



State-Level Policy Advocacy for Children Affected by Parental Substance Use

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Introduction

This advocacy guide:

- Provides compelling data to demonstrate that alcohol and drug use is a key factor in a high percentage of child welfare involved families
- Outlines eight barriers to taking substance abuse seriously in the child welfare system
- Summarizes five levers for advocates aiming at going beyond pilot projects to systems change
- Highlights policy and practice innovations that advocates can promote

State-level policy advocates working in the field of child welfare face many challenges. At the same time, they have many opportunities to build on programs that have proven successful in improving child welfare outcomes. In many ways, child welfare is an open system, requiring support and close collaboration from other agencies and from the community to achieve its goals. For advocates, that means a wider lens for advocacy is often needed, extending beyond child welfare to advocate for the resources needed by the child welfare system from other agencies and systems.

The needs of the children and families affected by child abuse and neglect can be so immediate that at times the symptoms of child maltreatment can receive more emphasis than their causes. Advocates can make headway on goals to prevent child maltreatment and keep families together by working on the causative factors that bring families to the attention of child welfare services before the abuse or neglect occurs, especially substance use, mental disorders, family violence, and family poverty.

Chart 1 makes two points for advocates to consider:

- The growth in recognition of substance abuse as it affects removal of children from their homes
- The great variations among states in identifying, recording, and responding to the use of alcohol and other drugs (AOD) as it increases risks to the safety and well-being of children

Yet, most child welfare practitioners would react to this data as a major under-statement of the importance of alcohol and drugs in child welfare. In fact, there is widespread recognition across the child welfare system that substance use is an underlying factor for the majority of families involved with the child welfare system, especially in cases where removal of children is necessary.

Chart 1: Parental AOD Abuse as Reason for Removal in the United States, 1998-2012

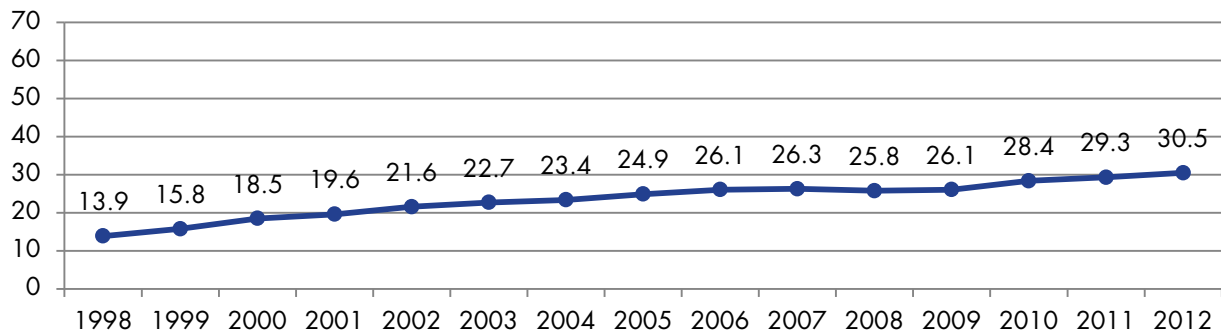


Chart 2 underscores the wide variations among states in detecting and recording substance abuse as an element of child maltreatment.

