Addressing Substance Abuse in the Child Welfare System: A Summary of Practice and Policy Issues

by Sharon G. Elstein

This article series has focused on the challenges of dealing with substance-abusing parents in child neglect and abuse cases. Beginning in December 2000, with the support of the David and Lucile Packard Foundation, CLP authors have researched and written about many facets of addressing parental substance abuse within the child welfare system. We have provided information, practice and policy tips, recommendations for systemic change, and suggestions for how you can best represent the children in your care, while meeting the requirements of the Adoption and Safe Families Act (ASFA).

This final article in our 13-article series synthesizes what we’ve learned, and proposes practice and policy recommendations arising from the findings. This synthesis will save you precious time by providing both the “big picture” and key findings in one place. A synopsis of policy and practice recommendations identifies what policymakers and agency administrators can start doing today to improve case processing.

We are also delighted to report that researchers at the ABA Center on Children and the Law were recently awarded a two-year grant from the Robert Wood Johnson Foundation’s Substance Abuse Policy Research Program, based in part on our work on this series. The project will obtain a national picture of dependency courts’ experiences handling parental substance abuse in the context of ASFA. Policy and practice recommendations will be developed and shared.

Key Findings

- Parental substance abuse is common in child welfare cases.
  Many studies report anywhere from 40-80% of child welfare cases involve substance abuse. surveys of child welfare agency and family court professionals by the National Center on Addiction and Substance Abuse (CASA) found that three-quarters believe substance abuse is a top reason for the increase in child abuse and neglect reports in the past 15 years. Further, three-quarters report that children of substance abusers are more likely to be placed in foster care and stay in foster care longer than other children.

  These are telling statistics that cannot and should not be ignored by the agencies and justice systems working with these families. The realization that substance abuse underlies or contributes to removal of a majority of children from their homes requires that practitioners get grounded in the causes and effects of, and treatments for, drug and alcohol addiction. It also suggests that legislators and policymakers ensure laws, funding, and other supports are in place so parents trying to recover from addiction have access to appropriate services, so they have a chance to reunify with their children. However, the safety of the children is most important, and requires thoughtful and prompt decisions that result in safe and permanent homes.

  Given that parental substance abuse is common in child neglect and abuse cases, what have we learned to help child welfare professionals improve their responses to the children and parents, and help them make permanency decisions in the best interests of the children?

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Families involved in the child welfare system often face numerous problems simultaneously, including substance abuse.

The multidimensional problems faced by children and families create challenges for judges, lawyers, and caseworkers making permanency decisions. These problems include substance abuse, poverty/unemployment, domestic violence, mental illness/depression, stress, social isolation, and poor parenting skills, which may be intergenerational.

Addressing the substance dependence alone may not provide a safe and nurturing environment in which to raise children. Even if a parent successfully recovers from addiction, she may still lack adequate parenting skills, live with a violent partner, or suffer debilitating depression. In addition, she may lack employment, child care, and transportation. Treating substance abuse without addressing the family’s other problems makes it less likely the parent will succeed in treatment. “[A]ddressing the substance abuse alone is not likely to produce the changes in a family that are necessary to ensure a healthy family environment for a child. Unless the whole of a family’s situation is addressed, substance abuse treatment is unlikely to be successful — and even if a parent achieves abstinence, the other issues present may continue to pose safety problems for the child.”

Substance-dependent mothers face additional challenges.

In child welfare cases, women are most likely the parent responsible for the welfare of their children. They put their need for drugs ahead of their children’s needs and may feel guilty for doing so. They are affected differently by drugs than men, and can become addicted faster. They use drugs in the context of their relationship with a man. They have often been the victim of maltreatment, either as children or adults. Research shows that substance-abusing women are more likely to become victims of domestic violence. They are likely terrified that their children will be taken away from them if they ask for help.

Further, traditional substance-abuse treatment is geared to the needs of men, requiring isolation from drug-involved people and places and a focus on getting themselves better rather than looking out for the needs of others (including children). The end result is reluctance to enter treatment, and a lack of treatment programs designed to meet the multiple needs of drug-dependent mothers.

Domestic violence is linked with maternal substance abuse.

