partners forourchildren

March 2019

Systems improvements for child welfare involved parents who are impacted by substance abuse

Note: This research brief was developed by Antonia Eberhart, MSW during her practicum at Partners for Our Children. While it has evolved since that time, and may evolve further, we are excited to share this iteration of the work, as part of our continuing policy and research efforts.

Summary

Parents involved with the child welfare system have numerous barriers that can prevent and/or delay reunification with their children. Many parents struggle with substance use disorders (SUDs) which impact their relationships with their children and the child welfare system in a myriad of ways. In the spring of 2018, we conducted a thorough literature review and stakeholder interviews. Our goals were to understand available treatment services for parents who are child-welfare involved, barriers to accessing treatment, and to create recommendations that may improve outcomes for parents impacted by SUDs and their children.

Recommendations

Overall Systems Lens

- Prioritize families who are child-welfare involved and at-risk of losing their children

Workforce Development and Training

- Require child welfare supervisors to provide regular and supportive supervision sessions and/or other trainings that address potential bias among case workers
- Train workforce using evidence-based screening methods
- Provide regular training through the Alliance for Child Welfare and the Department of Children, Youth, and Families (DCYF) on substance use disorders, co-occurring disorders, and current treatment options for parents

Service Delivery

- Conduct timely and systematic screening related to substance abuse for all child welfare involved parents
- Expand the Parent and Child Assistance Programs (PCAP) and Family Treatment Courts across Washington
- Ensure inclusion of additional parent allies
- Reinstate practice of locating Substance Abuse Specialists, ideally dually trained (and certified) in mental health and substance abuse, within Department of Children, Youth, and Families (DCYF) offices

- Increase collaborative efforts and cross-training between the courts, substance abuse treatment providers, and DCYF
- Expand available out-patient and long-term residential treatment services that ensure parents and children can stay together (including child care options) throughout the state
- Require treatment programs to provide evidence-based programming for SUDs and co-occurring disorders; increase program oversight and accountability
- Increase access to medication assisted therapy (MAT)

Background

Parents involved with child welfare, who are disproportionately low-income, housing unstable, and people of color,[1, 2] are not receiving the treatment they need for SUDs. For parents referred to programs, studies indicate only 22 – 50% of them successfully complete all program requirements.[3, 4] As parents affected by substance abuse face multiple/ a myriad of challenges, their children are more likely to experience longer stays in out of home care[5,6] and are less likely to be reunified compared to children whose parents are not impacted by substance abuse.[7] Additionally, when parents do not receive appropriate treatment and continue to abuse substances, their children are likely to experience lifelong mental health instability,[8] including substance use disorders,[9] thus perpetuating intergenerational struggles of addiction and child welfare (CW)-involvement.

The prevalence of substance abuse (SA) in the child welfare population is extensive and likely underreported. In 2016, 40% of child welfare cases nationwide[10] and 39% in Washington state[11] opened as a result of a parent's substance abuse. Other studies suggest between 40-80% of child maltreatment cases include a parent who has an SUD,[12, 13] yet only a fraction of them receive and complete treatment services,[14] resulting in severe consequences for parents and their children.

A high percentage of parents who are involved with child welfare have SUDs and co-morbid mental health diagnoses, known as co-occurring disorders,[15] ultimately creating additional barriers to access treatment services. Parents who have co-occurring disorders often require long-term integrated interventions. What may appear as "non-compliant" behavior actually may be related to a co-morbid condition, such as post-traumatic stress disorder (PTSD),[16] that makes it difficult to engage and remain in treatment.[17]

Another concern is the lack of comprehensive SA services for low-income families involved with child welfare. When an SUD is identified, the caseworker may not be able to find treatment services that meet the needs of the family. Further, when low-income parents are ready to get help, often they face additional barriers, such as lack of transportation and childcare, to enter treatment.[18]

The challenges outlined above can delay treatment and recovery, placing parents with substance abuse issues at risk for termination of parental rights. If parents cannot complete mandated services within the timelines required by the U.S. Adoption and Safe Families Act (1997), the law requires an alternate permanent plan for the child(ren).