Chart 2: Parental AOD Abuse as Reason for Removal, 2012

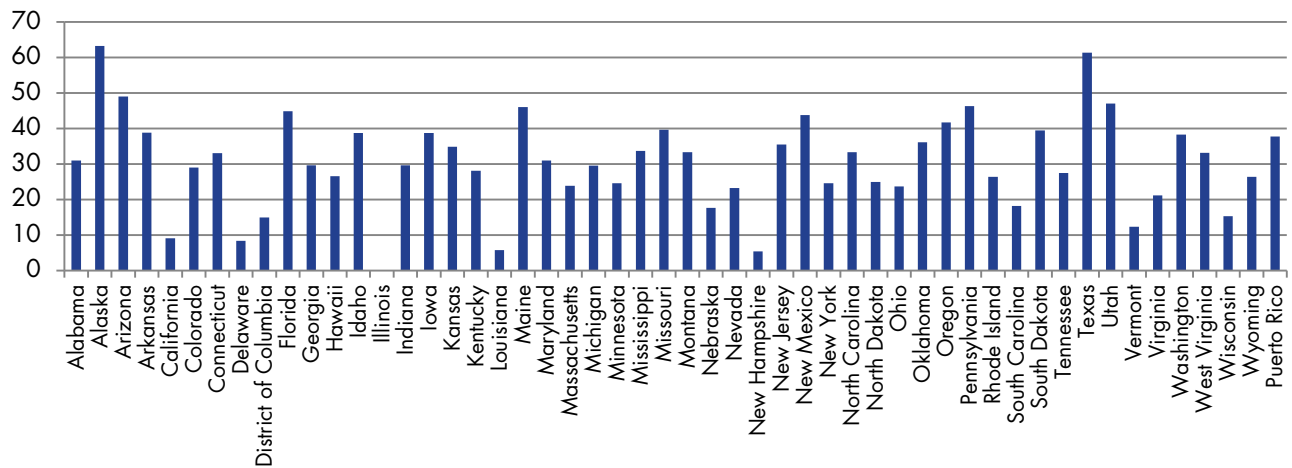
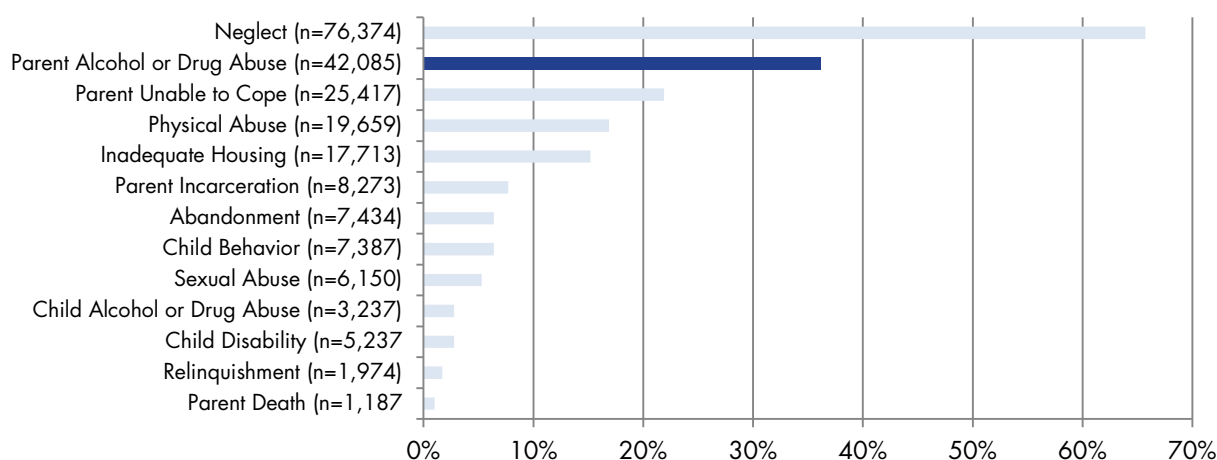


Chart 3 makes clear that substance abuse, while certainly not the factor that drives all child welfare cases, is one of the most important factors in parents losing their parental rights. For advocates, the question this raises is whether the state agency devotes proportionate attention to substance abuse as it affects risk, removals of children, and terminations of parental rights.

Chart 3: Percent and Number of Children with Terminated Parental Rights by Reason for Removal, 2012



Incidence of Child Exposure to Parental Substance Use

More than 8.3 million children, or 11 percent of all children in the United States, live in homes where at least one parent or caretaker has a substance use disorder involving AOD.¹ Parental substance abuse places the family at an increased risk of child abuse, neglect, and trauma. Most of these children are not identified by child-serving agencies. Two-thirds of children in foster care had lived with someone with an AOD problem, according to the recent analysis of the 2011-2012 National Survey of Children's Health.² Substance abuse problems are especially severe among families with infants in foster care, who make up a disproportionately large percentage of first-time admissions to out-of-home care, consisting of 24 percent of first-time admissions in urban areas. The challenge is responding to these issues with early identification and early intervention in providing these children and their parents with needed services. The National Survey of Child and Adolescent Well-being data reviewed by Chapin Hall researchers found that caseworkers reported active AOD abuse by caregivers for nearly 41 percent of older children and almost 61 percent of infants.³

Another critical statistic is the estimate from federal sources that as many as 15 percent of live births were prenatally exposed to AODs, which yields an annual total of 585,000 infants whose life chances may be at risk due to the effects of that prenatal exposure and the accompanying family stress and instability.⁴ Again, most of these infants are not identified as prenatally exposed, despite federal legislation in the Child Abuse Prevention and Treatment (CAPTA) amendments of 2010. CAPTA requires states to have a plan for safe care of prenatally exposed infants and a plan for receiving referrals of such births from child protective services.⁵ The intent of these agreements is to enable mothers' enrollment in treatment and to ensure safety for children.⁶

When all of this evidence of the importance of substance abuse in child welfare is added up, a strong case can be made for expanding the policy goals of the child welfare system from safety, permanency, and child well-being to include recovery for the many parents affected by AOD. Without resources and results focused on recovery, the other three goals are much less likely to be achieved. Greater attention to timely access to effective treatment can be the glue across the child welfare and treatment systems that make all four goals possible.