Battered women have high rates of substance abuse, particularly alcohol, and substance-dependent women are more likely to be the victims of domestic violence. They may use substances to blunt emotional or physical pain, or to avoid seeing the impact of the violence on their children. Drug use may be a survival strategy, as the batterer may insist she engage in drug/alcohol use with him or risk injury. Further, a batterer will actively sabotage the recovery process, as a woman’s recovery takes away his power over her. And a woman weakened by the batterer’s power over her will be unlikely to protect her children from any maltreatment of them at his hands.

Children exposed to parental alcohol or drug use are often harmed, whether exposed during pregnancy or during childhood.

Exposure due to parental substance abuse can be prenatal, environmental, or both. Prenatal exposure to alcohol is the leading preventable
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cause of mental retardation. The consequences of alcohol and/or drug use during pregnancy may include medical, mental health, developmental, and behavioral anomalies in children. Research suggests that prenatal exposure to alcohol and/or drugs may affect a child in the short- and long-term, and effects may be moderated or exacerbated due to the substance used, when it was used, frequency of use, the mother’s general health and well-being, and whether or not she obtained prenatal care.

Prenatal exposure may result in: Fetal Alcohol Syndrome; withdrawal symptoms at birth; exposure to sexually transmitted disease during birth; increased risk for Sudden Infant Death Syndrome; cognitive delays; behavior problems; and increased risk of developing addiction disorders as a teen or adult. Environmental exposure (growing up in a family with parental substance abuse) carries its own risks, including neglect, abuse, injury, emotional and social problems, and even death. Children of substance-abusing parents are four times more likely to be neglected and three times more likely to be abused than children whose parents don’t abuse drugs. They are also more likely to end up in foster care. Neglect is a probable scenario as parents spend their time getting their drugs, spend their money to buy the drugs, get high, and get over the effects of being high, rather than caring for the needs of their children.

While parental substance use does not always lead to child abuse, it does increase the risk of injury to children: when they are left with inappropriate caregivers while the parent is unavailable (buying, using, being intoxicated, being hungover); when they are present during episodes of domestic and family violence; or when they are present during criminal activities which expose them to further violence. Methamphetamine (meth) deserves special attention due to its toxicity and flammability. As it is easily manufactured in homes or garages, children may be exposed to burns and inhalation of meth particles, as well as to extreme violence and sexual acting-out perpetrated by meth users.

Finally, parental substance abuse is the most important indicator that a child is at risk for becoming a substance abuser, and that risk increases threefold during adolescence. The risk is genetic and a result of modeling the behavior seen in the home. But we can’t conclude that a child of a substance abuser will become a substance abuser on the basis of genetics and home situation alone. Associating with a drug/alcohol-accepting peer group, a risk-taking personality, an anti-authoritarian attitude, and anxiety and depression all increase the chances that a teen will turn to drugs or alcohol.

Treating addiction is complex and relapse is an integral part of the life-long recovery process.

There is no guaranteed cure for substance addiction. The road to abstinence is littered with social, legal, familial, relationship, employment, and financial issues. Other factors include the type and amount of substances used, length of use, personal motivation for quitting, and type and quality of treatment programs entered. Treatment programs report a relapse rate of 37-78%, and argue that addicts need one-to-two years of treatment to sustain abstinence (although some programs and addicts report recovery in as little as a year). Recovery from addiction means the person has to confront and acknowledge the problem, commit to and work through a treatment program, and make significant life changes post-treatment to maintain abstinence.

Recovery for a substance-abusing mother is made more difficult because known triggers for relapse
include many related to parenthood and relationships. Such triggers include: a nonsupportive, hostile, or abusive environment; a substance-abusing partner; the guilt and shame of putting their drug needs ahead of their children’s needs for food and shelter; and the challenges of parenting during recovery (children may have special-needs, may resist the mother’s new-found authority, or may be in a placement situation that makes the mother nervous).

Treatment is a critical component of permanency planning, yet:

- success (recovery) depends on many factors (age, employment history, motivation, consequences, environment/social support, legal status/criminal history, drug history/type and amount of drugs used, treatment history, physical and mental health);
- recovery is a process that includes periods of relapse;
- not all treatment modalities and programs match the needs of/ have space for everyone (they differ in their effectiveness, their retention, graduation and acceptance rates, and in the services they provide); and
- length of treatment may exceed the ASFA timelines for achieving permanency.

