Parental Substance Use Disorders and Child Maltreatment: Overlap, Gaps, and Opportunities

Nancy K. Young
Sharon M. Boles
Cathleen Otero
Children and Family Futures

There are relatively few empirically sound studies or nationally representative data on the number of children in Child Welfare Services (CWS) who are affected by their parents’ substance abuse or dependence. The two systems that could systematically monitor this population, CWS and substance abuse treatment, are not required to capture the data elements that would identify families in both systems. The studies that are based on CWS populations or parents in treatment indicate that there is a substantial overlap in client populations. This review provides a summary of the available data; provides estimates of the overlap between populations, including the number of infants born each year with prenatal substance exposure; and suggests important opportunities to close the data gap between the systems. The findings underscore both the need for obtaining accurate data within the systems and the opportunities for states to improve their cross-system data efforts as part of their outcome monitoring.

Keywords: prevalence; substance use disorders; child welfare

For more than a decade, studies have suggested that a sizable majority of the families involved in child welfare services (CWS) are affected by parental substance use disorders (SUDs). However, the information systems that routinely collect and store data in the CWS and substance abuse treatment systems—the Statewide Automated Child Welfare Information System (SACWIS) and the Treatment Episode Data Systems (TEDS)—do not require states to collect the specific data elements that would allow policy makers to monitor three critical populations: families in CWS who are affected by parental SUDs, the children of parents who enter substance abuse treatment and may be at increased risk of child abuse or neglect, and children who come to the attention of CWS because they are prenatally exposed to alcohol or drugs. In addition to the lack of federal mandates to monitor these data, there are no standardized methods across state information systems to capture information on these groups of families. When the data collection systems were originally designed, the need to coordinate these data was not anticipated. Collecting data on these subsets of families did not become a priority until more recently, when policy makers and administrators recognized the value of collecting data on families who represent an overlap in client populations.

This review highlights the existing prevalence data from some of the more rigorous studies available to create estimates of the scope of the problem in CWS and substance abuse treatment, identifies gaps in the data systems, and suggests ways in which these gaps can be reduced. In particular, it focuses on the need to understand the overlap in populations as states and communities implement both a second round of Children’s Bureau’s Child and Family Service Reviews (CFSRs) and the Center for Substance Abuse Treatment’s National Outcomes Measures (NOMs). These improvements in outcome monitoring in the two systems are important opportunities for states.
and communities to improve their overall data collection strategies on this population of children and families and to address the gap in data between the systems.

The available data on the overlap between the systems comes from specific studies using case reviews or prospective samples of families entering CWS. But, as noted by Jones (2005), the available studies on this issue report wide variance in estimates of the percentage of substance-affected families in the child welfare population. National reports in the late 1990s, based on small-scale case reviews or surveys of practitioners’ opinions, often cited estimates of 40% to 80% of CWS-involved families with substance abuse problems (Semidei, Radel, & Nolan, 2001; Young, Gardner, & Dennis, 1998). The U.S. Department of Health and Human Services (USDHHS) in its Report to Congress in 1999 stated that between one third and two thirds of children in CWS were affected by parental substance abuse (USDHHS, 1999).

The variance in estimates can be attributed to several factors, including the population studied (e.g., in-home vs. out-of-home cases, urban vs. nonurban populations, foster care vs. investigations), the definition of substance abuse used in the study (e.g., different criteria from the spectrum of use, abuse, and dependence may be used; a specific substance may be included in one study and excluded in another), the method used to determine substance involvement (e.g., risk assessment measures, prospective assessment tools, workers’ perceptions, retrospective case reviews), whether the substance use is a primary or secondary contributing factor in the child welfare case, and the method of analysis. For example, USDHHS (1999) suggests in its study that the lower estimate (one third) may be based on in-home child welfare cases in which children were not removed from the parents’ care and the higher estimate (two thirds) may be based on out-of-home cases in which children were removed and placed in protective custody.

Data on three categories of affected children are highlighted: children in CWS whose parents are identified as having SUDs, children of parents who enter substance abuse treatment and who may therefore be at risk for abuse or neglect, and children who have been prenatally exposed to drugs or alcohol. The population of prenatally exposed children is included in the review because some states currently consider prenatal substance exposure detected at birth to be evidence of child abuse or neglect and prenatally exposed children are at greater risk of entering CWS through neglect or abuse related to ongoing parental substance abuse (Barth & Needell, 1996). Also, amendments to the Child Abuse Prevention and Treatment Act (CAPTA) as part of the Keeping Children and Families Safe Act of 2003 require states to assure that they have a system in place to refer families to CWS if an infant is identified at birth as having been prenatally exposed to drugs (P.L.108-36). Although prenatally exposed children may enter CWS or enter treatment with their parent, they deserve unique attention to determine appropriate intervention and prevention needs. Including the population of prenatally exposed children also emphasizes the fact that parental SUDs can affect children before and after they are born; they may be placed in protective custody as very young children. Although these issues also significantly affect the courts that have jurisdiction in cases of child maltreatment, there are no national data on child welfare court cases or on the subset of court cases in which parental substance use is a factor. Thus, the data from the juvenile court system are not included in this review.

