



STRENGTHENING CHILDREN AND FAMILIES •

SUBSTANCE USE & THE CHILD WELFARE SYSTEM

A REPORT FOR
A NEW WAY OF LIFE

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I. Executive Summary

In the United States, an estimated 1 in 8 children (ages 17 and younger), approximately 8.7 million, live in a home in which someone has a substance use disorder.^{1 2 3} Substance use encompasses a wide range of behaviors, including situational alcohol use, use of legalized drugs or prescribed medications, and/or illicit substances. Substance use escalates to a disorder once physical and psychological dependence develops, leading to social and health consequences.⁴ Substance use disorder (SUD) exists on a continuum from mild to severe and is based on multiple criteria, such as legal problems, hazards associated with use, tolerance, time spent using, and neglect of responsibilities.^{5 6} Children whose parents suffer from a substance use disorder, referred to as parental SUD, are at an increased risk of impaired developmental outcomes, as substance use can significantly impair a parent's ability to provide a safe, stable environment for the children in their care.

The impact of parental substance use exposure on a child's mental health and cognitive development varies significantly based on a multitude of factors. In general, children who live with parents that have a SUD are at an increased risk of adverse childhood experiences (ACEs), such as neglect and physical abuse, which can have lasting negative developmental and mental

¹ Bridget Freisthler et al., *Enhancing Permanency in Children and Families (EPIC): a child welfare intervention for parental substance abuse*, 21 BMC Public Health 1 (2021)

² Vincent C. Smith et al., *Families Affected by Parental Substance Use*, 138 Pediatrics 1 (2016)

³ Rachel N. Lipari & Struther L. Van Horn, *Children Living with Parents Who Have a Substance Use Disorder* § 1 (2017)

⁴ Deborah S. Hasin et al., *DSM-5 Criteria for Substance Use Disorders: Recommendations and Rationale*, 170 The American Journal of Psychiatry 834 (2013)

⁵ The diagnosis criteria for SUD are divided into 2 categories: Social consequences (legal trouble, issues with employment, etc.) and health consequences (withdrawal, injuries, etc.)

⁶ Hasin et al., *DSM-5*, *supra* note 4

health effects.^{7 8} The risk of negative outcomes can differ between families based on many contextual factors, including the type of substance(s) used, length/duration of use, age of the child at the time of exposure, and community support.^{9 10 11} As such, the child welfare response to parental substance use should account for the diverse needs of these families, particularly when considering child removal.

Variability in SUD presentation and consideration of each family's unique environmental context add to the difficulty of predicting the effects of at-home substance use exposure on a child's development. However, the negative mental health and developmental effects of childhood exposure to SUDs are well documented and have been observed in children as young as 2 to 3 years old.¹² Children of parents with SUDs have been identified as having exacerbated risks of emotional, behavioral, and adjustment problems, in addition to struggles with cognitive functioning and academic performance.¹³ The significant developmental and mental health consequences of childhood exposure to SUD warrant a robust system of support.¹⁴ Healthcare workers, educators, and community advocates/resources have the opportunity to intervene early

⁷ Freisthler et al., *Enhancing Permanency*, *supra* note 1 at 2

⁸ Elizabeth Crouch et al., *Prevalence of adverse childhood experiences (ACEs) among US children*, 92 Child Abuse & Neglect 209 (2019)

⁹ *Id.* at 210

¹⁰ Sofie Kuppens et al., *The Enduring Effects of Parental Alcohol, Tobacco, and Drug Use on Child Well-being: A Multilevel Meta-Analysis*, 32 Development and Psychopathology 765 (2019)

¹¹ Maria X. Sanmartin et al., *Association Between State-Level Criminal Justice-Focused Prenatal Substance Use Policies in the US and Substance Use-Related Foster Care Admissions and Family Reunification*, 174 JAMA Pediatrics 782 (2020)

¹² Jessica M. Solis et al., *Understanding the Diverse Needs of Children whose Parents Abuse Substances*, 5 Current Drug Abuse Reviews 135 (2012)

¹³ *Id.* at 3

¹⁴ Anthony Biglan et al., *A Strategic Plan for Strengthening America's Families: A Brief from the Coalition of Behavioral Science Organizations*, 23 Clinical Child and Family Psychology Review 153 (2020)

and support children at risk of lasting developmental and mental health concerns. The need for intervention is increasingly emergent once child welfare services become involved, as these families have likely fallen through the cracks of the social services meant to protect and aid them.

In California, the use of substances by a caregiver, whether it be situational use or disordered use, is not reason enough to open a child welfare case. For a child welfare case to be substantiated, there must be some evidence of abuse or neglect indicating that the child is at risk.¹⁵ Child welfare interventions would ideally focus on the unique needs of each family and prioritize maintaining the family unit while working to improve the stability and safety of the home environment. Unfortunately, the chronic nature of SUD recovery is at odds with a child welfare system that prioritizes establishing stability and permanency within a limited time frame. Parents with SUDs who become involved in the child welfare system are more likely to lose custody of their children and have their parental rights terminated than those without SUDs.¹⁶

While the risks associated with childhood exposure to parental SUD are well known, the harm of family separation, placement with kin, and foster care placement are less clear. Foster care placement can be protective. However, recent work has demonstrated that it can negatively impact the child, since family separation and the instability often associated with foster care placement are classified as ACEs.¹⁷ Several publications include depression, increased aggression, and behavioral issues as some of the primary mental health implications of experiencing family

¹⁵ Cal. Pen. Code §11165.13

¹⁶ M O Marcenko et al., *Childhood experiences of abuse, later substance use, and parenting outcomes among low-income mothers*, 70 *American Journal of Orthopsychiatry* 316 (2000)

¹⁷ Kylie Rymanowicz, *Adverse Childhood Experiences (ACEs): What are they and how can they be prevented?* (December 13, 2018) available at [<https://perma.cc/G3FR-STE6>]

separation.¹⁸ Child removal results in a disruption of both a child's bond with their caregiver and their feelings of security and stability. Furthermore, family separation and subsequent foster care placement can negatively alter a child's sense of identity. Previous research¹⁹ has found that transracially placed foster youth, specifically ethnic minority children being placed with a family of ethnic majority, are prone to experience disconnection from their foster families, loss of interest in their birth culture, and hyper-awareness of physical differences between individuals based on race. These components, in addition to removal itself, can adversely affect a child's mental well-being.