Methods

During the spring of 2018, researchers at Partners for Our Children (POC) conducted interviews with 16 key stakeholders across Washington state. The goals were to understand available treatment services for parents who are child-welfare involved, as well as barriers to accessing treatment, and to create recommendations that may improve outcomes for parents with SUDs and their children. The table below shows the roles and organizations of stakeholders.

Table 1. Stakeholder organizations and roles

Organization	Role
The Parent and Child Assistance Program	Program Developer and Clinical Supervisors
Family Treatment Court	Program Supervisor
Children's Administration, DSHS	Program Supervisor, former Caseworkers, former Safety Administrator, former Area Administrator, and former Family Team Decision Making Facilitator
The Alliance for Child Welfare Excellence	Child Welfare Trainer
The Office of Public Defense, Parent Representation Program	Parent Representatives and Managing Attorney
Washington State Parent Ally Committee	Parent Ally
The Administrative Office of the Courts	Program Director
Washington State Department of Social and Health Services, Division of Behavioral Health and Recovery	Behavioral Health Program Manager and Child, Youth, and Family Behavioral Health Policy Manager
The Washington Recovery Line through the Crisis Clinic	Program Director
University of Washington Northwest Leaders in Screening, Brief Intervention and Referral to Treatment Programs	Program Director and former SUD Treatment Director

Results

Stakeholders identified the following barriers for parents struggling with substance use/abuse: poverty, lack of available treatment services and long wait times to get in for those that do exist, large caseloads among child welfare employees, and lack of training related to substance use and abuse. Stakeholder interview findings are consistent with the literature cited above.

► Barriers related to poverty/resources

Most stakeholders mentioned themes related to poverty and lack of statewide resources. They reported that child welfare-involved parents struggle to get into treatment. Barriers included housing, transportation, childcare, and lack of basic provisions, such as access to a phone (necessary to contact treatment providers and social workers).

"What if the parent is put on the waitlist and required to call every day until a bed becomes available, but the parent doesn't have a phone?" **Program Supervisor, Family Treatment Court**

"Accessibility is a huge barrier. If you have to take a bus for two hours to get to your assessment, and you're not on time, they say you're not taking your sobriety seriously, and the appointment gets cancelled." **Supervisor, Children's Administration**

► Lack of programs and services

Long-term residential family treatment – Nearly all stakeholders identified a paucity of substance abuse programs and services and the need for long-term residential treatment for parents, including programming about healthy parent-child bonding and attachment. They also noted that that parents involved with child welfare who need treatment frequently require childcare, rarely available on-site at SUD programs.

"A large unmet need for in-patient treatment are places where parents can be with their kids. Currently so few beds and so few locations are available for kids to be placed with parents.

"We send parents and kids to different parts of the state; a kid might be picked up in Kitsap County and the parent goes to treatment in Spokane, so they never get to have visits. And the longer-term programs are needed, especially those equipped to deal with co-occurring disorders." **Attorney, Office of Public Defense**

"There's always the issue of childcare. We don't have enough facilities that provide that service." **Program Director, Crisis Clinic**

Geographic availability -The limited geographic availability of services in Washington creates multiple challenges for child welfare workers and parents who do not live in these areas. Three treatment programs in Washington allow children; they are located in Yakima, Spokane, and Everett. As of spring 2018, two of the three programs are mothers-only. As one stakeholder noted, some parents may not be able to participate in parent-child visits due to transportation issues and treatment rules that restrict off-site travel, resulting in that may lead to separation for parents and children for months.

"Lack of substance abuse treatment causes delays in many cases…you have to coordinate and figure out rides, and the children are here and the parent is far away. Reports from all counties document an unmet need for residential treatment for mothers and children, and for fathers and babies." **Program Director, Administrative Office of the Courts**

"By the time you get to the point where you've lost custody of your kids you're in late stage addiction, so the odds are higher of needing longer term treatment. The vast majority of our parents need long-term treatment, so we send them to Yakima or Snohomish, if we're lucky, and then we have to figure out how to do visits, with questions like 'do we send the baby over the mountain?' It's not good for the baby to be spending so much time traveling back and forth, so it's a big problem." **Supervisor, Family Treatment Court**

Programming for fathers – Stakeholders report that it is particularly challenging to find residential treatment programming for fathers. Currently, Rising Strong in Spokane is the only program in Washington that offers residential treatment and family programming to fathers and children.