Although this article focuses on the prevalence of the issues across systems, it is important to note that the prevalence of SUDs among parents in CWS does not tell us the nature and extent of the SUDs or how parents’ substance use might affect the risk or safety factors associated with the child abuse and neglect. In addition, the prevalence of SUDs does not in itself provide sufficient information on which to base decisions about the custody status of children or about how the parents’ SUDs must be addressed in the case plan so that children can remain in the home or so that reunification might occur.

**THE DATA SYSTEMS: CHILD WELFARE AND SUBSTANCE ABUSE TREATMENT**

To determine the number of families affected by parental SUDs and child abuse/neglect, it is important to have an accurate view of the ways that family members are counted in the systems. CWS uses the individual child as the unit of analysis and collects data pertaining to reports of child abuse and/or neglect, substantiation of child maltreatment, and services that are delivered. Substance abuse treatment uses the individual who is admitted to treatment as the unit of analysis; data on parenting status are collected in a limited number of states. These state-level data on the parenting status of individuals in treatment are not accumulated at the national level, however. Estimates of the number of minor children of parents in treatment have been calculated in a few specific studies. The following section reviews the data regarding children and parents involved in each system.
Child Welfare Services

During 2004, an estimated 3 million referrals were made to CWS, involving 5.5 million children nationwide. According to the National Child Abuse and Neglect Data System (NCANDS), an estimated 3.503 million children (64% of child referrals) received an investigation by CWS in 2004. A total of 1.24 million children (23% of child referrals) received postinvestigation services (also termed remedial or postresponse services). These services address the safety of the child and are usually based on an assessment of the family’s strengths, weaknesses, and needs. An estimated 872,000 children (25% of children who received an investigation) were found to be victims of abuse or neglect. Almost two thirds (64.5%) of those receiving an investigation or assessment were victims of neglect; 17.5% were victims of physical abuse; 9.7% were victims of sexual abuse; 7% were victims of emotional or psychological abuse; 2.1% experienced medical neglect; and 14.5% were in the category of other abuse or neglect.2 It is estimated that 268,000 children (31% of child victims) were removed from their homes and entered out-of-home care as the result of child abuse or neglect investigations in 2004 (USDHHS, Administration of Children, Youth and Families, 2006).

Substance Abuse Treatment

In 2004, there were 1.875 million admissions to publicly funded treatment for abuse or dependence on alcohol and drugs. Women represented 31.5% of the admissions (N = 590,261). The average age to admission was 34 years old. Sixty-two percent of the admissions were to ambulatory treatment (i.e., outpatient treatment and intensive outpatient); 20% were to detoxification, and 17% were to residential treatment. More than one third (36%) of the admissions were referred to treatment through the criminal justice system and 34% represented self- or individual referrals. Five substances accounted for 95% of all the treatment admissions in 2004: alcohol (40%), opiates (18%, primarily heroin), marijuana/hashish (16%), cocaine (14%), and stimulants (8%, primarily methamphetamine; Office of Applied Studies [OAS], 2006).

In summary, the systems involved with families at the intersection of child abuse and/or neglect and parental SUDs use different units of analysis. CWS counts child victims, and substance abuse treatment counts individuals admitted to a specialty substance abuse program. The information needed to determine whether a specific child’s parent is participating in treatment is not always available in the CWS data set, and data on whether a specific individual in treatment is a parent are not available in the treatment data set. The most recent data from the two systems are summarized in Table 1. We will return to these overall system data in estimating the overlap in the systems in a later discussion.

### RESEARCH STUDIES ON THE PREVALENCE OF SUBSTANCE USE DISORDERS IN THE CHILD WELFARE POPULATION

Most studies examining the prevalence of parental SUD problems in CWS focus on out-of-home cases in which the child is removed from the parent’s care. These studies are limited in their utility in estimating SUDs in the larger CWS population. As indicated above, most CWS cases involve in-home cases (69% of child victims). To date, there is only one published, nationally representative study reporting the prevalence of substance dependence among child-involved families in which the children had not been removed from the parents’ custody. The data come from the National Study on Child and Adolescent Well-Being (NSCAW), which collected data on caregiver substance...
dependence among children living at home from a nationally representative sample of 5,504 families who had been investigated by CWS (Gibbons, Barth, & Martin, in press). In addition to the national study, there is one published study that included data on in-home cases from a large county in the Southwest (Jones, 2005), and prevalence data from the Child and Family Service Reviews included both in-home and out-of-home cases (Young, Gardner, Whitaker, Yeh, & Otero, 2005). Both studies are described below.