Barriers to Increasing the Emphasis on Substance Abuse in Child Welfare Cases

Good policy advocacy must anticipate who will favor and who will oppose a policy change, and why. Child welfare officials do not consistently respond to substance abuse as an issue for some understandable reasons, just as substance abuse system administrators may not respond to the need to provide specialized services to the children in the child welfare system. It is important to recognize the origins of both kinds of resistance so advocacy efforts can prepare to respond. Child welfare and treatment agency attitudes may not always be founded on facts, but they can still be powerful obstacles to change. These attitudes include the following concerns, which advocates can address in several ways:

Reason 1: “Treatment will not work for most parents.” This is founded in a root belief held by many professionals and laypeople alike that “once an addict, always an addict.” It is based on prejudice, a lack of information about the science of addiction, and lack of familiarity with successful programs. However, it may also be based on the reluctance of proponents of treatment to acknowledge that treatment does not always work and that the outcome for first-time entry to treatment may not be completion or recovery. What this ignores is that the savings for those parents who do recover and re-unify with their children, as well as the benefits for the children, are more than enough to justify greater investments in effective treatment. One analysis suggested that the cost savings from as few as one-third of parents recovering from their substance use disorders would more than pay for the costs of treating all parents in the child welfare system with substance abuse problems.⁷

Reason 2: “The treatment system is not responsive to child welfare clients and/or the child welfare system.” This is founded on skepticism, based on practical experience in some cases, about the capacity or willingness of the treatment system to enroll and give priority access to clients from the child welfare system. There are multiple facets to this skepticism, within both the treatment system and child welfare systems, as described in the following sections.

Reason 3: “We cannot be held accountable for systems that we do not control.” This is a much more pragmatic concern, based in part on budget realities of the past several years, in which cuts to all health and human services agencies force concentration on resources that are under the direct control of agency heads. The deeper issue here is that child welfare agencies have difficulty, at times, acknowledging that they do not themselves have control of the resources they need to achieve their mandated results. They need and deserve help from other agencies. Services beyond their direct control may be needed, but they can be more challenging to negotiate with equals, rather than subordinates.

Reason 4: “The slots are not there.” This is rarely based on an accurate, up-to-date inventory of treatment resources across the various levels of care, such as residential, outpatient, or detox. Most often this attitude arises from bad experience with child welfare referrals that are not followed up with adequate recovery support or based on thorough interagency negotiations for set-asides or priority status. States and localities that have done the analysis have found that as little as 5 percent of all available treatment slots could provide universal treatment for all child welfare parents who enroll and engage in treatment with supportive staffing and retention efforts. But not knowing these numbers, which are readily available online, makes it impossible to refute the claim that there are no slots.

In some states and localities, as few as 5 percent of all available treatment slots would provide treatment for all parents in the child welfare system who needed it and would enroll.

Reason 5: “Treatment is voluntary and we cannot force parents to enroll.” In recovery, while it is true that some parents are non-compliant, there is ample evidence that many others have responded to a combination of incentives and sanctions through family drug courts and motivational approaches from trained staff who understand addiction and recovery.

Reason 6: “Treatment quality for parents is weak.” It is true that many treatment programs do not include the full elements of good practice set forth in publications by the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute of Drug Abuse, and other organizations that describe standards and dosage for quality treatment. To the extent that insurance is involved, insurance (and Medicaid) coverage is rarely in conformance with recommended standards of dosage and quality. If a 90-day course of treatment is described as the minimum for effectiveness, but the typical treatment program is a 30-day program, this skepticism is justified. The answer, of course, is not refusing to refer parents, but to refer them to programs that meet these standards and to advocate for program effectiveness measures that legislators can use to direct funding to the most effective agencies and programs.