This report will explore the mental and developmental health concerns related to childhood exposure to parental substance use. The three areas of focus are (1) how parenting is impacted by substance use and how these effects differ based on the type of substance; (2) how the resulting mental and developmental health concerns may present in a child; and (3) the relevant legal and procedural aspects of child welfare intervention, focusing on family separation.

II. What Are the Impacts of Different Substances on Parenting?

The harm caused to a child from exposure to parental SUD is not uniform or unpreventable. There is evidence that suggests the impact of parental SUD varies based on a variety of factors, including the type of substance used, the timing and frequency of use, age of the child when exposed, as well as protective factors that may mitigate negative outcomes. Common characteristics identified in parents with SUDs include difficulty regulating their own emotions, difficulty assessing and attending to their children's emotions, preoccupation with drug seeking,

¹⁸ Alan J. Dettlaff et al., *It is not a broken system, it is a system that needs to be broken: the upEND movement to abolish the child welfare system*, 14 *Journal of Public Child Welfare* 500 (2020)

¹⁹ Clementine J. Degener et al., *The ethnic identity complexity of transculturally placed foster youth in the Netherlands*, 113 *Children and Youth Services Review* 1 (2020)

problems regulating their stress, poor techniques for disciplining their children (e.g., using coercive and harsh discipline), and a lack of supervision. These parental behaviors have the potential to cultivate a home environment where children are not receiving adequate nurturing and attention, leading to disproportionate rates of neglect and/or abuse that can cause developmental and mental health concerns. The changes seen in parenting behavior because of SUDs can differ based on the mechanism of action and the associated psychological and physical changes.

When assessing how exposure to parental substance use impacts development, it is helpful to examine how parenting can differ based on the physical and cognitive effects of specific substances.

A. Alcohol

Alcohol use, even at low levels, is associated with disinhibition, and parental impairment negatively affects parent-child interactions.²⁰ A review of cohort studies on the consequences of parental alcohol use for children found that in almost two of every three published articles, parental drinking was found to be significantly associated with a child harm outcome measure.²¹ Alcohol use can cause parents to become hyper-focused on their child's "bad" behaviors, resulting in an aggressive disciplinary response and increased risk of abuse.²² Alternatively, drinking can impair the parent's ability to perceive and respond to their child's behavioral, emotional, and safety needs,

²⁰ Marlene Oscar-Berman & Ksenija Marinković, *Alcohol: effects on neurobehavioral functions and the brain*, 17 *Neuropsychology Review* 239 (2007)

²¹ Ingeborg Rossow et al., *Parental drinking and adverse outcomes in children: A scoping review of cohort studies*, 35 *Drug and Alcohol Review* 397 (2016)

²² Claude M. Steele & Robert A. Josephs, *Alcohol Myopia. Its Prized and Dangerous Effects*, 45 *American Psychologist* 921 (1990)

creating a neglectful environment lacking necessary parental oversight.^{23 24} In addition, households that include a parent with alcohol use disorder report higher levels of unpredictability in nurturance, finances, and discipline.²⁵ Resulting instability in the home environment can impair development.

B. Opioids

Opioids are sedating in nature and can cause significant cognitive impairment.²⁶ Their use is associated with an initial euphoria, followed by sedation or loss of consciousness. As a result, parents who use opioids may overlook or misread their child's needs. Additionally, the withdrawal period can be physically taxing and associated with significant irritability, both of which can diminish parenting ability.²⁷ One study found that opioid dependent mothers had poorer emotional availability for their 7-month-old children than those without a history of substance use.²⁸ A consistent lack of responsiveness can impair the development of healthy attachments between parent and child.

Interestingly, when assessing mother-child interaction patterns in a family dealing with parental opioid addiction, children and mothers in the opioid group reported higher levels of maternal acceptance and perceived maternal warmth than those in the alcohol and cocaine and

²³ Babita Mahato et al., *Parent-child relationship in children of alcoholic and non-alcoholic parents*, 18 *Industrial Psychiatry Journal* 32 (2009)

²⁴ Lisa T. Ross & Elizabeth M. Hill, *Comparing alcoholic and nonalcoholic parents on the family unpredictability scale*, 94 *Psychological Reports* 1385 (2004)

²⁵ *Id.* at 1386

²⁶ Erin L. Winstanley & Amanda N. Stover, *The Impact of the Opioid Epidemic on Children and Adolescents*, 41 *Clinical Therapeutics* 1655 (2019)

²⁷ *Id.* at 1656

²⁸ Saara Salo, et al., *Emotional availability, parental self-efficacy beliefs, and child development in caregiver-child relationships with buprenorphine-exposed 3-year-olds*, *Parenting: Science and Practice* 9.3-4 (2009)

alcohol groups.²⁹ Additionally, mothers with opioid use disorder (OUD) showed less undermining autonomy behaviors than mothers with alcohol use disorder. These findings suggest that the relationship between opioid addiction and parent-child interaction may be less negative than what is observed in alcohol addiction. The outcomes related to childhood exposure to OUD are likely not specific to punitive parenting behaviors and may be more indicative of neglect.³⁰

1. Prescribed Opioids

Prescribed opioid medications, including methadone and buprenorphine, can be used in the treatment of opioid use disorder during pregnancy.³¹ In combination with behavioral therapy and close medical management, this treatment can be protective for the mother, allowing for maintenance of sobriety and engagement in parenting. Neonatal abstinence syndrome is a known risk factor but should not be a deterrent from seeking or providing treatment.³²