The NSCAW research protocol included assessing caregivers’ substance dependence using the Composite International Diagnostic Interview–Short Form (CIDI-SF) and questions from the child welfare worker interview. The CIDI-SF evaluates criteria of substance dependence in the year prior to the data collection. The analysis included both open cases (those that received some type of service beyond the CWS investigation) and closed cases (those that did not receive any services after the CWS investigation). Among caregivers retaining custody of their children, 9.6% had a problem with alcohol or drugs according to the child welfare worker assessment and 3.9% of caregivers were alcohol or drug dependent according to the CIDI-SF. Overall, 11.1% of caregivers whose children lived at home with them were determined to have a substance abuse problem (Gibbons et al., in press). This rate is lower than the rate that is generally estimated (Semidei et al., 2001) and is similar to the percentage of children in the general population (11%) who are living with a parent who needs treatment for alcoholism or illicit drug abuse (DHHS, 1999).

It is also important to note that in the NSCAW study, child welfare workers failed to identify a substance use problem in 61% of the caregivers who actually met Diagnostic and Statistical Manual of Mental Disorders (4th ed.; DSM-IV) criteria for alcohol or drug dependence (Gibbons et al., in press). Child welfare workers were even more likely to miss potential alcohol or drug problems among caregivers who used but were not dependent on a substance. Child welfare workers also were significantly more likely to identify substance abuse problems with open in-home cases compared to closed in-home cases (Gibbons et al., in press).

Another analysis by NSCAW examined the prevalence of substance abuse problems among caregivers of different races or ethnicities involved in CWS who had retained custody of their children (Libby et al., 2006). Rates of substance abuse problems were found to be lowest among Hispanic (6.1%) and American Indian (7.5%) caregivers, Caucasian (13.2%) and African American (11.3%) caregivers had the highest prevalence of substance abuse problems based on child welfare worker reports.

The lower than anticipated prevalence rate may be attributable in part to the fact that the CIDI-SF measures substance dependence, a narrower category than substance abuse, and is limited to symptoms reported in the prior 12 months. One study found that estimates of the rate of substance dependence varied according to the time frame of the questions about use. In a sample of persons receiving Temporary Assistance to Needy Families (TANF), Phinney, Seefeldt, Danziger, and Pollack (2005) found that among TANF recipients, “very few respondents satisfy criteria for drug (3.4%) or alcohol (4.1%) dependence in any given year, but that a significant group (20.5%) had a disorder at some point in their lifetime.” These data, although from a TANF population, appear to support the possibility that using dependence as a criterion results in lower rates of parental substance involvement and may partially explain the lower rates of caregivers’ substance-related problems in the NSCAW study.

Jones (2005) reported on a retrospective case review study using a random sample of 443 children with substantiated child abuse or neglect cases in an urban setting. The children initially received in-home services between January 1 and June 30, 1995. He found that 68% of the children had mothers who abused alcohol or drugs and 37% of them had mothers who abused both. The study specified a range of circumstances that identified a child as having a parent with a substance abuse problem. They were (a) the mother received a referral or services for drug or alcohol abuse, (b) the child tested positive for drugs at birth, (c) the mother self-reported substance abuse, (d) a professional reported the substance abuse problem, or (e) another person who knew the mother (e.g., parent or spouse) reported the mother’s substance abuse to the social worker. The inclusion of these categories may have led to the higher rates of SUDs.

The studies highlighted above represent the prevalence of SUDs among in-home cases. The CFSRs report on the prevalence of parental SUDs among children in CWS in the 50 states, Puerto Rico, and the District of Columbia. The CFSR data regarding SUDs did not differentiate between in-home and out-of-home cases. The CFSRs are conducted by the Administration on Children, Youth and Families (ACYF), to help states achieve positive outcomes for children and families and to monitor state child welfare services. ACYF is currently implementing the second round of CFSRs. Round one of the CFSRs found that parental substance abuse was reported as a factor in cases in
32 states. It was identified as a factor that brought the child to the attention of CWS in 16% to 61% of cases (Young et al., 2005). This wide range of estimates across states may reflect differences in substance use trends, difference in local practices regarding parental substance use, underreporting of SUDs in the case records, or underidentification in the review process.

Among out-of-home cases in which children have been removed, a higher percentage of parental SUDs often have been reported. Throughout the past decade, several state and local studies reported substance use rates based on various methods and operational definitions of substance abuse; a selection of these studies is summarized chronologically below. This selection is not comprehensive but represents the more rigorous research studies in this area to date (studies reporting surveys of social workers’ opinions about the extent of substance abuse problems in their caseloads are excluded).