Reason 7: “Substance abuse is just one more thing that these parents cope with.” It is true that many parents deal with mental illness, domestic violence, and poverty in addition to substance abuse. But the charts above make clear that it is one of the most important things that results in termination of parental rights, and that it can also greatly increase the risks to those children who remain at home after a substantiated charge of abuse or neglect.

Reason 8: “We are already doing it.” The “WADI response” at times includes the statements that “We already have interagency meetings,” or, “We already have a joint pilot project with outside funding.” But none of these are evidence of an effort at scale to respond proportionately to the impact of substance abuse in child welfare. And sometimes collaborative processes may substitute for collaborative results. Interagency meetings do not guarantee results at the practice level where caseworkers try to respond to clients. Such process-heavy meetings can displace the real mission of the collaborative by focusing on what agencies are doing rather than how children and families are doing.

What Has Been Tried? What Works? Practice Changes and Policy Approaches

To respond to the impact of parental substance abuse on child welfare, several reforms and innovative practices have been attempted. These can be sorted into those innovations that are primarily in the practice area and those that focus more on policy changes. Five basic types of practice innovation have been used to forge stronger ties among child welfare, treatment agencies and, the courts.⁸

Screening of parents for substance use and training staff to improve their ability and willingness to detect and record parental substance abuse, adoption of universal screening tools such as UNCOPE and the GAIN Short Screen.⁹

- In Maine, Oklahoma, Florida, and New Jersey, states adopted universal screening methods or assessed the screening they are now doing within child welfare caseloads to determine the prevalence of substance abuse among the families in the system.

Screening and assessment of children for the effects of substance abuse. Prenatal screening, screening at birth, and developmental screening as required by CAPTA should be in place for all children under age 3 in substantiated cases. But at present, these processes are in place in few states and localities, and very few provide annual totals of those screened and the results of the screening in aggregate. In the field of human services policy, an axiom is that “You cannot coordinate what you cannot count,” and inadequate screening of the conditions of children is an example of the reality behind the saying.

Engagement, treatment, and retention of parents can be more successful with **models such as recovery coaches, peer mentors, navigators, and other forms of parent support.**¹⁰

- The Miami, Florida, family drug court’s Engaging Moms Program, an evidence-based family intervention program, provides case management by specially trained case workers for mothers in treatment programs. Recovery coaches and peer advisors have been used in numerous programs as a means of improving retention in treatment programs.¹¹

Evidence-based programs for parents and children affected by substance abuse should be leveraged by child welfare agencies.

- Parenting programs that take substance abuse into account include Celebrating Families, Strengthening Families, and others described in the SAMHSA Children Affected by Methamphetamine grant program.¹²
- Interventions that emphasize parent-child relationships and the effects of trauma including Parent-Child Interaction Therapy and Parent-Child Psychotherapy, as implemented through Medicaid changes in Nebraska.
- In Illinois, the state child welfare agency contracts with a provider to do developmental assessments and provide therapy to prenatally exposed children. In several sites, prenatal screening for substance use is combined with post-natal follow-up services for infants and parents, using a framework for services to substance-exposed infants set forth in a SAMHSA report and highlighted in the 2012 National Drug Control Strategy.¹³

Training child welfare workers and others involved with substance abuse as it affects children and families.

- More than 55,000 persons have registered for the online training offered by the National Center on Substance Abuse and Child Welfare.¹⁴ North Carolina has done extensive clinical training throughout their seven-year funding with a Regional Partnership Grant. This training does not seek to make child welfare workers experts in substance abuse, but to familiarize them with the fundamentals of addiction and recovery.

Four Key Policy Approaches

Policy innovations that aim at stronger links among child welfare, treatment agencies, and the courts include the following four strategies:

Priority treatment for child welfare clients in treatment and other systems.

- State and county statements of policy providing child welfare parents priority access to treatment (Arizona, Sacramento, Massachusetts, Pennsylvania, Santa Clara County), stronger linkage to child development, early care programs that admit a portion of child welfare clients as priority cases, housing set-asides for transitional and supportive housing for families in recovery, and ensuring that clients of

federally funded home visiting projects include prenatally exposed infants and younger children of substance-affected parents.

Family Drug Court models (more than 350 now exist) and inclusion of families with children in adult drug courts (Montana and some veterans treatment courts have moved toward a family-centered approach).¹⁵ These programs have proven their capacity to achieve results in treatment success and family reunification that exceed those of family courts operating without the key ingredients in family drug courts: identification of families, early access to assessments and treatment, increased judicial supervision, increased case management of recovery services, and timely and collaborative responses to behavior.