C. Methamphetamine

Methamphetamine is a powerful stimulant that can cause elevated mood and increased energy for up to 12 hours.³³ Consistent usage or high doses can induce psychosis, a transient experience of delusions and hallucinations. Additionally, psychostimulants are associated with agitation and irrational behaviors, particularly during withdrawal. Chronic usage can lead to lasting functional impairment in memory, attention, and decision making, with variable recovery of these

²⁹ Natasha Slesnick et al., *Parenting Under the Influence: The Effects of Opioids, Alcohol and Cocaine on Mother-Child Interaction*, 39 *Addict Behaviors* 1 (2014)

³⁰ Andrea McGlade et al., *Child protection outcomes for infants of substance-using mothers: a matched-cohort study*, 124 *Pediatrics* 285 (2009)

³¹ Hendrée E. Jones et al., *Buprenorphine Treatment of Opioid-Dependent Pregnant Women: A Comprehensive Review*, 107 *Addiction* 5 (2012)

³² Centers for Disease Control and Prevention, *Treatment for Opioid Use Disorder Before, During, and After Pregnancy* (July 21, 2021), available at [<https://perma.cc/XKJ9-X7FY>]

³³ Shane Darke et al., *Major physical and psychological harms of methamphetamine use*, 27 *Drug and Alcohol Review* 253 (2008)

cognitive abilities after discontinuing use. Thus, methamphetamine can impair one's ability to create a safe environment that is appropriately responsive to a child's needs both when the parent's use disorder is active or in recovery.

Research assessing the effect of methamphetamine use on parenting and children has focused on the dangers and complications related to living in a home where methamphetamine is produced. As users of methamphetamines often create the substance, children are at risk of exposure to toxic by-products in addition to impaired parenting.³⁴

D. Cocaine

Parental cocaine use alters the dopamine regulated reward system of the brain and has been suggested to negatively impact a parent's attachment to their child, possibly contributing to the high rates of neglect and abuse impacting children whose parents use this substance.³⁵ Studies have shown that both perinatal and continued cocaine use into infancy are associated with impaired parent-child interactions during the early preschool period.³⁶ However, there is minimal evidence of prenatal cocaine exposure's effect on the developmental and mental health of preschool aged children.^{37 38}

³⁴ Timothy W. Lineberry & J. M. Bostwick, *Methamphetamine Abuse: A Perfect Storm of Complications*, 81 Mayo Clinic Proceedings 77 (2006)

³⁵ Lane Strathearn & Linda C. Mayes, *Cocaine addiction in mothers: Potential effects on maternal care and infant development*, 1187 Annals of the New York Academy of Sciences 172 (2010)

³⁶ Arnise L. Johnson et al., *Maternal Cocaine Use: Estimated Effects on Mother-Child Play Interactions in the Preschool Period*, 23 Journal of developmental and behavioral pediatrics 191 (2009)

³⁷ John P. Ackerman et al., *A Review of the Effects of Prenatal Cocaine Exposure Among School-Aged Children*, 125 Pediatrics 554 (2010)

³⁸ Deborah A. Frank et al., *Growth, development, and behavior in early childhood following prenatal cocaine exposure: a systematic review*, 285 The Journal of the American Medical Association 1613 (2001)

E. Marijuana

In the United States, marijuana is the most used federally illegal substance.³⁹ Approximately 18% of Americans report using marijuana at least once in 2019.⁴⁰ Despite its wide usage, the effect of marijuana on parenting and child mental health and behavioral outcomes remains under investigation, particularly considering recent de-stigmatization and legalization efforts. Research primarily focuses on developmental impacts of prenatal exposure. Marijuana can impair attention and short-term memory, making it more challenging to respond appropriately to a child's cues.⁴¹ Recent parental marijuana use was not found to be associated with physical or supervisory neglect.⁴² However, more frequent incidents of physical abuse were associated with a recent history of parental marijuana use.

III. What Developmental and Mental Health Concerns Are Associated with Parental Substance Use?

Parental substance use can lead to variable developmental and mental health concerns based on the type of substance used and when the exposure occurred. This table compares the type of cognitive issues that are associated with the previously discussed substances based on the age of symptom presentation.

³⁹ Centers for Disease Control and Prevention, Marijuana and Public Health: Data and Statistics (June 8, 2021), available at [<https://perma.cc/T69A-YM8K>]

⁴⁰ *Id.*

⁴¹ Bridget Freisthler et al., *Examining the relationship between marijuana use, medical marijuana dispensaries, and abusive and neglectful parenting*, 48 Child Abuse & Neglect 170 (2015)

⁴² *Id.* at 177

Substance	Child's Age				
	Prenatal	Toddler (1-3yrs)	Preschool (3-5yrs)	School Age (6-12yrs)	Adolescence (13-18yrs)
Alcohol	- Fetal Alcohol Spectrum Disorders: Birth defects and neurobehavioral changes. Common Features: abnormal facial features, smaller head circumference, poor vision and hearing, significant developmental delay. ^a	- Higher levels of internalizing behaviors such as depressed mood, anxiety, shyness. ^b - Higher levels of externalizing behaviors such as defiance, tantrums, aggression. ^b			- Poor school performance. ^c - Increased need for special education intervention. ^c - Deficits in social competence. ^c - Increased risk of mood disorders. ^c
Opioids	- Neonatal Opioid Withdrawal: Neonatal withdrawal syndrome following intrapartum exposure. Presents with hyperirritability, gastrointestinal dysfunction, respiratory distress, and nervous system dysregulation. Associated with lasting developmental delays, future hospitalization for a neuropsychiatric disorder, meeting criteria for a disability. ^d		- Impaired IQ performance. ^e - Impaired language performance. ^e - Prenatal exposure associated with lower visual-motor and perceptual performance. ^e	- Increased risk of attention-deficit/hyperactivity disorder. ^f	
Prescribed Opioids	- Buprenorphine and Methadone exposure: Can cause mild neonatal abstinence syndrome, less severe than heroin. Data is inconclusive regarding differences in developmental impact between buprenorphine and methadone. ^g		- Impaired executive functioning associated with perinatal buprenorphine and methadone exposure. ^h - Prenatal methadone exposure: Deficits in expressive and receptive language. ^h		