Murphy and colleagues (1991) required that substance abuse be noted in reports from a psychiatrist or psychologist or in a court-ordered screening before the case was included in their study. In their sample of 206 cases from Boston, they found that in 43% of the cases at least one of the parents had a documented problem with either alcohol or drugs. The percentage rose to 50% when they included the cases in which allegations of substance use were in the court report. Alcohol, cocaine, and heroin were the three most frequently mentioned abused substances. Parents with documented substance abuse were significantly more likely than non-substance-abusing parents to have been previously referred to child protective agencies, to be rated by court investigators as presenting high risk to their children, to reject court-ordered services, and to have their children permanently removed (Murphy et al., 1991).

Another case review was conducted of 190 randomly selected records from the case load of a large, urban, juvenile court in which the state took legal custody of the children following a finding of significant child maltreatment (Famularo, Kinscherff, & Fenton, 1992). The random review of records involved cases that were completed between 1985-1988 and were selected from actions in which the court had granted a petition to transfer legal custody from the parents due to severe maltreatment of the children. The authors found that 67% of the cases involved parents who were classified as substance abusers (Famularo et al., 1992).

In 1994, the U.S. General Accounting Office (GAO) analyzed a random sample of 759 case files from California, New York, and Pennsylvania. They found that 78% of foster care cases had at least one parent who was abusing drugs or alcohol (GAO, 1994). At the request of the Senate Finance Committee, another study by the GAO reviewed 519 case records in Los Angeles, California, and Cook County, Illinois, in 1998. They estimated that about two thirds of all foster children in both California and Illinois had at least one parent who abused drugs or alcohol and most had been doing so for at least 5 years. Most of these parents abused one or more drugs such as cocaine, methamphetamines, or heroin (GAO, 1998).

Besinger, Garland, Litrownik, and Landsverk (1999) reviewed child protective services (CPS) case records of 639 urban children placed in out-of-home care between May 1990 and October 1991 due to maltreatment. Only children who remained in care for at least 5 months were included in the study. The authors found that 79% of children in foster care had a parent with parental substance abuse. The authors defined parental substance abuse as including any known history of substance abuse, a court report stating that the caregiver was ordered to attend substance abuse treatment, substance abuse was indicated as the reason for the children’s removal from the home, or the CPS case file included a DSM-III-R diagnosis of substance abuse or dependence. The wide definition of substance abuse may explain the relatively higher rates of substance-abusing parents in their study.

McNichol and Tash (2001) examined current and closed cases of 268 school-age children placed into foster care. In a review of case files, they found that 14% of the children were in specialized foster care due to a primary reason of parental substance abuse. Overall, 74% of children were “affected in some way by parental substance abuse.” Determination of parental substance abuse was made from referral information and case notes of observed or inferred evidence such as a court mandate to drug testing or treatment, incarceration for drug-related charges, or documentation of prenatal drug exposure (McNichol & Tash, 2001).

Sun, Shillington, Hohman, and Jones (2001) explored the impact of caregiver alcohol and other drug use (AOD) on CPS case substantiation among 2,756 families from the Department of Family and Youth Services in a Nevada county. Data were collected from a subset of CPS referrals between June 1, 1998, and December 31, 1999. The authors found that 11% of investigated cases and 16% of substantiated cases had an indication of caregiver AOD use (Sun et al., 2001). In addition, the authors found that CPS cases with indications of AOD use were more likely to be substantiated than cases without AOD use. The authors attributed the low prevalence rate to the fact that social workers in Nevada are
not required to document AOD use in their case records. The authors report that it is more likely for the social worker to assess and document AOD use if the client’s initial allegations are related to AOD (Sun et al., 2001).

A similarly low rate of 11.2% caretaker substance abuse was found among 500 children in kinship while under CPS supervision in a large, urban, southeastern county (Rittner & Dozier, 2000). A total of 300 caregivers were reported as substance abusers: In total, 258 mothers, 92 fathers, 5 maternal or paternal relatives, 2 stepparents, and 3 nonrelatives (i.e., godparents). Caregivers were considered substance abusers if records referred to arrests for possession of substances, if paraphernalia was found at the residence, or if evaluations provided by substance abuse programs indicated substance abuse histories. The lower rate of caregiver substance abuse may be due to the fact that the authors included all kinship caregivers (approximately 2,680) that were potentially available to care for the child, not just the biological parents, in their estimate. If only the biological parents were examined, it is believed that the rates of SUDs would be much higher. For example, women who delivered substance-exposed newborns represented 32.9% of the total CWS reports.

The studies are summarized in Table 2 and indicate that the percentage of parents in CWS with substance abuse problems vary considerably based on the population studied and methodology used. The estimates range from as low as 11% to as high as 79%.

