PARENTAL SUBSTANCE USE IN CHILD WELFARE SYSTEM

Introduction

National and local data reveal that up to 80 percent of adults associated with a child welfare case have a substance use problem that contributes to the abuse or neglect of their children.\(^1\) From 2015 to 2017, 51 percent of all child fatalities in Texas involved a caregiver who was actively using or under the influence of substances at the time of the child’s death.\(^2\) Figure 1 shows an increase in overall rates of removing children from their biological homes (removals) by child welfare systems in Texas and across the U.S. The Adoption and Foster Care Analysis and Reporting System (AFCARS) of the U.S. Department of Health and Human Services (HHS) found in 2016 that more than 34 percent of children nationally were removed due to parental alcohol or drug use, while in Texas 63 percent of children were removed for the same reason.\(^3\) Preliminary data provided by the Texas Department of Family and Protective Services (DFPS) indicates that the rate of returning children to live in their biological homes (reunification) for families with alcohol or drugs as a risk factor are much lower than reunification without this factor present.\(^4\)

In Texas, substance use in child welfare is classified as “neglectful supervision” under the Texas Family Code. Specifically, neglectful supervision means "placing a child in or failing to remove a child from a situation that a reasonable person would realize requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that results in bodily injury or substantial risk of immediate harm to the child."\(^5\) In 2017, 71 percent of all cases with confirmed instances of abuse and/or neglect (confirmed investigations) in Texas involved neglectful supervision; however, it is difficult to determine what percent of these confirmations and any subsequent removals are related to parental substance use as a primary factor. In addition, research indicates that the prevalence of specific substances used by adults involved with child welfare systems is frequently underreported and challenging to track.\(^6\) In many states, for example, alcohol and overall substance use is tracked, but the type of drug used may not be indicated as often.

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\(^1\) Children and Family Futures, Inc. Navigating the pathways: Lessons and promising practices in linking alcohol and drug services with child welfare. Nancy K. Young, Ph.D., Sidney L. Gardner, M.PA. Substance Abuse and Mental Health Administration, Center for Substance Abuse Treatment, Technical Assistance Publication, 27.


\(^4\) Department of Family and Protective Services (2018). Data request and intake tracking.

\(^5\) Texas Family Code §261.001

Texas’ program for families referred from DFPS as needing prevention and intervention services, Family Based Safety Services (FBSS), are designed to maintain children safely in their homes or make it possible for children to return home. FBSS includes substance use treatment services and seeks to strengthen protective factors of families and reduce risks to the safety of children. The number of families in need of services through FBSS increased by 28 percent over the past five years. Moreover, the number of families who have experienced one or more children removed from their homes and placed into Child Protective Services (CPS) where the state is legally responsible for the child’s welfare (conservatorship; CVS) increased by 15 percent over the last five years (See Figure 2). Substitute care is provided from the time a child is removed from their home and placed in CVS until the child returns home safely or is placed into another living arrangement that does not require CPS supervision. The objectives of substitute care are to 1) provide temporary placements for a child at risk of abuse or neglect; 2) arrange for social, therapeutic, medical, and educational services appropriate to the child’s needs; and 3) make reasonable efforts to either reunite the child with family, transfer conservatorship to another appropriate adult, or find an adoptive parent.⁷

Figure 1 DFPS vs National Removal Trends (10-year) ⁸,⁹

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CPS and Families Experiencing Substance Use

Whether the substance use is by a parent or by another adult caregiver in the home, the behaviors of adults while under the influence of alcohol or drugs can have life-long effects on children. Children who are impacted by an adult caregiver using substances could experience unmet developmental needs, impaired attachment, economic hardship and legal problems in the home, emotional distress, and sometimes violence. Children have an increased risk of developing a substance use disorder themselves.\textsuperscript{11} Children affected by parental substance use are at higher risk for nearly every diagnosable childhood mental and emotional disorder in the Diagnostic Statistical Manual of Mental Disorders (DSM-5). Thus, it is important for child welfare workers to recognize when alcohol or drug use is a factor in the case of child abuse or neglect in order to help parents obtain appropriate treatment and understand the process of recovery in the context of child safety.