Development of **multi-year strategic plans for child welfare-treatment linkages** at state and local levels that implement systems linkages interagency agreements for communication, access to services and shared staffing, and data sharing aimed at shared outcomes:

- Connecticut developed a strategic plan combining efforts from child welfare and treatment agencies.
- Kentucky, Sacramento, and other sites have negotiated data sharing agreements that ensure that parents can be tracked from child welfare and the courts through treatment programs. Models of this kind of data-sharing are described in a separate publication on interagency information systems.¹⁶

Changes in financing methods for treatment and other services for children and parents affected by substance abuse:

- IV-E waivers
- Medicaid waivers
- Dedicated taxation on alcohol, tobacco, and other sources of revenue used for children’s services and/or treatment; alcohol taxation based on the total costs of alcohol to the state
- Dedicated taxing districts (Florida)
- Special focus taxes (California mental health and early childhood programs)
- Social bonding/finance methods that rely on revenues from future cost offsets (Maryland, Oregon, Connecticut)
- Affordable Care Act expansion of treatment funding streams, including home visiting programs

Policy Advocacy Aiming at Enforcing Laws Already on the Books

Sometimes advocacy is best aimed at legislative oversight rather than new legislative enactments. Enforcing laws and regulations already on the books can be more important, and can leverage considerably more funding, than securing token-level allocations for new programs. Examples include CAPTA regulations, evolving interpretations of “reasonable efforts,” state insurance agencies’ interpretations of the Wellstone parity regulations, and wide differentials among counties’ child welfare outcomes, which are available in some, but not all states’ online information bases or can be requested as part of states’ mandated reporting to the U.S. Departments of Health and Human Services.¹⁷ Persuading legislators to ask questions about enforcement of these laws and regulations in budget hearings and oversight reviews can have a significant effect on executive agencies’ priorities, especially if legislators return to those questions in more than one budget cycle to demonstrate their ability to persevere in paying attention to these issues.

Legislators can also ask for better data than child welfare and treatment agencies sometimes provide to report on their effectiveness over time. Advocacy based on a core set of key numbers can provide a score card that allows an annual accountability review. Knowing how states compare with other states is increasingly possible

with federal and policy research organizations' annual reports, such as Kids Count, the Guttmacher Institute's reviews of prenatal policies, the annual Adoption and Foster Care Analysis and Reporting System and Child Maltreatment reports, and the Treatment Episode Data Set and other reports available from SAMHSA that track mental health and substance abuse treatment enrollments, completions, and treatment availability.¹⁸

Advocates should also be aware of the leverage provided by the state's participation in the Child and Family Services Review (CFSR) process that has been revised to begin a new cycle of state reviews in 2015. The CFSR process requires states to prepare a summary of key child welfare outcomes, including the array of services that should in all cases include substance abuse treatment services for parents who are involved in substantiated cases involving AOD abuse. Requesting status as part of the stakeholder teams, requesting a role in the case reviews that are done as part of the CFSR, and requesting that data on referrals to and completions of treatment programs all provide opportunities to increase the spotlight on the effects of substance abuse in the child welfare system.

Data and Information Systems as Advocacy Tools

Maintaining databases that include the most recent annual child welfare, children's services, and treatment data by county or locality can help advocates see where enforcement and program implementation is strongest and weakest. This data can also make clear how many children are entering out of home care, as well as the much larger number of substantiated cases who remain home or are returned home, suggesting strongly that in-home services should get proportionate attention along with concern for the adequacy of out-of-home care. The data available on the increasing number of diverted, alternative response cases, and what actually happens to them, is a further data set that makes clearer what is happening in child welfare caseloads. Data is also available on ethnic disparities, including the responses to families who are Native Americans, which can spotlight child welfare agencies' responses to these groups, some of which have disproportionate enrollments in child welfare caseloads. Treatment data that tracks length of stay in treatment and positive completions can also help advocates to monitor the important differences between referral to treatment and referral to *effective* treatment.

An additional tool is a dropoff analysis, in which referrals for children and family services are tracked at multiple levels, including referrals to service, enrollments in service, completions of service program requirements, and final outcomes such as reunification and recovery. Seeing where parents drop out of treatment or do not achieve positive outcomes, even when referred to services, is an important indicator of agencies' effectiveness in monitoring the engagement of families in services and serving children and families. New Jersey, Florida, and other states have used these data to understand where parents are enrolling and where they are dropping out of treatment.¹⁹

A dropoff analysis is an advocacy tool because it measures the difference between clients who enter child welfare, are screened, assessed, and referred to treatment, those who enroll, those who complete treatment, and those who do not reunify in a given period of time. Just counting "heads and beds" is not an effective way of measuring results.