Methamphetamine	- Neonatal Abstinence Syndrome: Excessive sympathomimetic activation causes irritability, gastrointestinal dysfunction, fever. ⁱ	- Prenatal exposure associated with psychomotor delays. ^j	Prenatal exposure associated with: ^j - Impaired social skills - Impaired hand-eye coordination - Deficits in inhibitory behaviors/ impulse control	- Prenatal exposure associated with difficulty relating to peers, possibly due to increased aggression. ^j	- Prenatal exposure associated with poor school performance in math, language, and physical fitness. ^j
Cocaine				- Perinatal exposure associated with impaired attention and behavioral regulation. ^k	
Marijuana				- Prenatal exposure associated with increased risk of depression symptoms. ^k	- Prenatal exposure associated with difficulty with higher order thinking, including memory, problem solving, and impulse control. ^k - Increased risk of marijuana, tobacco, and opioid use. ^l

a. CDC: Basics About FASDs. <https://www.cdc.gov/ncbddd/fasd/facts.html>.

b. Ellen Edwards et al., Behavior Problems in 18- to 36-Month-Old Children of Alcoholic Fathers: Secure Mother–Infant Attachment as a Protective Factor, Development and Psychopathology 18 (2006).

c. Berg L, Bäck K, Vinnerljung B, Hjern A. Parental alcohol-related disorders and school performance in 16-year-olds-a Swedish national cohort study. Addiction (2016).

d. CDC: Prenatal Opioid and Substance Exposure. <https://www.cdc.gov/ncbddd/aboutus/pregnancy/nas.html>.

e. Samantha J Lee, et al., Neurodevelopmental outcomes of children born to opioid-dependent mothers: a systematic review and meta-analysis. Academic pediatrics 20.3 (2020).

f. Asher Ornoy, et al., Developmental Outcome of School-Age Children Born to Mothers with Heroin Dependency: Importance of Environmental Factors. Developmental Medicine & Child Neurology 43. (2001).

- g. Susan B. Brogly, et al., Prenatal Buprenorphine Versus Methadone Exposure and Neonatal Outcomes: Systematic Review and Meta-Analysis. *American Journal of Epidemiology* 180.7 (2014).
- h. Hyun Min Kim, et al., Preschool Language Development of Children Born to Women with an Opioid Use Disorder. *Children (Basel)* (2021).
- i. Lorenz Harst, et al., Prenatal Methamphetamine Exposure: Effects on Child Development—A Systematic Review. *Dtsch Arztebl Int.* (2021).
- j. Fatima Anne Perez, et al. Prenatal methamphetamine—impact on the mother and child—a review. *Addiction* (2022).
- k. Sonia Minnes. Prenatal tobacco, marijuana, stimulant, and opiate exposure: outcomes and practice implications. *Addiction Science and Clinical Practice* (2011).
- l. Bertha K Madras, et al., Associations of Parental Marijuana Use With Offspring Marijuana, Tobacco, and Alcohol Use and Opioid Misuse. *JAMA Network Open* (2019).

While exposure to substance use in childhood is consistently associated with negative outcomes, these issues rarely arise in a vacuum. Families struggling with substance use frequently report problems related to housing, social support, employment, and mental health, all of which can lead to behavioral and mental health impairments.⁴³ Additionally, the often-challenging path to recovery has been described as a form of ambiguous loss for children.⁴⁴ Once children are old enough to comprehend when their recovering parent is maintaining their sobriety and engaged in healthy parenting behaviors, subsequent relapses can contribute to a feeling of instability and unresolved loss. However, there are protective factors that can buffer the potential harm caused to a child's development and encourage resilience.

Protective factors promote resilience by helping children adapt to stressors and navigate adverse experiences. Secure attachments to one parent, a relationship in which the child feels safe and can consistently depend on the parent, can moderate the relationship between parental SUD

⁴³ Deborah A. Ellis et al., *The Role of Family Influences in Development and Risk*, 21 *Alcohol Health and Research World* 218 (1997)

⁴⁴ Brandy M. Mechling et al., *Applying ambiguous loss theory to children of parents with an opioid use disorder*, 31 *Journal of Child and Adolescent Psychiatric Nursing* 53 (2018)

and externalizing behaviors.^{45 46} In households with fathers who struggle with alcoholism, mother responsiveness and a mutual positive affect between mother and infant are associated with improved cognitive development, as well as a reduction in both externalized and internalized behaviors.⁴⁷ A positive father-child bond, indicated by time spent together and parental warmth, is protective against adolescent defiant-disorders and substance use when one parent has alcoholism.⁴⁸ Additionally, a robust social network, capable of providing consistent support is associated with better mental health outcomes during childhood in the setting of parental substance use.⁴⁹ Finally, the home environment can be protective even when the initial insult occurs prenatally. Among school aged children who were exposed to opioids prenatally, intellectual development was less severely impacted in those who lived in an environment in which their health and safety needs were met.⁵⁰

IV. How Does Family Separation Affect Parental Substance Use?

Parental substance use is a significant risk factor for entry into the child welfare system.⁵¹

In most states, parental substance use is the leading cause of child maltreatment and neglect.⁵²

⁴⁵ Ellen P. Edwards et al., *Behavior problems in 18- to 36-month-old children of alcoholic fathers: Secure mother–infant attachment as a protective factor*, 18 *Development and Psychopathology* 18 (2006)

⁴⁶ Olga Wlodarczyk et al., *Protective mental health factors in children of parents with alcohol and drug use disorders: A systematic review*, 12 *PLoS One* 1 (2017)

⁴⁷ Edwards et al., *Behavior Problems*, *supra* note 45 at 8

⁴⁸ Wlodarczyk et al., *Protective*, *supra* note 46 at 10

⁴⁹ Daniel J. Pilowsky et al., *Resilient Children of Injection Drug Users*, 43 *Journal of the American Academy of Child & Adolescent Psychiatry* 1372 (2004)