**CHILD ABUSE AND NEGLECT AMONG PARENTS IN SUBSTANCE ABUSE TREATMENT**

There are no national data on the number of children of persons in treatment because there is no federal requirement that this information be collected or reported. Some states collect these data and others plan to add data elements regarding children as they upgrade their information systems to implement NOMs. Specific studies have indicated that approximately 58% of those in treatment are parents of minor children (Brady & Ashley, 2005; Hser et al., 2003). This percentage of parents is estimated based on only two sources. Shillington, Hohman, and Jones (2001) analyzed data from the San Diego County Office of Alcohol and Drug Services. They included 6,023 women admitted to treatment from 1997 to 1999 who had children. The number of women admitted to treatment without children were not reported. Of those in the study, there was notation in the case record if the woman had or did not have contact with CPS. They found that 20.2% of women with children reported contact with CPS before their admission to treatment.

An analysis of 15,618 consecutive admissions in 13 California counties found that 58.9% of the individuals in treatment were parents of minor children (Hser et al., 2003). In the California sample, Hser and colleagues (2005) found that 27.1% of parents in treatment had one or more of their children removed by CWS and that 36.6% of the parents who had a child removed also had their parental rights terminated. The California study also revealed that the percentage of parents who had parental rights terminated varied significantly by the type of treatment the parent received. Among parents in outpatient treatment, 29% had a child removed; among patients in residential treatment, 55% had a child removed; and among parents in narcotic treatment (primarily methadone maintenance), 80% had a child removed (Hser et al., 2003).

Data from a nationally representative sample of alcohol and drug treatment facilities found that a similar percentage of clients were parents of minor children, with 56.6% of clients admitted to treatment having a child younger than age 18. The authors did not report parenting status data based on type of substance abuse program but female clients were more likely than male clients to have minor children (69.2% vs. 52.5%; Brady & Ashley, 2005).

**PRENATAL SUBSTANCE EXPOSURE**

One of the important aspects of parental substance use in terms of the risks posed to children is prenatal substance exposure. Prenatal exposure to alcohol, tobacco, and illicit drugs can be associated with risks of health and social consequences for children. Some studies suggest that children whose parents have SUDs are at increased risk of poor outcomes in several critical areas of development and that they are also at increased risk of involvement with CWS (Byrd, Nelstadt, Howard, Brownstein-Evans, & Weitzman, 1999; USDHHS, 1999; Lagasse & Lester, 2000; National Center on Addiction and Substance Abuse, 1999). More recently, Doris, Meguid, Thomas, Blatt, and Eckenrode (2006) found that prenatal exposure to cocaine did not increase risks of subsequent maltreatment or foster care when demographic and maternal lifestyle variables were controlled.

In some states, hospital staff who identify evidence of prenatal substance exposure by testing either the infant or the mother at the time of birth are required to file a report with CWS. As mentioned earlier, the amendments to CAPTA in the Keeping Children and Families Safe Act of 2003 (Public Law 108-36) have placed new requirements on states.
### TABLE 2: Summary of Studies of Parental Substance Use Disorders in Child Welfare Service Populations

<table>
<thead>
<tr>
<th>Author</th>
<th>Population</th>
<th>Criteria</th>
<th>Findings</th>
</tr>
</thead>
</table>
| Gibbons, Barth, & Martin      | In-home services (N = 5,504 families)                                       | Caseworker assessment CIDI-SF                                                                                              | 9.6% alcohol or drug problem  
3.9% alcohol or drug dependent                                                                                                           |
| (in press)                    |                                                                             | Record review with five criteria of mother’s substance abuse:  
(a) mother received referral or services for alcohol or drug abuse, (b) child tested positive at birth, (c) mother self-reported, (d) a professional reported to social worker, (e) someone in position to know reported to social worker | 68% of children had mothers who abused alcohol or drugs; 37% of children had mothers who abused both alcohol and drugs |
| Jones (2005)                  | Initial in-home services and random sample of substantiated cases (N = 443) |                                                                                                                             |                                                                                                                                           |
| Murphy et al. (1991)          | Out-of-home care (N = 206)                                                  | Substance abuse noted in psychiatrist or psychologist report or in court-ordered screening                                          | 43% with at least one parent with documented problem of either alcohol or drugs; 50% when cases were included from court reports       |
| Famularo, Kinscherff, & Fenton (1992) | Cases brought to court for “care and protection” due to “severe child maltreatment” (N = 190) | Record review indicating if parent had abused alcohol, cocaine, opiates, or other drugs with (a) substantiated allegations by two or more professionals of substance misuse or (b) parent's self-report of substance abuse meeting diagnostic criteria | 67% of cases involved parents who were classified as substance abusers                                                              |
| General Accounting Office     | Out-of-home care (N = 759)                                                  | Record review of random sample of cases in California, New York, and Pennsylvania                                              | 78% with at least one parent who was abusing alcohol or drugs                                                                        |
| (1994)                        |                                                                             |                                                                                                                                                                                                 |                                                                                                                                           |
| General Accounting Office     | Out-of-home care (N = 519)                                                  | Record review of cases in Los Angeles and Chicago                                                                                | 67% with at least one parent who abuses alcohol or drugs                                                                                |
| (1998)                        |                                                                             |                                                                                                                                                                                                 |                                                                                                                                           |
| Besinger, Garland, Litrownik, | Out-of-home care (N = 639)                                                  | Record review for any known history of substance abuse, a court report stating that the caregiver was ordered to attend substance abuse treatment, an indication of substance abuse as the reason for the children’s removal from the home, or a DSM-III-R diagnosis of substance abuse or dependence | 79% of children had a parent with substance abuse noted in the file                                                                     |
| & Landverk (1999)             |                                                                             |                                                                                                                                                                                                 |                                                                                                                                           |
| Rittner & Dozier (2000)       | Children in kinship care and under CPS supervision (N = 500)                | Record referred to arrests for possession, paraphernalia found in residence, or substance abuse program’s evaluation indicated substance abuse history                                                                 | 11.2% of all kinship caregivers that were potentially available to care for the child (n = 2,680) had substance abuse problems     |