Responding to Half-Measures: Reorganization and Commissions

Creating a new agency, interagency body, or commission is not an automatic win for advocates, especially if implementation of the new body becomes a reason for delaying more concrete remedies. But having an agency or commission with a clear charge to look at the entire child welfare system, as well as the resources it

needs from other agencies, can be a step forward. Children’s cabinets have been created in New Hampshire and other states; commissions are currently or recently assessing child welfare issues and child fatalities in Arizona, California, Florida, Los Angeles County, and other states and localities.

Some of these commissions and interagency bodies have cast a wide net in examining policy options, and have used data effectively to ask questions about the impact of child welfare reforms and the underlying causes of child abuse and neglect. In others, however, policy and recommendations have been narrower and less effective. Some have added new investigative and front-line caseworkers without addressing their training, the information systems they will use, the services needed by parents and children, or the other agencies they will need to work with in new roles. Staffing matters, and high caseload ratios are an important obstacle to effective child welfare efforts.

But child welfare staffing without the supports needed by the new and existing staff, including staff from the other service systems needed to support families, is at best a partial answer, and may expend resources that could more usefully help ensure that new staff have the support they need from other agencies.

Advocates should review these reports carefully to ensure that these recommendations address issues that may go well beyond the boundaries of the child welfare system to the underlying causes and risk factors affecting child maltreatment. Does the proposed remedy mobilize new resources beyond the child welfare system, or does it assume the child welfare problem can be solved solely by reorganizing and other changes within child welfare systems?

Creating a new agency or a commission can at times be a setback for advocacy, since it may be used by policymakers to freeze action pending the establishment of the new unit or the commission’s report. What matters is not the charge given to the new unit or commission, but what longer-term commitment exists to implement its recommendations.

Prevention as an Advocacy Strategy

Upstream child welfare and early childhood efforts can provide services and supports to families before they reach crisis stage. Advocates should ask what resources are devoted to these front-end prevention efforts compared with those aimed at later interventions that are more costly. This review should include programs that refer cases to community agencies as an alternative response, meaning advocates should ensure that these agencies have the resources to provide evidence-based treatment and the information system to document results. Again, programs and agencies outside the child welfare system such as early childhood development, maternal and child health, and home visiting may be at least as important as those inside it in lowering caseloads by keeping families out of the system.

The special needs of adolescents affected by maltreatment and substance abuse are a key advocacy target, in light of the poor outcomes many of these older youth exhibit. Youth who have been or are in out-of-home placements show much higher rates of substance use than other youths of the same age ranges.²⁰ Their higher risks for adverse effects due to maltreatment and neglect, as well as their own higher substance use, strongly argue for programs that seek to prevent problems for youth aging out of child welfare, delinquency, and other systems from becoming problems experienced by young adults.

A final point about prevention involves the importance of balancing child well-being with family well-being. Several excellent reviews of child well-being as a priority in child welfare have recently appeared, including one in this State Policy and Advocacy Reform Center series of policy briefs.²¹ A challenge in implementing child well-being, however, is ensuring that advocates do not overlook a crucial lesson from the substance abuse field: the best prevention for children can be treatment for the child’s parents. The risks of a child in the child welfare system whose parents are affected by AOD themselves becoming a substance abuser are much higher than those for other children, so prevention for children involves treatment for parents to achieve a balanced, whole-family approach. Moreover, the evidence is strong that family treatment programs can be more effective than parent-only programs that do not seek a two-generation impact by including both children and parenting issues in treatment. Child well-being without a specific focus on parents’ well-being misses important opportunities for prevention impact, as does parent treatment without attention to the special needs of children affected by parental substance use.