"We need more programs that support dads. The way our social service system is constructed, it sets up dads for failure from the beginning (i.e., child support, birth certificates). We need more

support for dads who are using drugs and alcohol, who also are able to parent and need resources." **Supervisor, Children's Administration**

Programming for parents with co-occurring disorders - Services that integrate substance use and mental health treatment are rare in Washington. Unsupported practices, such as waiting for a parent to be sober for a period of time before assessing and treating mental health diagnoses, continue to be the norm, often decreasing the likelihood the parent will remain engaged in treatment services.

"One of the things parents and attorneys have been told for decades is 'we can't do a psych evaluation until the parent is clean for 30, 60, or 90 days.' If the client has a co-occurring disorder, the person won't be able to get clean within that timeframe without that mental health piece." **Attorney, Office of Public Defense**

Treatment programs do exist in Washington that offer both mental and chemical health services, according to the *Washington State Directory of Certified Mental Health, Substance Use Disorder, and Problem and Pathological Gambling Services*, updated in March of 2018. Few, however, are licensed as integrated dual-disorder treatment programs.

"We really don't have residential treatment services for co-occurring disorders; our system is not integrated. We say we're moving in that direction, but, in order to implement we would need a shifting of Washington administrative codes. Currently, the actual treatment is likely not from a true co-occurring program." **Program Director, Crisis Clinic**

Medication Assisted Therapy –Despite high demand for medication assisted treatment (MAT), stakeholders reported waitlists and limited access throughout the state, creating many time and financial burdens for clients. Furthermore, MAT prescribers face multiple challenges to become licensed providers and access to providers is severely limited.

"Only one methadone clinic exists for Thurston, Mason, and Lewis Counties; the South Sound Clinic in Lacey. Some moms travel two hours round-trip daily to dose at this clinic." **Clinical Supervisor, PCAP**

"Recently the waitlist (for MAT) was reduced from about six months to somewhere between three weeks to 90 days. Although better, that is still an extremely long time to wait for MAT." **Clinical Supervisor, PCAP**

"For patients with adverse reactions to Suboxone, Subutex, Buprenophine, or Vivitrol and use Methadone, the nearest dispensing center is in Shoreline, Washington which can require a $35 dollar round trip ferry ride and approximately five hours driving every day." **Clinical Supervisor, PCAP**

Stakeholders reported persons taking prescribed medications to treat SUDs are often considered not truly to be "in recovery" by social workers and some peer support groups despite overwhelming evidence showing positive outcomes for these individuals.

"There's a huge gap in parents not receiving medication assisted therapy because of so much bias that recovery requires complete abstinence…yet the outcomes for people who are getting medication assisted therapy are superior." **Former Treatment Director**

► High caseloads

Nearly all stakeholders identified concerns including high caseloads and job retention, for caseworkers in child welfare.

"Smaller caseloads are necessary, and this has been an issue for many years. A direct impact and connection exists between the amount of work caseworkers can do based on how many clients they are assigned. They need support from the top down and reduced caseloads. **Supervisor, Family Treatment Court**

Stakeholders reported concerns that high caseloads make it difficult for caseworkers to spend adequate time identifying SUDs, engaging parents struggling with use, and referring them to appropriate services in a timely manner. Again, all issues that were identified in the literature.[19]

"Professionals don't get to choose when the window opens for a parent who's struggling with addiction…but when that window opens, you have to be ready to move." **Parent Representative, Office of Public Defense**

Overcoming barriers so clients can access treatment requires hand-holding and time-consuming practices on the part of the caseworker. Inquiring regularly with treatment programs about waitlists, driving parents to appointments, and providing warm hand-offs, all require time. Stakeholders noted these (and other) practices require time a caseworker may not have and skills they may not possess.

Stakeholders also reported that caseworkers may not be able to attend trainings on the most current interventions and research on SUDs. They also reported that lack of knowledge and training may contribute to caseworker bias often shown towards parents with SUDs, particularly parents of color.