⁵⁰ Asher Ornoy et al., *Developmental outcome of school-age children born to mothers with heroin dependency: importance of environmental factors*, 43 *Developmental Medicine & Child Neurology* 668 (2001)

⁵¹ Dana K. Smith et al., *Child maltreatment and foster care: Unpacking the effects of prenatal and postnatal parental substance use*, 12 *Child Maltreatment* 150 (2007)

⁵² Nancy K. Young et al., *A Review of Alcohol and Other Drug Issues in the States' Child and Family Services Reviews and Program Improvement Plans*, 20 (2005)

Further, parents involved in the child welfare system that have substance abuse problems are more likely to have their parental rights terminated.⁵³ The treatment of a chronic, ongoing substance abuse problem is fundamentally at odds with a child welfare system that prioritizes achieving permanency outcomes for children within a legally specified timeframe.

Literature on the effect of family separation on treatment completion is limited and mixed. Among mothers who retained custody of their children, one study of women dependent on cocaine found that having custody of one's children was a strong predictor for entry into a substance abuse program.⁵⁴ Another study found that women who resided with their children were 73% more likely to enter a methadone treatment program than women who did not.⁵⁵ For mothers who did not retain custody of their children, one study found that women with children in foster care were more likely to complete a treatment program, and those who had custody of their children were less likely to complete treatment.⁵⁶

These conflicting results could be attributed to the complex emotions mothers experience while separated from their children. A qualitative study examining parenting-related barriers and facilitators to drug treatment found that some women who did not have custody of their children found the prospect of reuniting with their children to be a strong motivator to complete treatment.⁵⁷ However, others found that the guilt and shame of having their children taken made them want to

⁵³ Marcenko et al., *Childhood experiences*, *supra* note 17

⁵⁴ Christine A. Saum et al., *Predictors of substance abuse treatment entry for crime-involved, cocaine-dependent women*, 91 *Drug & Alcohol Dependence* 253 (2007)

⁵⁵ Lundgren et al., *Parental status*, *supra* note 19

⁵⁶ Scott-Lennox et al., *The impact*, *supra* note 18

⁵⁷ Kristin D. Seay et al., *Substance abuse treatment engagement among mothers: Perceptions of the parenting role and agency-related motivators and inhibitors*, 20 *Journal of Family Social Work* 196, 199 (2017)

leave the treatment facility and use drugs again.⁵⁸ Many women interviewed for the study who had custody of their children but had to find care arrangements for them to attend treatment (whether residential treatment or outpatient sessions) expressed a strong desire to have their children with them during the program.^{59 60} Some also cited anxiety and guilt over separation from their child to attend treatment as an inhibitor to treatment.⁶¹ Subjects who went to residential treatment often stated that having the option to bring their children was a strong motivator and that they selected their treatment program because it had this option.⁶² On the other hand, when asked about any ways in which having their children in the facility negatively affected their treatment, mothers described discomfort with being surrounded by multiple other families in close quarters. They also described how patients often take turns watching each other's children during treatment sessions, and that this added childcare responsibility was taxing.⁶³

Studies have shown that women who are mandated to enter treatment stay longer in treatment⁶⁴ and are more likely to complete programs.⁶⁵ Interestingly, a study comparing child protective services (CPS) treatment mandates to mandates from the criminal justice system found

⁵⁸ One parent stated, “I can’t help my baby, so boom. Forget y’all. I’m gonna go over here and use this substance.” For this parent, relapse was directly associated with guilt over being separated from her child. *Id.* at 202

⁵⁹ *Id.* at 203

⁶⁰ Quantitative studies have also found that giving women the ability to bring their children to residential treatment was a significant predictor of retention. See Xiaowu Chen et al., *Factors associated with retention of drug abusing women in long-term residential treatment*, 27 *Evaluation and Program Planning* 205 (2004)

⁶¹ Seay et al., *Substance supra* note 7 at 205

⁶² *Id.* at 203

⁶³ *Id.* at 206

⁶⁴ Claire D. Brindis et al., *Options for recovery: California's perinatal projects*, 29 *Journal of Psychoactive Drugs* 89 (1997); and Dean Rivera et al., *Examination of referral source and retention among women in residential substance use disorder treatment: a prospective follow-up study*, 16 *Substance Abuse Treatment and Policy* 1 (2021)

⁶⁵ Danica K. Knight et al., *Predictors of program completion for women in residential substance abuse treatment*, 27 *American Journal of Drug and Alcohol Abuse* 1 (2001)

that women in the CPS mandate group had a 34.4% higher retention rate.⁶⁶ This may suggest that family reunification is a strong external motivator in treatment retention. Researchers also hypothesize that higher rates of retention for women mandated to treatment by CPS may be due to the additional support, resources, and monitoring that come attached to these mandates.⁶⁷ For example, women mandated by CPS are normally provided with wraparound services such as childcare support, parenting classes, and housing transition support.⁶⁸

Research addressing the timelines related to drug treatment and the child welfare system focus on the average time to reunification for children who have been removed from their parents. These results are presented in various forms, including measuring the average days spent in out of home care, or the number of months it takes for children to be reunified with their parents after being removed. Many studies have found that parents who participated in family drug courts (FDC) were reunified with their children significantly faster than those in comparison groups.⁶⁹ An evaluation of outcomes in the Sacramento Dependency Drug Court found that children in the FDC group spent fewer days on average outside of the home than children in the comparison group (981 days vs. 993 days).⁷⁰ Similar results have been found in evaluations of other family drug courts.⁷¹

⁶⁶ Rivera et al., *Examination supra* note 14

⁶⁷ *Id.* at 7

⁶⁸ *Id.*

⁶⁹ See the following for a literature review examining several studies with this result: Office of Juvenile Justice and Delinquency Prevention, *Family Drug Courts*, (2016). Available at https://www.ojjdp.gov/mpg/litreviews/Family_Drug_Courts.pdf