Child welfare system professionals and treatment providers have different orientations, resulting in a fragmented delivery of services to an overlapping population.

Both child welfare professionals (lawyers, judges, caseworkers) and treatment specialists work with families affected by substance abuse, but often without the benefit of their counterparts’ knowledge and expertise. There are five areas where the different orientations may result in poor or tragic decisions on behalf of children and their families.

- **Who is the client?** Child welfare professionals view the child as the “client,” and base their decisions on addressing immediate and long-term safety, nurturing, and stability of placement. Treatment providers view the “client” as the adult addict, and the goal is recovery. Child welfare professionals may view the relapsing parent as uncaring and unfit to parent, and move to terminate parental rights quickly. Treatment providers may view the addict’s parenting status as irrelevant, except as a motivator, and fail to take into account the impact of the parent/child relationship on recovery.

- **Training.** Lawyers, judges, and caseworkers rarely take classes on chemical or alcohol dependence, treatment, family dynamics in substance abusing families, or how to meet treatment needs. Treatment providers lack education or training in recognizing child abuse and neglect, the impact of substance use on children, and how separation affects parents and children.

- **Timelines.** ASFA mandates permanency hearings at 12 months, while treatment providers acknowledge the recovery process may take up to two years.

- **Assessment.** Child welfare professionals assess current or future risk of child abuse or neglect, and assess the child’s/family’s service needs. Treatment providers use assessment tools to identify substance abuse problems (nature, extent, which substances) and to match treatment to the individual.

- **Confidentiality.** Client information (whether a child or an adult) is protected either by law or by practice, hampering collaboration.

- **Drug screening and assessment tools are useful but were not developed with child welfare clients and permanency planning in mind.**

Drug tests offer hard evidence of parental substance use and relapse, and can provide information on the

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**Addiction is a Brain Disease—and it Matters**

“Not only does acute drug use modify brain function in critical ways, but prolonged drug use causes pervasive changes in brain function that persist long after the individual stops taking the drug . . . . The addicted brain is distinctly different from the nonaddicted brain, as manifested by changes in brain metabolic activity, receptor availability, gene expression and responsiveness to environmental cues. . . . that addiction is so clearly tied to changes in the brain structure and function is what makes it, fundamentally, a brain disease.”

*Science* (October 3, 1997)  
Alan Leshner, Ph.D., Director for the National Institute on Drug Abuse (NIDA)

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**Related CLP Titles**

  Janet Chiancone  

- ✓ Family Drug Courts May Hold the Key for Abused and Neglected Children of Substance Abusers  
  Sharon G. Elstein  
  Vol. 18 (1), March 1999.

- ✓ Methamphetamine: The Big Red Flag  
  Claire Sandt  
### Factors Associated With Drug Treatment Success