"They look at substance abuse as a moral problem and not a disease and approach families from a very punitive standpoint. So, out the gate, there is stigma….and parents of color involved with child welfare who are addicted to drugs are more severely stigmatized and punished." **Parent Representative, Office of Public Defense**

"Workers refer to parents as 'the crack mom,' or 'the heroin mom.' This person has a name. With white parents, they say 'this is something that happened to them.' With families of color, it's 'this is the heroin family.' The attitude is not just with child welfare caseworkers; it exists with substance abuse professionals, too." **Former Safety Administrator, Children's Administration**

Limitations

16 stakeholders were interviewed, all of whom have worked in their respective fields for many years and possess extensive content expertise and systems knowledge. They were therefore able to offer highly relevant feedback about how to best support child welfare-involved families struggling with SUDs in Washington.

Limitations exist about who was interviewed and the sample size. Feedback is limited, yet the expertise was instructive. More input could be gathered from communities of color and Tribes to better understand the contexts and needs for serving these overrepresented groups. Further steps to identify barriers for these families and appropriate recommendations must include their input.

The report also lacks data on the incidence and service demands of child welfare-involved mothers experiencing domestic abuse, which is highly correlated with SUDs.[20]

POC strongly recommends further analysis of systems issues associated with poverty, not adequately examined in this report. Many of the stakeholders identified the lack of housing and resources that have a dramatic impact on these families. Potential to mitigate these barriers could be addressed by basic income support for these families, particularly those experiencing extreme poverty.

"As necessary as they are, I don't really believe that programs in- and of- themselves are going to solve these problems. More thinking must happen about income support." **Child welfare trainer, the Alliance for Child Welfare Excellence**

Despite the study limitations, the recommendations for Washington to prioritize SUDs for families who child welfare-involved, expand access to SUD services, and improve training offerings and workforce overload are sound. Recommendations are substantiated by the literature and were consistently reported by the key informants.

Discussion/Recommendations

After reflecting upon the literature review, the stakeholder interviews, and POC knowledge of child welfare systems, we propose recommendations in three domains: 1) an overall systems lens that prioritizes substance abuse treatment for child welfare involved parents, 2) workforce development and training, and 3) service delivery.

► Create a decision-making framework that prioritizes parents who are child welfare-involved

Based on our current thinking, we advocate more systems thinking that prioritizes child welfare-involved parents for substance abuse treatment services. We advocate for this lens knowing the these parents are often at increased risk for further problems due to their life circumstances and also at further risk of losing their children based on federal timelines.

► Workforce development and training

Improve training, education, and cross-system collaboration

Many of the stakeholders identified concerns regarding the lack of effective training new caseworkers receive o SUDs. The Children's Administration offers extensive training for new employees, however, stakeholders reported that mentorship and specialized training opportunities to integrate this information are lacking.

"They are bombarded with training, but don't have the space to assimilate the information, and if you have to train the workforce every year, you can never develop the layers." **Supervisor, Family Treatment Court**

The Children's Administration could institute more effective training on SUDs as a chronic brain disorder and offer best practices for treatment and referral to appropriate services. Stakeholders recommended CA offer trainings that provide a more compassionate view of parents struggling with SUDs to minimize the impact of negative biases.

"I can categorize drugs like no other, that's the training we get. But we don't get the person side of it, the disorder side of it." **Program Supervisor, Children's Administration**

"I walked away with a lack of understanding about the institutional issues that impact parents' ability to be successful parents, whether that's substance abuse, or physical abuse, or many other things." **Former Safety Administrator, Children's Administration**

"I teach a critical thinking course, and I don't find many people willing to admit they have biases." **Child Welfare Trainer, Alliance for Child Welfare**

Another suggestion that emerged from the interviews is for supervisors to support case workers to identify and address their biases and how they may impact their abilities to assess and refer parents to appropriate services.

