she wanted to remain in treatment.
As the treatment provider, do you believe Courtney should be discharged from treatment for noncompliance?

Courtney is demonstrating a common pattern of destabilization secondary to addictive relationships. Although her behavior indicates she is in danger of relapse, she has not yet relapsed and has remained in treatment. Her significant progress before her boyfriend’s release speaks strongly for her motivation, for recovery, and reunification. She could benefit from remaining in the program, on restricted contact with her boyfriend until she restabilizes her recovery. Once she is grounded, couples counseling could help her determine whether she and her boyfriend can manage to have a healthier relationship, or if continuing involvement with him will undermine her recovery and her family reunification. Should she succeed in completing the residential program, Courtney will require continuing outpatient services addressing relapse prevention, relationships, parenting, and stress management. 

Vostina DiNovo, Clinical Supervisor, New Generations, Vienna, VA

As the child’s representative in the case, consider the treatment provider’s recommendation. What services would you seek to protect the children? What would you need to see to support reunification as the case goal? What are the obstacles and how might they be addressed?

This case is especially hard because of the age of the child and because the mother’s progress is derailed each time her ex is released into the community. Courtney seems to consistently sacrifice her future for this man and I am not certain that the behavior would stop even if she was sober. I have to protect what I think is in her daughter’s best interest, not only short-term but long-term as well. I am troubled by the fact that the threat of imprisonment coupled with the very real possibility of losing her daughter has not given Courtney incentive enough to stay away from this destructive ex-boyfriend.

Long-term, I do not foresee a positive outcome for reunification. The positive factors that I see are the re-established relationships with healthy family members and her five-year-old child. Completing her GED and demonstrating strong parenting skills are also positive indicators. What concerns me is that she achieved these goals when her ex-boyfriend was incarcerated and not a factor in her life. Once he was released, most of her progress was lost. As he is the father of the child, I am concerned that that fact will be her excuse for maintaining that unhealthy relationship.

To support reunification, I would have to see Courtney actively engaged in intensive individual therapy which addresses her dependence on this relationship and which includes a safety plan when she is tempted to revisit this destructive connection. I would have to see Courtney establish a secure network that would actively support her endeavors to maintain her sobriety and that would hold her accountable for acts of dishonesty and manipulation. Regular visitation and continued compliance in drug treatment and with the rules of the facility would also have to be demonstrated.

Kim-Marie Walker, Attorney, Washington, DC

As the judge presiding over this case, consider the treatment provider’s recommendation. What would you need to see to support reunification as the case goal? What are the obstacles and how might they be addressed?

Though the court must consider the treatment provider’s recommendation, the court’s role is to make decisions regarding the best interest of the child (in this case, Courtney’s one-year-old daughter). The primary obstacle “hanging” over Courtney’s head is the suspended portion of her five-year sentence for narcotics violations. The primary underlying obstacle that will cause her to violate probation is her drug-using and dealing boyfriend.

Courtney’s past criminal behavior compounds the issues concerning reunification with her daughter. First, her daughter not only faces the continued possibility of neglect from her drug abuse, but her safety is compromised due to the inherent dangers of drug-distribution. Second, her involvement in drug-distribution increases the potential for a substantial prison sentence. This second issue could surely lead to termination of her parental rights to her daughter, similar to her first son, as she has not developed healthy family resources to care for the child if incarcerated again. Therefore, the court would need to see a clear severance of any contact between Courtney and her boyfriend, which would negate the recommendation for couples counseling. For visitation and other related matters pertaining to the daughter and the father, the
As Courtney’s lawyer, how will you advise your client? What obstacles do you foresee and how can they be addressed?

I must explain the ASFA regulations to her in great detail, because she is running out of time. I would advise her to work with her treatment provider in setting up a contract that would keep her on task so that custody could be restored ASAP. I would also point out to Courtney how far she has come in 10 years and what the recent involvement with her boyfriend has led to. I would attempt to convince child welfare to increase Courtney’s supervised visits with her daughter to keep her focused. I would also suggest that periodic visits be arranged with her older daughter and supportive family members to encourage Courtney on the right path. Her attitude at this point is the only thing she can control and she must be enthusiastic so that all her good work will not go unnoticed when it comes to deciding whether or not to terminate her rights. I might also suggest Courtney get an order of protection against her boyfriend. Kathleen Phillips, Attorney, Legal Aid Society of Suffolk County, Inc., Family Court Bureau, Central Islip, NY

In conclusion, the court would require that a third party always be involved on Courtney’s behalf.

In conclusion, the court would need to see long-term sobriety, no further criminal behavior, the development of healthy relationships, and an end to her dependence on the daughter’s father. Judge Martin P. Welch, Family Division, Circuit Court, Baltimore, MD

Feedback
Have a different perspective? How would you handle Courtney’s, Diana’s, Felicia’s or Roberta’s cases? Share your responses with CLP. We’ll pass them along in a future issue. Send an e-mail to childlawpractice@staff.abanet.org, or call 202/662-1724.

Next Month: Domestic Violence in Immigrant Communities