A working knowledge of alcohol and drug treatment services can help child welfare workers meet the 1997 Adoption and Safe Families Act (ASFA) timelines for family preservation and permanency. This knowledge can also help workers fulfill the child welfare commitment to child safety, permanency, and family stability.

and well-being. For cases in which CPS has taken conservatorship of a child, ASFA requires a permanency plan within 12 months after a child enters foster care and requires states to initiate proceedings to terminate parental rights if a child has been in foster care for 15 of the most recent 22 months.

While 12 or 15 months is a long time in the life of a child, it is relatively short in the recovery process of a parent who has years, or even decades, of substance use. It is critical that the 15-month period be beneficial and efficient. When substance use is an issue, child welfare workers should evaluate the treatment needs of the parent and ensure the parent accesses appropriate alcohol and drug services in a timely manner. To be effective, workers must understand dependence on and abuse of alcohol and drugs. They should also feel comfortable conducting random drug screenings and asking routine questions about substance use, treatment, and recovery.

CPS workers need sustained training in recognizing substance use disorders and understanding the nature of substance use and related best practices. Currently, caseworkers receive training in basic skills development on types of substances and their impact on a caregiver’s ability to parent, what types of drug testing to utilize and when, and local services that address substance use issues. However, training on the best practices around how to work with a family experiencing substance use is limited. Workers may want to use Motivational Interviewing (MI) with caretakers who are experiencing substance use problems. MI is a counseling method that helps individuals resolve ambivalent feelings and insecurities to find the internal motivation they need to change their behavior. It is a practical, empathetic, and short-term process that takes into consideration how difficult it is to make life changes. The intervention helps individuals become motivated to change the behaviors that are preventing them from making healthier choices. It can also prepare individuals for further, more specific types of therapies. MI has a strong evidence base and research has shown that this intervention works well with individuals who start off unmotivated or unprepared for change.

As turnover and caseloads have decreased at CPS, the agency is in a better position to provide more targeted and specialized services within the existing workforce. In Region 3 (North Texas) between 1998 and 2009, DFPS operated a specialized FBSS unit specific to families with substance use as their primary risk factor. Referral criteria and limited caseloads ensured that caseworkers had the opportunity to meet with families at least twice a week, offering in-home support that yielded positive outcomes.

In addition, providing families with access to qualified substance use disorder specialists can ensure they receive timely assessment and referral to resources in the community that are the most likely to facilitate recovery. In 2011, the funding for regional substance use specialists was eliminated, resulting in only one substance use specialist for the state limiting this essential resource in regions. Restoring these positions in local communities would greatly improve service delivery.

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12 SAMHSA-HRSA Center for Integrated Health Solutions. Motivational interviewing.
Certified Recovery Coaches (RCs), also known as Peer Support Specialists (PSS), are a relatively new way to expand formal in-home and community-based substance use treatment. RCs are themselves in successful recovery from alcohol or substance use disorders and able to combine their lived experiences with certification training. They can be employed by or volunteer with community organizations and professional Substance Use Disorder (SUD) treatment providers to give guidance to parents who are in various stages of the recovery process. These peer specialists provide support and access to resources through one-on-one mentoring relationships and group facilitation.\(^{12}\) RCs also have been utilized to deliver brief intervention services in hospital emergency departments. They are often available not only during, but also after, the initial inpatient or intensive outpatient treatment process. Peer specialists are sometimes able to attend primary care visits with those in recovery. A qualitative study found that compared with primary care physicians, RCs respond more quickly and able to meet more frequently with people in various stages of the recovery process. The study also found that those in recovery are more likely to listen and take the advice of RCs over their primary care physicians, feel more motivated to change their substance use behavior, and are better connected with local community resources.\(^{13}\) Although more research is needed on the efficacy of peer specialist roles in providing support, they have been found to be valuable not only to the individual, but also to any agency in which the individual is involved during the treatment process.\(^{14}\)

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CPS Process for Substance Use and Alcohol Services

CPS Investigation initiated
(timeframe 0-60 days typically)
- Caseworker will screen for drug and alcohol use
- Address any allegations pertaining to drug and alcohol use
- Possibly administer drug testing (oral swab, urinalysis and hair strand)

Staffing w/supervisor-PD or both
- Depending on information gathered in the case, CPS can make the decision to:
  - close the case
  - implement a safety plan (including service referrals)
  - refer to FBSS
  - remove children from the home
  - place children in a Parental Child Safety Placement (PCSP)
  *Service referrals can be made*