⁷⁰ Sharon M. Boles et al., *The Sacramento Dependency Drug Court: Development and Outcomes*, 12 Child Maltreatment 161 (2007)

⁷¹ See Sonia D. Worcel et al., *Effects of family treatment drug courts on substance abuse and child welfare outcomes*, 17 Child Abuse Review 427 (2008); Beth L. Green et al., *Building the evidence base for family drug treatment courts: Results from recent outcome studies*, 6 Drug Court Review 53 (2009); Gayle A. Dakof et al., *A randomized pilot study of the Engaging Moms Program for family drug court*, 38 Journal of Substance Abuse Treatment 263 (2010); Scott W.M. Burrus et al., *Show Me the Money: Child Welfare Cost Savings of a Family Drug*

V. What Are the Statutory and Legal Responses to Parental Substance Use?

State statutes regarding child welfare and parental substance use fall into two main categories: those geared towards infants who test positive for substance exposure at birth, and those that address the presence of drugs in the home environment for children of all ages.⁷²

A. Substance-Exposed Newborns

All states require healthcare providers to notify CPS when an infant tests positive for substances under the Child Abuse and Treatment Prevention Act, reauthorized in 2016.⁷³ However, the report does not need to be made as one of child abuse or neglect; once the notification has been made, CPS staff will decide whether an investigation should be initiated.⁷⁴ The act also requires states to develop safety plans for substance-exposed newborns that address the needs of both the infant and caregiver and monitor the progress of any case plans implemented.⁷⁵ Notably, this section of the Act specifies that “such notification shall not be construed to I. establish a definition under Federal law of what constitutes child abuse and neglect; or II. require prosecution for any illegal action.”^{76 77}

Court, 62 Juvenile and Family Court Journal 1 (2011); and Eric J. Bruns et al., *Effects of a Multidisciplinary Family Treatment Drug Court on Child and Family Outcomes: Results of a Quasi-Experimental Study*, 17 Child Maltreatment 218 (2012)

⁷² Authors of this report have chosen to include a comparison of state policies to make this report a useful tool for those engaging in legislative research and work around this issue. Exploring how various states have addressed parental substance use can inform and shape policy change both in Los Angeles and in other cities and states.

⁷³ Child Abuse and Treatment Act § 106(b)(2)(B)(ii)

⁷⁴ Children’s Bureau, *Child Welfare Policy Manual*, §2.1F CAPTA, *Assurances and Requirements, Infants Affected by Substance Abuse* (as updated 2016)

⁷⁵ Child Abuse and Treatment Act § 106(b)(2)(B)(iii)

⁷⁶ Child Abuse and Treatment Act § 106(b)(2)(B)(ii)(I) and (II)

⁷⁷ The 2001 decision in *Ferguson v. City of Charleston*, 532 U.S. 67 (2001) found that involuntarily drug testing women in labor for the purpose of criminal prosecution was a violation of their Fourth Amendment rights. The Medical University of South Carolina implemented a program in 1989, in conjunction with local law enforcement, that targeted women with certain medical indicators for drug screenings. Those who tested positive were arrested for crimes such as drug possession, child neglect, or distribution of drugs to a person under eighteen (the fetus). A group of these women brought legal action against the hospital administrators and law enforcement in charge of the

In some states, substance abuse on its own cannot serve as the basis for neglect.⁷⁸ For example, California’s Penal Code §11165.13 specifies: “A positive toxicology screen at the time of the delivery of an infant is not in and of itself a sufficient basis for reporting child abuse or neglect.”⁷⁹ Some nexus between the substance abuse and actual risk to the child’s safety must be established before a child welfare report is initiated. This statute is codified into Los Angeles DCFS practice in the DCFS Child Welfare Policy Manual: “The mere fact that a parent is abusing drugs or alcohol does not mean that a child should be removed from the home. An infant’s prenatal exposure is also not an automatic reason for removal and detention of that infant from the parent(s).”⁸⁰

B. Children Exposed to Parental Substance Use

States have incorporated parental substance use into their definitions of child abuse and neglect in several ways. Examples include parents using a substance that impairs their ability to

program. The Supreme Court ruled in a 6-3 decision that 1. The hospital staff conducting the tests were government actors, since it was a public hospital; 2. The medical indicators used to target women for testing were not enough to constitute “reasonable suspicion”; and 3. The testing did not fulfill a “special need” justifying a warrantless search. Thus, the testing constituted a violation of the Fourth Amendment. This does not mean, however, that prenatal drug exposure can never be used as the basis for a criminal charge; Alabama, for example, regularly prosecutes women for “Chemical Endangerment of a Child.” See Ala. Code 1975, § 26-15-3.2

⁷⁸ The following are statutes, agency policies, and state supreme court cases that specify that prenatal substance exposure cannot be used as the sole basis for a report of neglect: Cal. Pen. Code § 1165.13; Florida Department of Children and Families, Operating Procedure No. 170-4; KY Rev. Stat. § 214.160(3)-(4); Md. Code Ann., Fam. Law, § 5-704.2(i); Michigan Department of Health and Human Services, Children’s Protective Services Manual (PSM 716-7), 2020; *NJ DCF v A.L.*, 59 A. 3d 576 (2013); and *Nassau Cty. Dep’t of Soc. Servs. on Behalf of Dante M. v. Denise J.*, 661 N.E.2d 138 (N.Y. 1995)

⁷⁹ Cal. Pen. Code §11165.13

⁸⁰ DCFS Child Welfare Policy Manual §0070-521.10

care for a child⁸¹, storing or using drugs in a home or vehicle where a child is present⁸², and providing drugs or alcohol to a child.⁸³

Statutes specifically addressing the manufacturing of drugs when a child is present can be found in a state's criminal code⁸⁴, under their definition of child endangerment⁸⁵, in their definition of child abuse and neglect⁸⁶, or in all three.⁸⁷ Interestingly, some statutes address the manufacturing of methamphetamine separately from the manufacture of substances in general, presumably because of the increased danger of methamphetamine manufacture ("meth labs"). California's