(continued)
Each state must have a statewide system of policies and procedures that ensure appropriate referrals are made to child protective services to address the needs of infants identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure. Although CWS would not be involved with a family during the prenatal period (unless there are older children in the home for whom there have been allegations of child abuse or neglect), CWS is now required to be involved with families when infants are identified as affected by mother’s substance use at birth.

There are no national data on the number of children affected by maternal substance use during pregnancy but there are several federal efforts to monitor substance use among pregnant and postpartum women. The data come from self-reported surveys, state monitoring systems, several state studies of substance use detected at birth, and several research studies that have been conducted using screening tools. These data are relevant for state and local policy makers as they respond to the CAPTA requirements and to changes in drug use patterns that may affect CWS. These efforts to monitor maternal substance use are discussed below.

**National Survey on Drug Use and Health (NSDUH)**

Federal data available from the NSDUH reports the 2003-2004 annual averages of self-reported substance use by pregnant women. The survey found that 4.6% of pregnant women between the ages of 15 and 44 used illicit drugs in the past month (OAS, 2005). Rates varied by length of gestation: 8.0% of women who were in their first trimester reported past month illicit drug use and rates declined to 3.8% of those in their second trimester and 2.4% of those in their third trimester (OAS, 2005). Alcohol use was reported by 11.2% of pregnant women, with 22.2% of women in their first trimester reporting alcohol use and the rates declining to 7.0% and 4.9% in the second and third trimester, respectively (OAS, 2005). Binge drinking, defined as five or more drinks on the same occasion, was reported by 4.5% of pregnant women. Again, rates varied by length of gestation, with 10.6% of women in their first trimester, 1.9% of second-trimester women, and 1.1% of third-trimester women reporting binge drinking (OAS, 2005). These data are summarized in Table 3.

**The Pregnancy Risk Assessment Monitoring System (PRAMS)**

The PRAMS is an ongoing state- and population-based surveillance system designed to monitor selected self-reported maternal behaviors and experiences (including alcohol use) that occur before, during, and after pregnancy. PRAMS, funded by the federal Centers for Disease Control and Prevention (CDC), is currently used in 32 states. Through cooperative agreements between the CDC and these 32 state governments, information on the use of alcohol prior to and during pregnancy is compiled; questions on illegal drug use are included in the survey at the discretion of the state. In some of these states, maternal substance use is reported at levels that corroborate states’ other estimates and the
NSDUH data. For instance, PRAMS indicates that during their last trimester of pregnancy, 1.8% to 8.2% of women used alcohol (Beck et al., 2002).

**Infant Development, Environment, and Lifestyle (IDEAL) Study**

IDEAL is a longitudinal study to assess the outcomes associated with prenatal methamphetamine exposure. Participating sites were selected based on their known high rates of methamphetamine use and include Los Angeles, California; Des Moines, Iowa; Tulsa, Oklahoma; and Honolulu, Hawaii. The prevalence of drug use has been determined by mothers’ self-report of substance use during pregnancy and testing of infants’ meconium at birth. The results of the IDEAL study, which are not representative of the country as a whole, were collected in 2004 and have been compared to the National Pregnancy and Health Survey, which was collected in 1992-1993 (Arria et al., 2006; National Institute on Drug Abuse, 1996).

**Screening During Pregnancy**

In a study of more than 7,800 pregnant women enrolled in prenatal care clinics in five communities who were screened for substance use with the 4P’s Plus, a verbal screen used by health care providers in concert with prenatal care, approximately one third (32.7%) had a positive screen for substance use. Four of the communities conducted follow-up assessments on all women with a positive screen and found that 15% of those continued to use substances after learning of the pregnancy (Chasnoff et al., 2005).