Removal Occurs
At time of removal, investigator can refer parents directly to services

Removal Staffing Occurs Before TMC Hearing
- Staffing typically involve the caseworkers, supervisors and a PD from one of the programs
- Visitation, permanency goals, placements, potential kin, services and the order of services are decided
- Services are outlined, sometimes for specific vendors
- This is the first stage of developing the family service plan

TMC Hearing Occurs
- Services are court ordered
- Judges can make their own recommendations for services or follow CPS recommendations; time frames can be outlined by judges

CVS Case Typically Lasts 6-18 months
- Caseworker will develop service plans for each adult in the case in need of services
- Services, including which vendor, can be changed or follow up services can be ordered as the case progresses – either requested by CPS or a judge
- Drug testing usually occurs ongoing throughout the case

Types of Substance Use Services CPS Utilizes
- Drug testing (2054)
- Substance Abuse Assessment (2054)
- Drug Counseling (2054 or refer to community provider)
- Psychosocial Assessment (2054)
- Psychological Assessment (2054)
- Psychiatric Assessment (refer parent directly to community provider)
- Referral to OSAR (refer through form)
- Referral to Drug Treatment (refer parent directly to community provider)

Case is closed
Any services family was referred to with a 2054 are end dated

Case is referred to FBSS
Assessment is conducted by FBSS Caseworker, INV is encouraged to attend

FBSS Staffing Occurs
- Staffing typically involve the caseworkers, supervisors and a PD from one of the programs
- Frequency of visits, services and the order of services are decided
- Services are outlined, sometimes for specific vendors
- This is the first stage of developing the family service plan

FBSS Case Typically lasts 3-9 Months
- Caseworker will complete family service plan and monitor progress
- Case is staffed monthly with supervisor
- Additional services can be ordered throughout the case
- Drug testing is typically ongoing throughout case
- Upon conclusion, if safety factors are not addressed, CPS can pursue removal or long-term placement with kin
Substance Use Programs in Texas for CPS Families

The following treatment options are the most commonly made available services through FBSS or CVS to families who are involved with CPS.

**Inpatient Drug Treatment: Women and Children’s Programs**

Women and Children Residential Treatment provides substance use treatment services for women and children living together in a licensed residential facility. The services include counseling, parenting education, health education, skills training, and case management services. These services are more appropriate for women who are diagnosed with a moderate or severe substance use disorder, are pregnant, and/or have children in the custody of the state. Research and performance measurements from the Texas Department of State Health Services (DSHS) support that inpatient women and children’s programs have higher completion rates\(^\text{15}\) and more successful outcomes related to sobriety, employment, and health.\(^\text{16}\) The number and age of children allowed to attend treatment varies from program to program. Texas currently has seven similar programs across the state providing either supportive or intensive residential treatment (see Figure 3). For families identified by CPS as at risk for removal of a child, inpatient women and children’s programs can be utilized as a measure to prevent foster care entries.

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\(^{15}\) Department of State Health Services (2016). Performance measurement data.

Outpatient Programs
Outpatient treatment services are for people with substance use disorders who do not need to live at a facility to maintain sobriety. Outpatient treatment services provide counseling, education, and support services. It allows patients to continue to live in their home community. These programs also support change through cognitive-based treatment modalities, which often involve attending sessions or classes multiple times a week. While this is the most frequently utilized treatment for families involved with CPS or FBSS, it has much lower completion rates (38 percent) than inpatient programs (59 percent).17

17 Department of State Health Services (2016). Performance measurement data.
Services provided through DFPS
For families in need of services who do not qualify for the programs mentioned above, or families who reside where services are limited or unavailable, DFPS can contract with community agencies to provide individual treatment services with funding allocated through Purchased Client Services (PCS). Contractors for services include inpatient Chemical Dependency Treatment Facilities (CDTFs) and inpatient or outpatient meetings with Licensed Chemical Dependency Counselors (LCDCs).¹⁸