"Workers need to feel safe enough to make mistakes and be open to receiving feedback that might question who they are as people. That's ok, as long as they're in an environment where it's safe for them to process and receive that information from someone they trust." **Former Safety Administrator, Children's Administration**

Additionally, stakeholders advocated for more opportunities for cross-training and increased collaboration between all systems with which the parent interacts. They reported this will increase knowledge and understanding of SUDs as brain disorders, thereby promoting more effective and compassionate engagement practices and timely referrals to appropriate treatment programs. Furthermore, chemical dependency professionals would gain knowledge of the timelines enforced by the Adoption and Safe Families Act as well as the importance of information sharing between agencies to ensure child safety.

"I love cross disciplinary practice, love the idea of raising practice not just on one leg, but all of us upping our game. I think it's the model of taking people out of silos, not just child welfare workers, but defense attorneys and CASA volunteers and program staff and volunteers, putting them in the same room and saying you need to teach each other about what you do. Treatment needs to know about child welfare because you can't' just float along forever waiting for the parent to change to action because there's a time clock." **Attorney, Office of Public Defense**

► Service delivery

Conduct timely and systematic screening related to substance abuse for all child welfare involved parents

Promote and expand practices from Parent Child Assistant Program (PCAP)

Nearly all stakeholders mentioned the promising practices of the Parent Child Assistance Program (PCAP). PCAP is a highly regarded case management intervention, offered in Washington state since 1991.

"PCAP is intensive case management that really works. Mothers respond well to a PCAP home visitor/case manager who works in a coordinated way with other service providers (such as housing treatment, and CPS). Together they create a plan that responds to a family's needs. Having a navigator is so helpful." **PCAP Developer**

Mothers involved with PCAP show improved rates of alcohol and drug abstinence and are less likely to deliver subsequent children with pre-natal exposure to alcohol and drugs.[21] PCAP addresses many of the barriers identified by the stakeholders. PCAP provides intensive case-management services for three years to help parents actively engage with community resources and peer support groups and secure housing. The positive outcomes for mothers and

children after engaging with PCAP warrant further determination of practices across the state to improve current child welfare practices and can be added to SUD services.

Expand access to and ensure stability of Family Treatment Court (also called Family Dependency Treatment Court or Family Drug Court, depending upon county)

Family Treatment Court (FTC) is a highly effective, multi-disciplinary approach that addresses the complex needs of parents with SUDs. Stakeholders noted the promising practices of FTC, specifically identifying the intensive case management services, frequent client contact, long-term support, and a team approach that typically includes representatives from various systems with which the client is involved. The team approach allows for cross training, increased case oversight, and expedient referral services, all of which stakeholders identified as lacking for parents not involved with FTC.

Research shows that FTC participants engage in services more quickly, show greater treatment retention, and are more likely to complete treatment programs.[22] Furthermore, FTC data shows similar outcomes for families of color and white families, which is of significance considering concerns about systemic bias negatively impacting parents of color with SUDs.

Stakeholders frequently referred to the promising practices of Family Treatment Court as a way to engage parents more quickly and refer them to the SUD services they need.

Reinstate practice of locating substance abuse specialists in DCYF offices

Stakeholders identified great success when substance abuse specialists, also called chemical dependency professionals (CDPs), worked alongside child welfare caseworkers.

In 2004 – 2005, several child welfare offices tested co-location practices to increase child welfare's knowledge and understanding of SUDs and treatment resources, and, thereby, better serve families with SUDs. Nearly all informants reported that co-location of services promoted better understanding of each system, improved family engagement and timely treatment referrals, and showed better treatment outcomes. An additional study found the more intense the collaboration between SA and CW, the greater the availability of resources.[23]

However, in 2009, Washington state stopped funding that allowed CA offices to offer on-site services provided by CDPs. CDPs provided immediate assessments, attended home visits, assisted with urinalyses, and made speedy referrals to chemical dependency programs. All stakeholders who worked with CDPs identified their services as highly valuable, and the current lack of CA on-site services as a significant loss for the parents. Washington could provide necessary funds to hire CDPs located in DCYF offices to more effectively engage parents during the initial days when a case opens and a parent may be more motivated to begin treatment services.