The basic numbers in child welfare caseloads illustrate the need for child and parent well-being:

- Only 20 percent of children in substantiated abuse or neglect cases are removed
- Approximately half of those children removed will be reunified with their parents

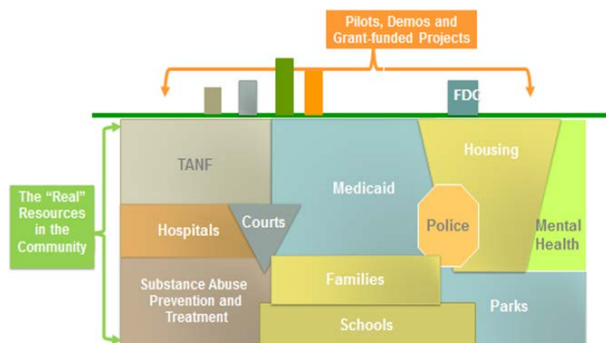
So about 90 percent of children in substantiated cases either remain home or return home to their parents. Parents’ recovery happens in the treatment system, but it has direct effects in the child welfare system as well.

The best prevention for children can be effective treatment for their parents.

Sustaining What Works as an Advocacy Strategy

Child welfare innovations often begin with external funding, and then encounter the challenges of sustaining the project with another grant. This ignores the reality that far more current funding is already available in the state or locality than new grant funding that could be accessed. Chart 4 illustrates the differences between more visible projects and the larger, but less visible funding from institutionalized funding sources.

Chart 4: Redirection of Resources Already Here



Advocates should also recognize that when a child welfare agency (or its partners) state that it cannot support a new and effective program with their existing funding, they are, in essence saying that everything they are now doing is more important than the new program, regardless of its proven effectiveness or long-term cost savings. That can be a difficult position to defend when the innovation has strong evaluation findings that prove its outcomes and support its claims for continuing resources.

A critical issue for advocates in child welfare is to compare the benefits of a new line-item program with those resulting from a higher priority for child welfare families in getting resources from existing sources. As discussed above, in some states and localities, child welfare clients are explicitly given priority status in allocating treatment slots, whether funded from the Substance Abuse Prevention and Treatment Block Grant, Medicaid, or other sources. Giving children priority access to Head Start, IDEA services for children with disabilities, and other services can also be more effective for more children than a new pilot project. Advocates need to weigh the advantages of priority status against the effort required to enact a new program that may often remain at token levels of funding.

As examples, Travis County, Texas, has developed a thorough sustainability planning process that aims at securing new funding for the components of a federally funded family drug court project. Oklahoma uses Temporary Assistance for Needy Families funding to provide treatment services for parents, including child welfare families. Washington, D.C., uses IV-E waiver funding for in-home treatment services, drawing upon a model from Rhode Island. Many models of closer child welfare-treatment-court linkages have been sustained by redirecting local funding once demonstration grants have proven their worth, as described in a Report to Congress on the Regional Partnership Grants.^{22,23,24}

A new pilot project may affect far fewer children and families than giving those families in the child welfare system priority access to other agencies' services.

Conclusion

State and local advocates for improved child welfare outcomes need to consider whether AOD effects on families are getting the level of attention that their prevalence demands. If these needs are not being addressed effectively, there are remedies that advocates can propose and support, drawn from the numerous models of practices and policy changes described in this paper. These models have worked to connect child welfare, treatment agencies, courts, and other agencies that can help families affected by substance abuse. Advocates need to work beyond the boundaries of the child welfare system to achieve better family outcomes, and partnership with advocates in these other arenas may be an important step toward working in these new arenas to achieve greater effectiveness for children and families.

Additional Resources from Children and Family Futures

Collaboration, if it is more than just meetings, has many dimensions. To make collaboration operational, a ten-element framework for collaboration among child welfare, treatment agencies, and the courts has been developed. This Collaborative Capacity Instrument enables child welfare agencies to self-assess their current and evolving ability to work across systems and secure the resources and cooperative efforts they need to reunify families and protect children.

A related tool that could also help advocates when underlying values are at issue among agencies is the Collaborative Values Inventory, which provides a neutral way of assessing how much collaborative members agree or disagree on the values that guide their work and influence their policy and practices. These tools are available at www.cffutures.org.



The First Focus State Policy Advocacy and Reform Center (SPARC), an initiative funded by the Annie E. Casey Foundation, Jim Casey Youth Opportunities Initiative, and Walter S. Johnson Foundations, aims to improve outcomes for children and families involved with the child welfare system by building the capacity of and connections between state child welfare advocates.

You can visit us online at www.childwelfaresparc.org or on Twitter at [@ChildWelfareHub](https://twitter.com/ChildWelfareHub).

This policy brief has been reviewed by Jennifer Miller and Rebecca Robuck of ChildFocus, and their comments have improved it significantly. This policy brief was prepared by Children and Family Futures and is not intended to reflect the views of its funders or partners.