DFPS caseworkers also have a few more options to provide support for the family member, although they are not allowed to provide direct treatment. In the case that a substance use screening counselor or treatment service provider denies the parent participation in a treatment program, or if the parent either refuses treatment services or denies the substance use, DFPS caseworkers may do one or more of the following: appeal the denial of services; offer random, frequent drug testing (oral swabs, urinalysis, and hair follicle and nail testing); refer the parent to 12-step programs and/or individual counseling within the community; and/or provide the parent with education materials. When treatment is unavailable due to a lack of resources in the immediate area or there are long waiting lists to receive treatment, caseworkers work collaboratively with the parent to determine appropriate interventions that they can incorporate into an individualized substance use service plan, which must be approved by a CPS supervisor.19

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**Stages of Substance Use Disorder**

*Substance Use Disorder*

In 2013, the Diagnostic Statistical Manual replaced the categories of substance abuse and substance dependence with a single category: substance use disorder. The symptoms associated with a substance use disorder include four main components: (a) impaired control, (b) social impairment, (c) risky use, and (d) pharmacological criteria (e.g. tolerance and withdrawal).

*Addiction*

According to the National Institute on Drug Abuse (NIDA) addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain; they change its structure and how it works. These brain changes can be long-lasting and lead to many harmful and self-destructive behaviors.

*Relapse*

Relapse refers to a person using substances again after a period of sobriety. Relapse is not an indication of failure. It is as common as relapses for other well-characterized chronic medical illnesses such as diabetes, hypertension, and asthma, which also have physiological and behavioral components.

*Recovery*

Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. This change in lifestyle is built on access to evidence-based clinical treatment and recovery support services for all populations. The Substance Abuse and Mental Health Services Administration (SAMHSA) has delineated four major dimensions that support a life in recovery:

- **Health:** Overcoming or managing one’s disease(s) or symptoms— for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem— and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being;
- **Home:** Having a stable and safe place to live;
- **Purpose:** Conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- **Community:** Having relationships and social networks that provide support, friendship, love, and hope.

*Source: Substance Abuse and Mental Health Services Administration*

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Family First Prevention Services Act

The Bipartisan Budget Act of 2018 passed in February provides significant opportunities for states to make sweeping changes to the ways they provide services to families impacted by substance use. The new law includes the Family First Prevention Services Act (Family First), which changes how Title IV-E funding through the Social Security Act can be used for foster care and family assistance services. Beginning October 1, 2019, DFPS will have the option of using this funding for prevention and family services programs, including substance use treatment programs. Title IV-E funds can only be used to provide services to the child and child’s family for a maximum of 12 months from the date the child is identified in a prevention plan as at-risk for entering foster care. If a child is subsequently identified as at-risk, the child may receive these services more than once and further federal funding may be available. Under these specifications, DFPS could use these federal matching funds for up to 50 percent of state expenditures. Programs should be provided either in the home or in community settings. To receive federal funding through Family First, substance use interventions for the family must be trauma-informed and evidence-based. They must fall under one of three levels of evidence rating categories: 1) well-supported, 2) supported, or 3) promising. The federal government is still working to clarify qualifications for evidence-based programs under Family First, but what guidance has been released shows similarities to the rating system utilized by the California Evidence-Based Clearinghouse for Child Welfare (CEBC). The federal government will establish its own evidence-based clearinghouse to facilitate their new rating system.

In a July 2018 report, Casey Family Programs identified substance use treatment programs or therapeutic interventions that have the potential to qualify as well-supported (four programs), supported (14 programs), or promising (seven programs) under Family First’s developing rating system. Casey Family Programs includes in their report, where available, cost-benefit analyses for each program. They are drawn heavily from the Washington State Institute for Public Policy (WSIPP), although the costs are estimated and adjusted to be specific to Washington State, they provide a guide to possible average cost for implementing a program per parent, family, or child, and the effectiveness of each program. Highlighted below are a few of the adult-targeted programs that have a more general approach, rather than those that are drug-specific. Also included below are adult substance use programs already funded and implemented by the state, although it is unclear as to whether these programs would qualify under Family First.

Adaptive Stepped Care

Adaptive Stepped Care (ASC) is an alternative to the standard methadone maintenance treatment for adults with opioid, cocaine, sedative, and general substance use disorders. The program integrates patient-service matching

21 Casey Family Programs (2018). Interventions with special relevance for the family first prevention and services act (FFPSA).
22 ibid.
and patient-provider matching with a behavioral component. ASC includes treatment through medication and counseling, and behavioral contingencies. It has four main goals: 1) higher rates of prescribed counseling attendance, 2) lower rates of partial and poor clinical response, 3) similar rates of retention, and 4) lower rates of drug-positive urine specimens. Casey Family Programs concluded that Adaptive Stepped Care would be supported under Family First requirements as they currently stand. The program also has a National Registry of Evidence-based Programs and Practices (NREPP) rating of effective.