⁸¹ Alaska Stat. § 11.51.110; Cal. Welf. & Inst. Code § 300; Del. Ann. Code Tit. 10, § 901(18); Fla. Ann. Stat. § 39.01(35)(a)(2), (g); Ky. Rev. Stat. § 600.020(1)(a)(3); Mn. Ann. Stat. § 626.556, Subd. 2(g)(6) & (8), (k)(9); N. Y. Soc. Serv. Law § 371(4-a); R.I. Gen. Laws § 40-11-2(1); Tex. Fam. Code § 261.001, and the V. I. Ann. Code Tit. 14, § 503

⁸² Alaska Stat. § 11.51.110; Ariz. Rev. Stat. § 8-201(2), (25); D.C. Ann. Code § 16-2301(9); Ill. Comp. Stat. Ch. 325, § 5/3, Iowa Ann. Code § 232.68(2)(a)(6)-(7); and S.D. Codified Laws § 26-8A-2(9)

⁸³ Ark. Ann. Code § 12-18-103(3)(A); Fla. Ann. Stat. § 39.01(35)(a)(2), (g); Haw. Rev. Stat. § 350-1; Ill. Comp. Stat. Ch. 325, § 5/3; Iowa Ann. Code § 232.68(2)(a)(6)-(7); Minn. Ann. Stat. § 626.556, Subd. 2(g)(6) & (8), (k)(9); and Tex. Fam. Code § 261.001

⁸⁴ Ala. Code § 13A-12-218; Ariz. Rev. Stat. § 8-201(2), (25); Ark. Ann. Code § 5-64-407; Cal. Health & Safety Code § 11379.7; Colo. Rev. Stat. § 18-6-401(1)(c); Del. Ann. Code Tit. 11, § 1102; Ga. Ann. Code § 16-5-73(b); Haw. Rev. Stat. § 712-1240.5; Idaho Code § 37-2737A(1)-(2); Ill. Comp. Stat. Ch. 720, § 646/50; Iowa Ann. Code § 726.6; Kan. Ann. Stat. § 21-5601(b)-(c); Ky. Rev. Stat. § 218A.1443; La. Rev. Stat. § 14:93; Minn. : Ann. Stat. § 609.378; Miss. Ann. Code § 97-5-39(4); Mo. Ann. Stat. § 568.045; Mont. Ann. Code § 45-5-622(3), (5)(b); Neb. Rev. Stat. § 28-457; N.H. Rev. Stat. § 639-A:2; N.M. Ann. Stat. § 30-6-1(I)-(J); N.C. Ann. Stat. § 15A-1340.16; N.D. Cent. Code § 19-03.1-22.2; Ohio Rev. Code § 2919.22(B)(6), (E)(3); Or. Rev. Stat. § 163.547; Pa. Stat. Tit. 35, § 780-113(a)(38), (p); S.C. Ann. Code § 44-53-378; Utah Ann. Code § 76-5-112.5; Va. Ann. Code § 18.2-248.02; Wash. Rev. Code § 9A.42.100; W.Va. Code § 60A-10-12; and Wyo. Ann. Stat. § 6-4-405

⁸⁵ Ala. Code § 26-15-3.2; Alaska Stat. § 11.51.110; Ariz. Rev. Stat. § 13-3623(C); Del. Ann. Code Tit. 11, § 1102; Ill. Comp. Stat. Ch. 720, § 646/50; Iowa Ann. Code § 726.6; Kan. Ann. Stat. § 21-5601(b)-(c); Ky. Rev. Stat. § 218A.1443; Minn. Ann. Stat. § 609.378; Miss. Ann. Code § 97-5-39(4); Mo. Ann. Stat. § 568.045; Mont. Ann. Code § 45-5-622(3), (5)(b); Wash. Rev. Code § 9A.42.100; and Wyo. Ann. Stat. § 6-4-405

⁸⁶ Ariz. Rev. Stat. § 8-201(2), (25); Ark. Ann. Code § 12-18-103(3)(A); Colo. Rev. Stat. § 19-1-103(1)(a); Ind. Ann. Code § 31-34-1-2; Iowa Ann. Code § 232.68(2)(a)(6)-(7); Mont. Ann. Code § 41-3-102(7)(b); N.M. Ann. Stat. § 30-6-1(I)-(J); N.D. Cent. Code § 19-03.1-22.2; Okla. Ann. Stat. Tit. 10A, § 1-1-105(21)(e), (23), (48)(b); Or. Rev. Stat. § 163.547; Pa. Cons. Stat. Tit. 23, § 6303(b.1)(8)(vi); S.D. Codified Laws § 26-8A-2(9); Tenn. Ann. Code § 37-1-102(23)(D), (E); Vt. Fam. Serv. Pol. Man., Policy 50; Va. Ann. Code § 63.2-100; and Wis. Ann. Stat. § 48.02(1)

⁸⁷ These states are Arizona, Iowa, and Montana; specific statutes cited above

statute is specific to the manufacture of methamphetamine and phencyclidine (commonly known as PCP).⁸⁸

C. Family Drug Courts

The FDC concept was developed in conjunction with the Office of Juvenile Justice and Delinquency Prevention in an effort to combat the rising number of drug-related cases entering dependency courts across the United States.⁸⁹ This need has intensified with the onset of the national opioid crisis, with 40-80% of child abuse and neglect cases now involving substance abuse by at least one parent or guardian.⁹⁰ FDCs emerged in part to align the requirements of the Adoption and Safe Families Act (ASFA) of 1997⁹¹ with the unique challenges presented by parental substance use. One of ASFA's new requirements was that permanency hearings take place within 12 months of a child first being placed in foster care.⁹² This timeline proved especially difficult for parents recovering from substance abuse, decreasing their chances of achieving family reunification. Therefore, FDCs were established to facilitate access to treatment programs, provide additional monitoring for parents undergoing treatment, remove barriers to access, and integrate treatment programs with related services.⁹³