"This was a great loss. We could get them into treatment faster." **Program Supervisor, Family Treatment Court**

"There were things that were very promising, such as substance abuse specialists..." **Child Welfare Trainer, Alliance for Child Welfare Excellence**

"At one point there was funding available where we had CDPs out stationed in offices, CDPs from community organizations that had cubicles in our offices. When that occurred we could schedule a drug screen right then prior to the assessment. Then the CDP would follow the parent

and help them through the process of getting the assessment done. Social workers don't have time to do that." **Program Supervisor, Children's Administration**

"The most helpful was to have CDP on staff to be able to meet with the client instantly. They were able to do assessments on the spot - that was a big link, they could get the parent in right away, offer to go out on home visits if time allowed and help social workers engage clients. No longer having CDPs on staff is among the biggest losses." **Former Safety Administrator, Children's Administration**

Increase options for residential treatment for mothers, fathers, and children

Stakeholders recommended Washington fund additional residential programs for parents and children. Most frequently, stakeholders identified long-term residential treatment for parents and children as a much needed resource as it is particularly helpful for parents working towards reunification. Staff are able to support the parent-child dyad and prepare the parent for life outside of the treatment setting.

"For us, it's a really nice length of time because you can get them into treatment, get them some stability so they can reunite with their child while we still have eyes on them. They can get used to parenting without having to worry about real life yet. And so helping transition from that with baby in care, to using skills in community is a way for us to reunite parents and kids quicker, whereas if they were out and about after 90 days and done, we'd have to be more cautious because there's not that stability." **Supervisor, Family Treatment Court**

Effective residential family programs offer a full range of services on a continuum of care[24] provided by highly skilled staff, such as child mental health workers and chemical dependency professionals, trained to provide evidence-based therapeutic interventions.[25] The stress of parenting can be difficult, particularly for those who have stopped using substances. Furthermore, the ability to practice new skills and learn new ways to cope with stress without using is critical. Of great need are on-site transitional services to help parents find safe and sober housing for their families once primary treatment is complete. Mothers have been shown to be twice as likely to reunify with their children when offered intensive family-oriented services[26] and show greater retention, improved psychosocial functioning, and improved parenting attitudes.[27]

Increase and improve co-occurring treatment services

Stakeholders endorse Washington state fund co-occurring, trauma-informed programs for the families. Treatment programs can indicate the evidence-based services they provide to treat co-occurring disorders, which would also help child welfare case workers make appropriate referrals. (At this time, there is no easy way to identify them.)

Department of Health and Human Services developed a tool for organizations to evaluate their program's capacity to treat co-occurring disorders.[28] This tool could assist with the development of a resource list to identify the best providers for each parent.

For better outcomes, treatment for parents with co-occurring SUDs and mental health disorders can be provided through integrated programs with the capacity to address both disorders.[29] Outcomes include reduced substance use, improvements in mental health symptoms and over all functioning, decreased rates of hospitalization, and increased housing stability.[30]

"If you remove the mental health issue by prescribing the correct medication, the drug and alcohol issue many take care of itself and vice versa." **Managing Attorney, Office of Public Defense**

"Parents may have had longstanding issues of traumatic incidences in their childhood that led them to use substances. If you only address substance use and not trauma, you may have a quick rate of reunification, but you will also have a higher rate of recidivism." **Former Safety Administrator, Children's Administration**

Increase access to Medication Assisted Treatment

According to the stakeholders, and supported by the literature,[31, 32] MAT, combined with comprehensive care, is a promising evidence-based practice. Stakeholders recommended Washington offer policy solutions to decrease the challenges providers face to become MAT prescribers, particularly now, as heroin indicators continue to rise.[33] According to operators from the Recovery Help Line, in the past two years, calls requesting assistance to find MAT prescribers have significantly increased. Expanding access to MAT could across the state could benefit some welfare-involved parents struggling with narcotics addiction.