Motivational Interviewing
Motivational Interviewing (MI) seeks to motivate and empower people wishing to recover from substance use to change their behaviors. It is a client-centered, directive approach which focuses on exploring and then resolving ambivalence to the idea of change. The program recommends one to three individual sessions lasting 30 to 50 minutes each. MI is typically provided in community agencies, hospitals, outpatient clinics, or residential care facilities. MI was found well-supported by CEBC and Casey Families Programs. The Campbell Systematic Review found the program had a significant impact on reducing substance use for one to six months and for the seven- to 12-month follow-up periods. The Casey Family Programs report estimated a cost of $263 per person, with an estimated $5,572 in cost savings.

Parenting Awareness and Drug Risk Education
Parenting Awareness and Drug Risk Education (PADRE) is a Texas DSHS-funded program that targets male caregivers of children under age 6 who either have or at risk for substance use disorders. It is a 15-week educational parenting group and includes intensive case management. PADRE’s goals are to help caregivers become well-equipped to handle parenting through the development of life skills and healthy lifestyles. In 2014, Texas had nine site locations. PADRE is not rated under any evidence-based clearinghouse and it is uncertain as to whether this program would qualify under Family First.

Post-Partum Pregnant Intervention Program
Post-Partum Pregnant Intervention Program (PPI) serves pregnant and postpartum women of all ages with children beginning in the prenatal stage to infancy who have a risk factor of substance use. It is funded by Texas DSHS and as of 2014, was implemented in 15 areas across the state (see Figure 5).

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24 Casey Family Programs (2018). Interventions with special relevance for the family first prevention and services act (FFPSA).
27 Casey Family Programs (2018). Interventions with special relevance for the family first prevention and services act (FFPSA).
29 Casey Family Programs (2018). Interventions with special relevance for the family first prevention and services act (FFPSA).
PPI’s goals are to reduce fetal and infant exposure to alcohol and substance use and to encourage a healthy lifestyle for mothers. Services include substance use assessment, counseling, referrals, home visits, individual and group crisis counseling, and education in reproductive health, child development, family violence prevention, and parenting. This program has not been rated by any evidence-based clearinghouse. It is uncertain as to whether this program would qualify under Family First.

Figure 5 Map of DSHS Locations for Post-Partum Pregnant Intervention Program and Number of Substance Abuse Removals by CPS in 2017
Seeking Safety
Seeking Safety (for adults) is targeted at people with substance use and/or past trauma. This treatment is based on coping skills therapy and can be conducted in either group (two to 50 participants) or individual sessions. The program consists of 25 topics, including safety, setting boundaries in relationships, creating meaning, recovery thinking, coping with triggers, and self-nurturing. The overall goals of the program are to reduce trauma and/or substance use symptoms and increase safe coping skills in relationships, thinking, behavior, and emotions. Seeking Safety is available as a book, complete with clinician guidelines and handouts for participants. Between each session, participants are asked to make a commitment of doing one thing for their recovery. CEBC rated Seeking Safety as promising and Casey Family Programs suggested the program will also be considered promising under Family First guidelines. The Casey Family Programs report estimated a cost of $526 per person.

Sobriety Treatment and Recovery Teams (START)
The START program uses an intensive intervention model that integrates addiction services and treatment providers, family preservation, community partnerships, and best practices in child welfare and substance use treatment. This program targets families with co-occurring substance use and child maltreatment. START aims to reduce recurrence of child abuse and neglect, improve substance use disorder treatment rates, build protective parenting capacities, and increase the county’s and state’s capacity to address co-occurring substance use and child maltreatment. START pairs specially trained CPS workers with family mentors, who have at least three years of sobriety and previous involvement with CPS, to work with at-risk families. Decision making is shared among all team members, including the family and court. Recent research has found that mothers who participated in START achieved sobriety at nearly twice the rate of mothers treated without START. The program has also proven to be effective at keeping children in the home. Children in families served by START were half as likely to be placed in state custody as compared with children in a matched control group. It was found that at case closure, over 75 percent of children served by START remained with or were reunified with their caregivers. A recent cost analysis by the Kentucky START program found that for every $1 spent on START, the state avoids $2.22 in the cost of foster care. START has also been successful in bringing much-needed support services to underserved areas. CEBC rated START as promising and Casey Family Programs suggested the program will also be considered promising under Family First guidelines.