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Notes

¹ Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2009). *The NSDUH Report: Children living with substance-dependent or substance-abusing parents 2002:to 2007*. Rockville, MD. Retrieved from <http://www.samhsa.gov/data/2k9/SAParents/SAParents.htm>.

² Matthew D. Bramlett and Laura F. Radel, “Adverse Family Experiences Among Children in Nonparental Care, 2011–2012.” Department of Health and Human Services, Office of the Assistant Secretary. National Health Statistics Reports Number 74, May 7, 2014.

³ Fred Wulczyn, Michelle Ernst, and Philip Fisher “Who Are the Infants in Out-of-Home Care? An Epidemiological and Developmental Snapshot” Chapin Hall, University of Chicago. May 2011.

⁴ Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2009). *The NSDUH Report: Children living with substance-dependent or substance-abusing parents 2002:to 2007*. Rockville, MD. Retrieved from <http://www.samhsa.gov/data/2k9/SAParents/SAParents.htm>.

⁵ Children’s Bureau, Administration for Children and Families. (2011). *CAPTA Reauthorization Act of 2010 P.L. 11-320*. Retrieved from: https://www.childwelfare.gov/systemwide/laws_policies/federal/index.cfm?event=federalLegislation.viewLegis&id=142.

⁶ Children’s Bureau, Administration for Children and Families. (2014). *Adoption and Safe Families Act of 1997 P.L. 105-89*. Retrieved from https://www.childwelfare.gov/systemwide/laws_policies/federal/index.cfm?event=federalLegislation.view.

⁷ N. Young, S. Gardner, and K. Dennis, (1998) *Responding to Alcohol and Other Drug Problems in Child Welfare*. Child Welfare League of America. 105.

⁸This section draws upon the “Collaborative Practice Model,” evaluation data from the Children's Bureau’s Regional Partnership Grants funded by PSSF, including four annual Reports to Congress, evaluations of SAMHSA’s Children Affected by Methamphetamine Grants, and other recent evaluations. These are available at www.cffutures.org and www.ncsacw.samhsa.gov.

⁹ These are other screening tools are described in more detail at <http://www.cffutures.org/presentations/screening-and-assessment-family-engagement-retention-and-recovery-%E2%80%93saferr-guidance-st>.

¹⁰ Center for Substance Abuse Treatment. (2010). *Substance Abuse Specialists in Child Welfare Agencies and Dependency Courts: Considerations for Program Designers and Evaluators*. HHS Publication No. (SMA) 10-4557 Rockville, MD: Retrieved from <http://www.ncsacw.samhsa.gov/files/SubstanceAbuseSpecialists.pdf>.

¹¹ Center for Substance Abuse Treatment. (2009). *Engaging Parents in Substance Abuse Treatment: The Role of Recovery Specialists and Drug Testing in Child Welfare and Dependency Courts*. Rockville, MD: Retrieved from http://www.cffutures.org/files/presentations/OCAN%20Engaging%20Parents_03312009.pdf.

- ¹² Children and Family Futures. (2014). *Family Drug Courts (CAM)*. Retrieved from <http://www.cffutures.org/projects/family-drug-courts-cam>.
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- ¹⁴ More information on the National Center on Substance Abuse and Child Welfare Training and Tutorials is available at <http://www.ncsacw.samhsa.gov/training/default.aspx>.
- ¹⁵ More information on FDCs is available at www.cffutures.org and <http://www.nadcp.org/>.
- ¹⁶ Nolan, C., DeCerchio, K., Ensign, K., Arthur, B., Boles, S., and Cook, M. (2008). *Connecting the Dots: How States and Counties Have Used Existing Data Systems to Create Cross System Data Linkages*. Retrieved from <http://www.cffutures.org/webinars/connecting-dots-how-states-and-counties-have-used-existing-data-systems-create-cross-system>.
- ¹⁷ The Child Abuse Prevention and Treatment Act (CAPTA) requires states to develop plans for safe care for infants who are detected as prenatally exposed to drugs or alcohol, and also requires referrals to early intervention agencies for all child welfare cases under the age of 3. But most states do not even count these referrals or what happens as a result. Reasonable efforts to serve parents whose children have been removed can be satisfied with little more than a referral slip given to a parent. The Wellstone-Domenici Mental Health Parity Act of 2008 requires that drug and alcohol treatment be given parity with insurance coverage for basic health services.
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