When the numbers in Tables 3 and 4 are evaluated together, the data can be summarized as follows. In 2004, an estimated 8% to 11% of the 4.1 million live births (328,000-451,000 births) involved prenatal exposure to alcohol and illegal drugs, and the rates vary by the trimester of pregnancy. Because prenatally exposed children are potentially at risk of future abuse or neglect and adverse developmental outcomes, they have an increased risk of entering CWS. Thus, they are an important subpopulation that should be monitored and provided with appropriate early intervention services.

**SYSTEM OVERLAPS AND DATA GAPS**

Based on the studies presented in this review, it is clear that (a) a large proportion of the families involved in CWS due to substantiated reports of abuse or neglect are affected by SUDs and need treatment services, (b) the majority of persons entering publicly funded substance abuse treatment are parents of minor children, and (c) a significant group of infants born each year are affected by prenatal substance exposure. The following section highlights the findings in each of these areas and projects national totals based on the current studies.

**Families Involved in CWS Due to Substantiated Reports of Abuse or Neglect and Affected by SUDs**

The nationally representative study conducted with families in which the children remained in the home, and that used criteria of substance dependence, found a rate similar to the rate of parental SUDs in the general population, approximately 11% (USDHHS, 1999; Gibbons et al., in press). Studies conducted using case review procedures specifically looking for notations of substance use problems have found rates from 43% (Murphy et al., 1991) to 79% (Besinger et al., 1999). Based on these numbers, it is estimated that 22,440 children (204,000 child victims × 11%) who were...
victims of child abuse and/or neglect and received in-home services had parents who would have met criteria for SUDs. It is estimated that 128,640 to 211,720 child victims in out-of-home care (268,000 child victims served out-of-home × 43% and × 70%) had parents who would have met criteria for SUDs.

**Persons Admitted to Publicly Funded Substance Abuse Treatment Who Are Parents of Minor Children**

Based on the number of men and women admitted to treatment in 2004 and the estimated percentage of those who are mothers (69.2%) and fathers (52.5%; Brady & Ashley, 2005), approximately 408,460 mothers of minor children and 674,487 fathers were admitted to treatment, with a combined total of approximately 1,082,947 parents. Assuming that the data are consistent across states and extrapolating those percentages to the total number of adults in treatment nationwide in 2004, these percentages indicate that approximately 295,000 parents (27.1% of 1.09 million) had one or more children removed by CWS, and approximately 108,000 of those parents (36.6% of 295,000) had their parental rights terminated.

**Infants Born Each Year Who Are Prenatally Exposed to Substances**

Of the approximately 4 million babies born each year, an estimated 8% to 11% are born exposed to alcohol and illegal drugs, resulting in 328,000 to 451,000 infants with prenatal substance exposure. However, only 89,816 children younger than the age of 1 were found to be victims of child abuse and/or neglect. In many instances, infants would only be reported if they or their mother tested positive at the time of the child’s birth and not necessarily if the mother used substances at some time during the pregnancy. Clearly, not all children with prenatal substance exposure need to be placed in protective custody and presumably not all of the 89,816 1-year-olds were prenatally exposed, but when the potential overlap between those at risk (328,000 to 451,000) is contrasted with those found to be child victims (89,816), the difference in numbers is striking. Many prenatally exposed children and their families may go without needed services.

**OPPORTUNITIES TO CLOSE THE GAP**

The child welfare system includes a subset of individuals who are also in the treatment system, and vice versa. Although the overlap between the systems may be extensive, CWS does not have a mandate to consider substance abuse issues unless substance abuse is identified as interfering with parenting and leading to abuse or neglect, and CWS is generally not set up to effectively manage the recovery of parents in treatment. Similarly, for the courts that have jurisdiction in cases of child maltreatment, there is no mandate to report data on child welfare court cases or on the subset of court cases in which parental substance use is a factor. Conversely, the substance abuse treatment system has no mandate to address the needs of children whose parents are in treatment. It will take the concerted effort of policy makers and administrators as well as political will and leadership to effectively utilize the data collected by each system and close the data gap.

The nature of the overlapping systems, each with its own particular focus and procedures, as well as the absence of effective linkages between the systems in most jurisdictions, indicate the challenges involved in responding to the issue of substance abuse among parents in CWS. One crucial aspect of the response must be substantial improvements in data collection and analysis; some of the most important data items are not even collected. In the next section, we will discuss the critical area of the impact of SUDs within the child welfare population in greater depth.

The data presented in this review allow us to estimate the number of families involved in both substance abuse treatment and CWS. It provides an estimate of the number of children in CWS whose parents were affected by SUDs and an estimate of the number of parents in substance abuse treatment who have minor children. Substance abuse by parents is not the only problem that leads to child abuse and neglect, but these data show that it is a very significant problem.