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32 Casey Family Programs (2018). Interventions with special relevance for the family first prevention and services act (FFPSA).
33 Zero to Three. Kentucky START program.
35 Casey Family Programs (2018). Interventions with special relevance for the family first prevention and services act (FFPSA).
Recommendations/Solutions

Based on the challenges identified with substance use prevention services to families, TexProtects recommends the following actions:

- Enhance data reporting for parental substance use disorders in the CPS data management system. Include more specific dispositioning for Neglectful Supervision.
- Reinstate substance use specialists regionally to assist in service planning for FBSS and CVS cases. Additionally, consider placement of CPS liaisons at major birthing hospitals to coordinate service delivery for families where prenatal substance exposure is present.
- Expand recovery coaches/peer support specialists for families involved in substance use and child welfare.
- In areas of the state where the need exists, establish specialized FBSS and CVS units focused on families where a substance use disorder is present. Ensure these caseworkers receive additional training on best practices, motivational interviewing, and family engagement.
- Invest in substance use disorder services statewide to ensure adequate array and geographic distribution and participate in maximizing funding for substance use treatment and prevention through Family First.

Conclusion

Many families involved in the child welfare system are negatively impacted by parental substance use. Although identifying and meeting the complex needs of parents with substance use disorders and those of their children can be challenging, innovative approaches along with new research and program evaluation can guide the state in implementing more effective, collaborative, and holistic service delivery to support both parents and children. To be successful in reducing and preventing the number of children and families suffering from substance use and the negative social and economic consequences, including children entering the foster care system, Texas must ensure access to and implementation of community-driven, cost-efficient and proven prevention, intervention, and treatment programs and practices.
### Alcohol and Drug Use Continuum and Its Impact on Child Welfare

| Use of alcohol or drugs to socialize and feel effects; use may not appear abusive and may not lead to dependence, however the circumstances under which a parent uses can put children at risk of harm | - Use during pregnancy can harm the fetus  
- Use of prescription pain medication per the instructions from a prescribing physician can sometimes have unintended or unexpected effects—a parent caring for children may find that he or she is more lethargic than expected and cannot respond to the needs of children in his or her care |
| --- | --- |
| Abuse of alcohol or drugs includes at least one of these factors in the last 12 months:  
- Recurrent substance use resulting in failure to fulfill obligations at work, home or school  
- Recurrent substance use in situations that are physically hazardous  
- Recurrent substance-related legal problems  
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the substance | - Driving with children in the car while under the influence  
- Children may be left in unsafe care—with an inappropriate caretaker or unattended—while parent is using  
- Parent may neglect or sporadically address the children's needs for regular meals, clothing, and cleanliness  
- Even when the parent is in the home, the parent's use may leave children unsupervised  
- Behavior toward children may be inconsistent, such as a pattern of violence then remorse |
| Dependence, also known as addiction, is a pattern of use that results in three or more of the following symptoms in a 12-month period:  
- Tolerance—needing more of the drug or alcohol to get "high"  
- Withdrawal—physical symptoms when alcohol or other drugs are not used, such as tremors, nausea, sweating, and shakiness  
- Substance is taken in larger amounts and over a longer period than intended  
- Persistent desire or unsuccessful efforts to cut down or control substance use  
- A great deal of time is spent in activities related to obtaining the substance, use of the substance or recovering from its effects  
- Important social, occupational, or recreational activities are given up or reduced because of substance use  
- Substance use is continued despite knowledge of persistent or recurrent physical or psychological problems caused or exacerbated by the substance | - Despite a clear danger to children, the parent may engage in addiction-related behaviors, such as leaving children unattended while seeking drugs  
- Funds are used to buy alcohol or other drugs, while other necessities, such as buying food, are neglected  
- A parent may not be able to think logically or make rational decisions regarding children's needs or care  
- A parent may not be able to prioritize children's needs over his or her own need for the substance |

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