Summary of barriers and recommendations

Barrier	Recommendation
Overall systems lens	• Prioritize families who are child-welfare involved and at-risk of losing their children
Workforce development and Training	• Require child welfare supervisors to provide regular and supportive supervision sessions and/or other trainings that address potential bias among case workers • Train workforce using evidence-based screening methods • Provide regular training through the Training Alliance and DCYF on substance use disorders, co-occurring disorders, and current treatment options for parents
Service delivery	• Conduct timely and systematic screening related to substance abuse for all child welfare involved parents • Expand the Parent and Child Assistance Programs (PCAP) and Family Treatment Courts across Washington • Ensure inclusion of additional parent allies

	• Reinstate practice of locating Substance Abuse Specialists, ideally dually trained (and certified) in mental health and substance abuse, within Department of Children, Youth, and Families (DCYF) offices • Increase collaborative efforts and cross-training between the courts, substance abuse treatment providers, and DCYF • Expand available out-patient and long-term residential treatment services that ensure parents and children can stay together (including child care options) throughout the state • Require treatment programs to provide evidence-based programming for SUDs and co-occurring disorders; increase program oversight and accountability • Increase access to medication assisted therapy (MAT)

ENDNOTES

[1] MCW, T. L. C. (2008). Disproportionality in child welfare. *Child Welfare*, *87*(2), 11.
[2] Shaw, T. V., Putnam-Hornstein, E., Magruder, J., & Needell, B. (2008). Measuring racial disparity in child welfare. *Child Welfare*, *87*(2), 23.
[3] Choi, S., & Ryan, J. P. (2006). Completing substance abuse treatment in child welfare: The role of co-occurring problems and primary drug of choice. *Child Maltreatment*, *11*(4), 313-325.
[4] Smith, B. D. (2003). How parental drug use and drug treatment compliance relate to family reunification. *Child Welfare*, *82*(3).
[5] Vanderploeg, J. J., Connell, C. M., Caron, C., Saunders, L., Katz, K. H., & Kraemer Tebes, J. (2007). The impact of parental alcohol or drug removals on foster care placement experiences: A matched comparison group study. *Child maltreatment*, *12*(2), 125-136.
[6] Adlin Bosk, E., Van Alst, D., & Van Scoyoc, A. (2017). A Chronic Problem: Competing Paradigms for Substance Abuse in Child Welfare Policy and Practice and the Need for New Approaches. *British Journal of Social Work*, *47*(6), 1669-1685.
[7] Huang, H., & Ryan, J. P. (2011). Trying to come home: Substance exposed infants, mothers, and family reunification. *Children and Youth Services Review*, *33*(2), 322-329.
[8] Child Welfare Information Gateway. (2014). *Parental substance use and the child welfare system.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.
[9] Söderström, K., & Skårderud, F. (2009). Minding the baby: Mentalization-based treatment in families with parental substance use disorder: Theoretical Framework. *Nordic Psychology*, *61*(3), 47-65.
[10] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, www.acf.hhs.gov/cb Preliminary Estimates for FY 2016 as of Oct 20, 2017 (24), Page 6
[11] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2016). Adoption and Foster Care Analysis and Reporting System (AFCARS), FFY 2016 [207]. Available from the National Data Archive on Child Abuse and Neglect Web site, http://www.ndacan.cornell.edu
[12] Osterling, K. L., & Austin, M. J. (2008). Substance abuse interventions for parents involved in the child welfare system: Evidence and implications. *Journal of evidence-based social work*, *5*(1-2), 157-189.
[13] Young, N. K., Boles, S. M., & Otero, C. (2007). Parental substance use disorders and child maltreatment: Overlap, gaps, and opportunities. *Child maltreatment*, *12*(2), 137-149.
[14] Oliveros, A., & Kaufman, J. (2011). Addressing substance abuse treatment needs of parents involved with the child welfare system. *Child welfare*, *90*(1), 25.
[15] Jarpe-Ratner, E., Bellamy, J. L., Yang, D. H., & Smithgall, C. (2015). Using child welfare assessments and latent class analysis to identify prevalence and comorbidity of parent service needs. *Children and Youth Services Review*, *57*, 75-82.
[16] Stromwall, L. K., Larson, N. C., Nieri, T., Holley, L. C., Topping, D., Castillo, J., & Ashford, J. B. (2008). Parents with co-occurring mental health and substance abuse conditions involved in Child Protection Services: clinical profile and treatment needs. *Child welfare*, *87*(3), 95.
[17] Conners, N. A., Bradley, R. H., Whiteside Mansell, L., Liu, J. Y., Roberts, T. J., Burgdorf, K., & Herrell, J. M. (2004). Children of mothers with serious substance abuse problems: An accumulation of risks. *The American Journal of Drug and Alcohol Abuse*, *30*(1), 85-100.