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<thead>
<tr>
<th>FACTORS</th>
<th>BARRIERS TO SUCCESS</th>
<th>STRENGTHS AND ASSETS</th>
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<tbody>
<tr>
<td>Age</td>
<td>Under age 30</td>
<td>Over age 30</td>
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<tr>
<td>Employment</td>
<td>Unemployed with little work</td>
<td>Stable employment history</td>
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<td></td>
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<tr>
<td>Motivation</td>
<td>Little acceptance of</td>
<td>Desire to recover</td>
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<tr>
<td></td>
<td>alcohol/drug history</td>
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<tr>
<td>Consequences/Sanctions</td>
<td>Little fear of consequences</td>
<td>Fear of consequences reinforced by sanctions</td>
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<td></td>
<td>(losing custody of children or job)</td>
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<tr>
<td>Physical/Social Environment</td>
<td>Return to neighborhood where drugs available and with drug-using peers</td>
<td>Little contact with a drug culture, and fewer stressors (e.g., poverty)</td>
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<tr>
<td>Legal Status/Criminal History</td>
<td>Numerous arrests prior to</td>
<td>Few pretreatment arrests and</td>
</tr>
<tr>
<td></td>
<td>treatment and involved with peers who commit crimes</td>
<td>noncriminally involved peer group</td>
</tr>
<tr>
<td>Social Support</td>
<td>Family members/peers do not</td>
<td>Family members/peers pressure to stop using drugs and support them in recovery</td>
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<tr>
<td></td>
<td>support recovery and have a</td>
<td></td>
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<tr>
<td></td>
<td>lot of conflict</td>
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<tr>
<td>Drug History</td>
<td>*Use variety of drugs</td>
<td>*Primarily used one drug only</td>
</tr>
<tr>
<td></td>
<td>*Drug use is frequent</td>
<td>*Became addicted at older age</td>
</tr>
<tr>
<td></td>
<td>*Became addicted at younger age</td>
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<tr>
<td></td>
<td>*Addicted for long period</td>
<td>*Was sober for a period before entering treatment</td>
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<tr>
<td></td>
<td>*Few days of sobriety before treatment</td>
<td></td>
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<tr>
<td>Treatment History</td>
<td>Numerous treatment attempts</td>
<td>Longer length of time in treatment</td>
</tr>
<tr>
<td>Psychiatric/Psychological</td>
<td>*Many psychiatric problems</td>
<td>No concurrent psychiatric disorders</td>
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<tr>
<td></td>
<td>*High levels of anger, depression</td>
<td></td>
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<tr>
<td></td>
<td>*Child sexual abuse</td>
<td></td>
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<tr>
<td>Physical Health</td>
<td>Chronic illnesses (ulcers, back pain, arthritis)</td>
<td>Good physical health</td>
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- **Use** is affecting parenting, if their partner is a drug user also, if they have a history of maltreatment or domestic violence, and any experiences in a family-friendly treatment environment.

**Many child welfare cases involve parents with both substance addiction and mental illness.**

Co-occurring psychiatric disease and addiction may be found in 60% of clients in substance abuse treatment programs. The Substance Abuse and Mental Health Services Administration recommends that child welfare specialists expect to find dual disorders; that they are the rule rather than the exception. Dual disorders complicate treatment for addiction, and may take two to five years before the client stabilizes. While dual diagnosis will differ based on the types of illness and the pattern of alcohol or drug abuse, recovery needs to focus on both problems within a comprehensive treatment program. Further, children of dually disordered parents may also be at risk for substance use and mental illness.

**Representing substance-abusing parents is complex.**

Lawyers representing substance-using parents have little or no guidance or support. Addiction changes brain chemistry, which affects a person’s ability to make decisions and to control impulses. Although it is rare, a parent may arrive at a child welfare hearing intoxicated or hungover, and be unable to testify on their own behalf. And like dependency court professionals, parents’ lawyers may know little about addiction and treatment, or how to match a person with an appropriate treatment program.
Policy/Practice Recommendations

Parental substance abuse is an underlying factor in many cases handled by the child welfare system. The impact of parental substance abuse cannot and should not be ignored by the child welfare professionals responsible for the safety and well-being of the children in its care. But where should you start? Recommendations for improving systemic responses include the following:2

- Provide interdisciplinary training.

  Child protection specialists (case-workers, lawyers, judges) and addiction counselors work with the same families. Yet their different orientations often mean the needs of these children and their families are not addressed in a systematic and comprehensive manner.

  Child welfare agencies, treatment programs, and the legal community in each jurisdiction should work together to:

  - build recognition and respect for their respective responsibilities;
  - arrange interdisciplinary training opportunities (on identifying and working with drug-abusing clients, how drug abuse impacts child development, understanding and planning for relapse and recovery, etc.);
  - develop mutually agreed-upon expectations and goals for clients;
  - put processes into place such as “intensive reunification,” “concurrent planning,” or joint child welfare and treatment programs that work together to speed up the process;
  - develop screening and risk assessment protocols and practices to ensure the safety of children living with drug-dependent parents;
  - screen all families coming to child welfare’s attention for substance-abuse issues;
  - overcome communication/confidentiality barriers by developing agreements to share information on the family which cannot be shared with outside parties; and
  - create a task force that meets regularly to discuss case progress and iron out administrative issues.

- Gear services and treatment to meet the needs of substance-abusing mothers and their children.

  Substance-abusing women in the child welfare system have multiple needs and responsibilities, including the care of their children. Women respond differently to drugs and alcohol than men. They have different recovery cycles, which may be impacted by the needs of their children, and relapse is expected.