Because there is no federal mandate that information be collected on families involved in CWS, substance abuse treatment, and the court system, the data presented are best estimates based on the available research. The available data highlight two important issues that states and communities face: (a) establishing accurate estimates of the need for services and (b) developing appropriate service capacity to respond to that need. This requires that states and communities fully understand the size, scope, and extent of the issue of families who are involved in both systems in their own jurisdictions.

The need for developing appropriate service capacity is exemplified by the Adoption and Safe Families Act (ASFA) of 1997, which requires states to move toward termination of parental rights when children have been in foster care for 15 of the previous 22 months. ASFA also requires that child welfare agencies plan not only for family reunification but also for a
Both the child welfare and substance abuse treatment systems have new federal requirements to establish outcome-monitoring systems in their states. The Children’s Bureau’s CFSR processes were described above. The Center for Substance Abuse Treatment’s establishment of NOMs is an additional element in the current policy context that indicates that now is a strategic and opportune time to focus attention on the data gap. The implementation of NOMs presents an opportunity to include indicators related to children and their safety in the state’s data systems.

In both cases, additional data compiled at the intersections of the two systems would help inform decisions regarding more extensive data collection within the systems. For example, in NOMs, data on the parenting status of persons entering treatment are not uniformly collected, which makes tracking the treatment outcomes of all parents very difficult. At the same time, CFSRs in the states could focus on the standardized data elements on parental SUDs and treatment services and yield better information about the finding of the first round of CFSRs that most states documented inadequate treatment services as a barrier to timely permanency planning (Young et al., 2005).

In addition, there are models from some states and communities that have found creative ways to collect, disseminate, and use information to better serve their families. They have created practice and policy changes to address the population overlap and the data gaps. Policy and practice changes exemplify how states and communities have begun to respond to the realities of overlap between the systems. These include out-stationing staff to conduct earlier screening and assessment of parents entering the child welfare system (such as is done in the Illinois Alcohol and Drug Abuse Waiver Demonstration project), initiating family drug treatment courts (such as Sacramento, San Diego, and Reno), expanding treatment programs that provide services to children of parents with SUDs (i.e., Arizona’s expansion of treatment services for the CWS population using TANF resources), and expanding prenatal screening and intervention (Chasnoff et al., 2005).

On the data front, the techniques of data matching, use of a common identifier across programs, and development of supplementary data collected at intake have had promising results in some states and localities. For example, a large county in California creates a unique identifier when children enter child welfare services that is compatible with locating parents’ data (when appropriate consents are in place) in the substance abuse treatment data set. Even without parental consent, these data can be analyzed
in the aggregate for evaluation purposes under the evaluation exceptions of the confidentiality statutes governing substance abuse treatment records. Examining the ways that states and communities establish the political will to collect information about these families and to overcome the challenges inherent in this kind of system change is an important next step in cross-systems collaboration research.

NOTES
1. The term substance use disorders (SUDs) is used in this article because it is the more accurate description from the DSM-IV-TR and includes both substance abuse and substance dependence.
2. The total percentage adds up to more that 100% because a child may be a victim of more than one type of abuse or neglect.

REFERENCES

Young, N. K., & Gardner, S. L. (2002). Navigating the pathways: Lessons and promising practices in linking alcohol and drug services with child welfare (SAMHSA Publication No. SMA 02-3752). Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.


Nancy K. Young is the director of Children and Family Futures, a California-based research and policy institute whose purpose is to improve outcomes for children and families affected by substance use disorders. She also serves as the director of the federally funded National Center on Substance Abuse and Child Welfare, which provides technical assistance to states in support of their efforts to enhance cross-system collaboration for the benefit of affected families and develops and disseminates information on advances in policy and practice in this field. She holds a PhD and master’s degree from the University of Southern California, School of Social Work.

Sharon M. Boles serves as evaluation director of Children and Family Futures, whose staff implements the National Center on Substance Abuse and Child Welfare (NCSACW). She serves as the lead evaluator for the Sacramento Dependency Drug Court. In addition, she serves as a grant reviewer for the Center for Substance Abuse Treatment and the Substance Abuse and Mental Health Services Administration. She is also a guest reviewer for several substance-related journals. She holds her PhD and master’s degree from the University of California, Santa Barbara.

Cathleen Otero is an associate with Children and Family Futures in Irvine, California, where she serves as the project manager for the National Center on Substance Abuse and Child Welfare. She received her master’s of social work and master’s of public administration degrees from the University of Southern California and earned her BA in psychology from Yale University. She previously worked in grant development for the Substance Abuse and Mental Health Services Administration’s Center for Mental Health Services and she served as clinical research interviewer at the University of Southern California, Social Science Research Institute.