[18] Rockhill, A., Green, B. L., & Newton-Curtis, L. (2008). Accessing substance abuse treatment: Issues for parents involved with child welfare services. *Child welfare*, *87*(3), 63.
[19] Chuang, E., Wells, R., Bellettiere, J., & Cross, T. P. (2013). Identifying the substance abuse treatment needs of caregivers involved with child welfare. Journal of substance abuse treatment, 45(1), 118-125.
[20] Victor, B., Resko, S., Ryan, J., & Perron, B. (2018). Identification of Domestic Violence Service Needs Among Child Welfare–Involved Parents With Substance Use Disorders: A Gender-Stratified Analysis. *Journal of Interpersonal Violence*, 886260518768569.
[21] Grant, T. M., Ernst, C. C., Streissguth, A., & Stark, K. (2005). Preventing alcohol and drug exposed births in Washington State: Intervention findings from three Parent-Child Assistance Program sites. *The American journal of drug and alcohol abuse*, *31*(3), 471-490.
[22] Bruns, E. J., Pullmann, M. D., Weathers, E. S., Wirschem, M. L., & Murphy, J. K. (2012). Effects of a multidisciplinary family treatment drug court on child and family outcomes: Results of a quasi-experimental study. *Child maltreatment*, *17*(3), 218-230.
[23] He, A. S., & Phillips, J. (2017). Interagency collaboration: strengthening substance abuse resources in child welfare. *Child abuse & neglect*, *64*, 101-108.
[24] Chi, F. W., Parthasarathy, S., Mertens, J. R., & Weisner, C. M. (2011). Continuing care and long-term substance use outcomes in managed care: early evidence for a primary care-based model. *Psychiatric Services*, *62*(10), 1194-1200.
[25] Conners, N. A., Bradley, R. H., Whiteside Mansell, L., Liu, J. Y., Roberts, T. J., Burgdorf, K., & Herrell, J. M. (2004). Children of mothers with serious substance abuse problems: An accumulation of risks. *The American Journal of Drug and Alcohol Abuse*, *30*(1), 85-100.
[26] Grella, C. E., Needell, B., Shi, Y., & Hser, Y. I. (2009). Do drug treatment services predict reunification outcomes of mothers and their children in child welfare? *Journal of substance abuse treatment*, *36*(3), 278-293.
[27] McComish, J. F., Greenberg, R., Ager, J., Essenmacher, L., Orgain, L. S., & Bacik, W. J. (2003). Family-focused substance abuse treatment: A program evaluation. *Journal of Psychoactive Drugs*, *35*(3), 321-331.
[28] Substance Abuse and Mental Health Services Administration. *Integrated Treatment for Co-Occurring Disorders: Evaluating Your Program.* DHHS Pub. No. SMA-08-4366, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.
[29] Mueser, R. T., Drake, R. E., & Noordsy, D. L. (1998). Integrated mental health and substance abuse treatment for severe psychiatric disorders. *Journal of Psychiatric Practice®*, *4*(3), 129-139.
[30] Substance Abuse and Mental Health Services Administration. *Integrated Treatment for Co-Occurring Disorders: Evaluating Your Program.* DHHS Pub. No. SMA-08-4366, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.
[31] Year, F. (1999). Substance abuse and mental health services administration.
[32] Rieckmann, T., Muench, J., McBurnie, M. A., Leo, M. C., Crawford, P., Ford, D., & Wright, N. (2016). Medication-assisted treatment for substance use disorders within a national community health center research network. *Substance abuse*, *37*(4), 625-634.
[33] Banta-Green, Caleb et al. 2016 Drug Trends for King County, Washington. Alcohol & Drug Abuse Institute, University of Washington, July 2017. URL: http://adai.uw.edu/pubs/pdf/2016drugusetrends.pdf