  Look for treatment programs that work cooperatively with dependency courts or child protective service agencies to identify families

<table>
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<tr>
<th>Relapse: Predicting, Assessing, Planning</th>
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<tr>
<td><strong>Major signs/precursors to a relapse:</strong></td>
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<tr>
<td>Life changes</td>
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<td>Stress</td>
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<td>Return home of children — this is a high stress/high risk time.</td>
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<th>Considerations in assessing relapse:</th>
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<tr>
<td>Program participation</td>
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<tr>
<td>Admission/denial of relapse and if parent sought support</td>
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<tr>
<td>Level of functioning in other areas of their life</td>
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<td>Level of involvement with children: visits and planning efforts</td>
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<td>Identification of triggers</td>
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<th>Relapse Planning should include:</th>
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<tr>
<td>Aftercare services</td>
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<td>Communication between child welfare and drug treatment professionals to give parents clear, consistent messages</td>
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<tr>
<td>Developing a support network to include self-help sponsors and peer counseling</td>
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<tr>
<td>Helping parents develop a personal recovery plan, including coping skills for those situations which are problematic (e.g., holidays)</td>
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<th>Recommendations:</th>
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<td>Recognize that relapse will occur and must be planned for.</td>
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<td>Acknowledge there is no standard number of relapses a parent should have before treatment goal is changed.</td>
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<tr>
<td>Develop a relapse assessment tool to help child welfare and treatment professionals assess the circumstances surrounding a relapse; incorporate this tool into a safety assessment.</td>
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<tr>
<td>Provide other essential services (food, transportation) to strengthen client.</td>
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<tr>
<td>Adopt a strengths-based approach to assessment and relapse prevention.</td>
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<td>Address the “snowflakes” early on to avoid the “snowball.”</td>
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<td>Preventive services should be in place when children are returned home.</td>
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needing drug-abuse services. Locate residential treatment programs that allow a child or children to live with the mother while in treatment. Identify programs that provide comprehensive services such as individual, family, and pediatric therapy; employment assistance; and medical care. Also look for programs that provide different interventions at different stages of recovery, including detoxification, residential/day treatment, intensive outpatient, continuing care, and aftercare. Other factors to consider when choosing a treatment program include acceptance rates, retention rates, and graduation rates.

Coordinate child welfare interventions with stages or phases of recovery, help the parent identify triggers for relapse, and make a safety plan for the children in the event of a relapse event. Work closely with the treatment provider to develop goals and identify signs of progress, and develop a system for notifying the child welfare caseworker of a relapse.

Support families to ensure children’s safety by: making reasonable efforts to finalize permanency plans for children in foster care; providing appropriate services to the whole family continually, gradually decreasing until the family stabilizes; and developing a safety plan for the children, including providing for relative care and standby guardianship. Best treatment outcomes result when the parent is allowed visitation with the children, with an increase in involvement in their lives over time.

Work with substance-impaired parents by being direct about the consequences of their continued substance use on their case. Be clear about the role the parent plays in the process, the goals (getting their children back), and what they need to do to succeed.

If the parent is also a victim of domestic violence (DV), work with treatment facilities that understand DV and coordinate with DV service providers. Ensure that the treatment facility will protect the victim from the batterer, perhaps by instituting a protection order. Put relapse in the context of DV: is she using again because of pressure by the batterer?

- **Intervene early with children exposed to parental substance abuse and provide comprehensive services.**

If parental substance abuse is suspected as contributing to the abuse or neglect, request a full developmental screen by a pediatrician specializing in substance abuse issues. This should be done no matter the child’s age, from infant through adolescent. A qualified pediatric specialist will take a detailed health and substance abuse history of the family; conduct a comprehensive physical exam (including toxicology tests) of the children; address psychosocial, emotional, and behavioral issues of children, pre-teens, and adolescents; and be able to make referrals to treatment, social services, and other service providers. Using prevention programs is crucial, as children of substance abusers are at increased risk for becoming users and addicts as adolescents. Treatment programs need to be designed for young people; programs designed for adults do not account for developmental dynamics and psychological complexities of adolescence.