⁸⁸ Cal. Health & Safety Code § 11379.7

⁸⁹ Office of Juvenile Justice and Delinquency Prevention, National Strategic Plan for Family Drug Courts, (2017)

⁹⁰ Nancy K. Young et al., *Parental Substance Use and Child Maltreatment: Overlaps, Gaps and Opportunities*, 12 Child Maltreatment 137, 138 (2007)

⁹¹ The Adoption and Safe Families Act of 1997, 42 U.S.C. §§ 670-679

⁹² See 42 U.S.C. §§ 675(5)(C)(i): "Procedural safeguards will be applied, among other things, to assure each child in foster care under the supervision of the State of a permanency hearing to be held, in a family or juvenile court or another court (including a tribal court) of competent jurisdiction, or by an administrative body appointed or approved by the court, no later than 12 months after the date the child is considered to have entered foster care...which hearing shall determine the permanency plan for the child that includes whether, and if applicable when, the child will be returned to the parent, placed for adoption and the State will file a petition for termination of parental rights, or referred for legal guardianship..."

⁹³ The OJJDP's Guidance to States gives the following examples of needs addressed by related services: "mental health, domestic violence, Court Appointed Special Advocates (CASA) for children, primary and oral health, childcare, housing, transportation, and employment-related services." Children and Families Futures, *Guidance to*

Family drug courts can be structured in three ways: parallel, integrated, and dual-track or two-tiered. A parallel court separates the drug court and dependency court, with separate judges overseeing each process. An integrated court combines the two, with the same judge overseeing both. The two-tiered model starts with an integrated court, then separates into parallel courts for parents that do not meet their goals in the integrated court.

D. Selected Family Drug Court Examples

1. Pima County Family Drug Court

The Pima County Family Drug Court was established in 2001 and was one of the earliest adoptions of the FDC model.⁹⁴ The court is parallel: it does not have jurisdiction over the dependency court process but offers separate judicial oversight for the parental substance use treatment ordered as part of dependency court case plans.⁹⁵ Parents in the program are required to start by observing a session of family drug court. After this observation, they meet with a court case specialist to review the program requirements and undergo a needs assessment to determine suitable treatment options. Participants then begin attending their assigned treatment program, and their case specialist prepares reports on their progress for the judge. The program has three levels, with participants on the first level being required to attend weekly court sessions. Once participants have displayed progress in treatment, they can move to biweekly sessions at the second level, and monthly sessions at the third. Non-compliance with the program is addressed with sanctions, which range in severity from community service hours to spending 48 hours in jail.⁹⁶

States: Recommendations for Developing Family Drug Court Guidelines, at 12(2013 rev 2015). Available at <http://www.cffutures.org/files/publications/FDC-Guidelines.pdf>

⁹⁴ Jose Ashford, *Treating Substance-Abusing Parents: A Study of the Pima County Family Drug Court Approach*, 15 *Juvenile and Family Court Journal* 46 (2004)

⁹⁵ *Id.* at 29

⁹⁶ The eleven possible sanctions employed by the PFDC are “(1) restrictions on associations and travel; (2) community service; (3) written essays; (4) increased treatment sessions; (5) increased court appearances; (6)

2. Sacramento Dependency Drug Court

The Sacramento Dependency Drug Court (SDDC) is also a parallel court but does separate into different tracks based on parents' success in reaching treatment goals.⁹⁷ If parents are compliant throughout the program, they participate in hearings monthly throughout the 180-day program. However, parents that are not reaching treatment milestones by the 60 day point in the program are placed into a separate, more intensive track, which requires weekly or biweekly hearings.⁹⁸ The program uses tiers of incentives and sanctions to encourage treatment compliance as participants advance in the program. If a participant is accused of non-compliance but denies it, they can challenge the accusation at a "show cause" hearing before the presiding judge.⁹⁹ At their final hearing, participants who have completed the program are given a graduation certificate and are encouraged to share their recovery story with their meeting group.¹⁰⁰

A 2007 study on SDDC outcomes found that children who had been removed from parents who enrolled in the SDDC were significantly more likely to be reunified with their parents at the 24 month point in the program.¹⁰¹ Additionally, children in the SDDC group spent significantly less days on average in out-of-home placements, such as foster care.¹⁰² The analysis also found

increased 12-step meetings; (7) increased drug testing; (8) up to 48 hours in jail; (9) residential treatment; (10) delay in graduation to the next level or from the program; and (11) dismissal or suspension from the family drug court." *Id.* at 30

⁹⁷ Boles et al., *Sacramento supra* note 20 at 163

⁹⁸ *Id.* at 164

⁹⁹ *Id.* at 165

¹⁰⁰ *Id.*

¹⁰¹ *Id.* at 169

¹⁰² *Id.*

significant differences in the rate of treatment entry between SDDC parents and the comparison group. However, it did not find significant differences in the rate of treatment completion.^{103 104}

VI. Conclusion

The negative effects of exposure to parental SUD are well documented in medical and social services literature. Similarly, the lasting effects of child welfare involvement and family separation are widely known. Decision makers in the child welfare system and related service providers should create policies and implement practices that account for both the harms of parental SUD on children, and the negative impacts of family separation. Social services systems, and public health agencies should prioritize early intervention for these families in an effort to avoid the child welfare system upstream and before involvement is imminent. Without these efforts, we can expect little to change for families, and for the harms of substance use and child welfare system involvement to remain prevalent in our communities.

¹⁰³ *Id.*

¹⁰⁴ Researchers in this study noted the methodological difficulties of conducting outcome studies on drug courts, primarily the small sample sizes and lack of randomization. They suggest a study that incorporates a comparison group, a group in the DDC program with a recovery specialist, a group in the DDC program without a recovery specialist, and a group assisted only by a recovery specialist. This isolation of the program components could determine which components are most effective, and the specific links between certain components and outcome measures. This is a helpful suggestion for future research studies on family drug courts.