- **Consider the family drug court model as a way to deliver individualized and intensive substance abuse services within a structure of sanctions and incentives.**

Family drug courts have civil jurisdiction over dependency, abuse, and neglect proceedings and focus on providing intensive drug treatment and services to parents in the child welfare system with substance abuse problems. Family drug court programs currently operate in 20 states. These programs share the following components:

  - Judicial leadership
  - Reunification as the goal
  - Provision of intensive treatment services
  - Interdisciplinary team involvement
  - Early identification and eligibility

### Increasing Reunification Success

- **Visitation plans** should be scheduled for “likely sober times.” Help parent prepare age-appropriate activities. As recovery progresses, increase length of visits and responsibilities of parent (haircuts, school conferences, doctor appointments).

- **Help locate drug-free housing.**

- **Encourage responsible family planning** (avoiding pregnancies).

- **Develop a written safety plan** that identifies “triggers” for relapse, and specifies who will take care of the children in the event of relapse.

- **Time reunification** to occur after 5-6 months’ progress in early recovery.

- **Monitor for relapse** by watching for parental withdrawal from services; regularly checking children’s school attendance; making frequent home visits; and requesting criminal history checks on all adult household members, paramours, and other caretakers.

Ongoing monitoring of progress
Focus on parent rehabilitation
Requirement of parental agreement to program conditions
Sanctions and incentives to ensure compliance
Program completion and follow-up services
Reunification following successful completion

While family drug courts are a relatively recent phenomenon, early evaluations are promising, reporting high graduation rates, reduced recidivism, and increased family reunifications.

- **Terminate parental rights when appropriate.**

Under ASFA, permanency decisions are required quickly so children don’t languish in foster care while their parents work toward providing a stable, safe, and nurturing home. Yet recovering from substance abuse often requires two years of treatment and support, and periods of relapse are common.

Child welfare professionals can look for progress in substance abuse recovery by assessing whether the parent is (and increasingly over time): actively involved in substance abuse treatment and education; participates in recovery support systems; remains abstinent for longer and longer periods of time; visits the children as often as allowed; complies with the child welfare service plan; improves parenting and life skills; and addresses interpersonal relationships appropriately.

If the parent repeatedly fails drug tests or attempts at drug treatment, makes little or no effort to improve parenting or coping skills, does not acknowledge having a substance abuse problem, and fails to consider the child’s best interests, TPR may be appropriate. The Adoption and Safe Families Act (ASFA) mandates that TPR petitions be filed when a child has been in foster care for 15 of the most recent 22 months, unless a “compelling reason” exists. Strong evidence of a parent’s success in and commitment to treatment and recovery could arguably be a compelling reason. However, when little commitment exists, and the likelihood that the parent will recover even if more time is granted is low, TPR should be pursued to free the child for another permanent placement.

- **Incorporate mental health service provision into permanency plans.**

Recognize that parental mental illness is likely to be a factor when working to provide a safe and nurturing family for child welfare clients. Integrate mental health services (screening, assessment, and treatment) for adult caregivers and children into the case plan. Be aware that comprehensive treatment may require from two-to-five years before the family is stable. This does not mesh with ASFA’s requirements, and may require an alternative placement for the children. Co-locate mental health, addiction, legal, and child welfare resource staff to more efficiently work with the families facing dual diagnosis in the child welfare system.

- **Increase training and support for parents’ attorneys.**

Parents’ attorneys need information on the impact of substance addiction and matching individuals to appropriate treatment services, and specialized training to prepare them to represent parents struggling with substance abuse effectively. Courts and local bar associations may be a source of guidance and training for these attorneys. They should also be included in cross-training efforts sponsored by child welfare agencies and the treatment community.

**Conclusion**

Parental substance abuse is pervasive among families in the child welfare system. It is one of a host of problems, which may include poverty, mental illness, sexual abuse (past and present), domestic violence, and poor parenting. As you work to ensure that the children are living in a safe and nurturing environment, look to your community for resources and expert help in addiction and recovery. Consider cross-training opportunities with treatment, mental health, and domestic violence service providers. Work with them to overcome the “turf” mentality that undermines efforts to address the multiple needs faced by the children and parents in your care.

This article series provides a foundation of knowledge. We encourage you to stay updated on advancements in the ever-changing field of addiction and treatment.

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**Endnotes**

1. Citations for quotes, statistics, and research are included in the original articles, from which this synopsis was written.
2. For a comprehensive list of practice and policy tips, refer to the original articles.