Children at the Crossroads: Integrating Services for Child Welfare Clients with Alcohol and Other Drug Problems

The following was excerpted from Children at the Crossroads, an article by Nancy K. Young and Sidney L. Gardner which appeared in the Winter 1998 issue of Public Welfare (vol. 56, no.1). The original article examines the overlap of families who are receiving services through the child welfare system, alcohol or other drug (AOD) treatment and Temporary Assistance for Needy Families (TANF). It discusses the conflicting values and identifies five major differences among these systems. The differences include: (1) purposes reflected in different laws and regulations; (2) timetables for carrying out program goals; (3) staff education and training; (4) definitions of clients; and (5) funding streams. In the remainder of the article, Young and Gardner present solutions and a framework for addressing these differences. Their recommendations are reprinted below with permission from the American Public Welfare Association. A more comprehensive discussion of these ideas can be found in the forthcoming publication, Responding to Alcohol and Other Drug Problems in Child Welfare: Weaving Together Practice and Policy, available from the Child Welfare League of America (800-407-6273 or www.cwla.org).

Assessment is the area of daily practice that presents some of the most important choices for workers in the three systems in determining the approach they take with clients. In addition, it is the program component that cuts across all five of the elements in the framework. Most CPS officials familiar with the risk assessment process agree that it does not typically include more than a cursory review of AOD issues. In many versions of risk assessment instruments, a single question is asked about visible AOD abuse, requiring a worker to make a subjective judgment about whether that abuse presents a risk factor for child safety. A 1996 survey by the Child Welfare League of America found that 40 percent of states do not address parental drug or alcohol abuse at all in their risk assessment protocols. The TANF assessment process is still emerging in most states and communities, but there is not yet a widely used or accepted model that combines assessment of clients’ overall work readiness and their AOD needs.

The task, then, is as clear as it is difficult: combining risk assessment in the CPS system with screening and assessment of AOD problems, family functioning, and work readiness. The consensus among workers in the CWS and AOD fields is that screening should be done within the CWS system, whereas detailed assessment and treatment matching should be completed in AOD systems to use their knowledge of treatment resources and modalities, rather than relying on CPS workers to make these in-depth assessments alone. Screening and assessment are separated under emerging proposals for managing care in AOD contracting, with screening done within the CWS system as a first step toward collaboration. It seems appropriate for an AOD expert to do an in-depth AOD assessment and set up the treatment plan for a client or family. This approach, however, would require much closer working links between the...
<table>
<thead>
<tr>
<th>MODEL</th>
<th>PROGRAM ELEMENTS</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Budget and Financing</td>
</tr>
<tr>
<td>Paired AOD counselor and CPS worker</td>
<td>Title IV-E waiver</td>
</tr>
<tr>
<td>AOD counselor paired with CPS office as technical assistance</td>
<td>Jointly funded by AOD and child welfare services</td>
</tr>
<tr>
<td>AOD screening in child protective service-welfare office; CPS and welfare staff on loan to state office</td>
<td>Jointly funded by AOD, child welfare and welfare services</td>
</tr>
<tr>
<td>Multidisciplinary team for joint case planning</td>
<td>Separate funding from each partner agency</td>
</tr>
<tr>
<td>Paired CPS worker and person in recovery</td>
<td>Foundation grant and CPS funding</td>
</tr>
<tr>
<td>Infusion of AOD treatment strategies through training</td>
<td>Foundation grant and CPS funding</td>
</tr>
<tr>
<td>Community partners of recovery and treatment staff with CPS</td>
<td>Primarily AOD funding</td>
</tr>
<tr>
<td>Drug family court</td>
<td>Family court</td>
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</table>
two agencies; as the models described in Table 1 make clear, some sites have already moved in this direction.

Both systems tend to categorize assessment into three processes (Table 2). The disconnection in processes, however, occurs in both the CWS risk assessment tools and the AOD assessment instruments. The CWS risk assessments typically ask one or two questions about AOD use and rely on workers' subjective rankings of clients based on the clients' reports or workers' observations of obvious AOD use. The AOD assessment instruments rarely include measures of family functioning and risks to children in their protocols.

Both Systems Need Changes

If AOD-related risk assessment screening tools are not combined with the existing CWS risk assessments to determine if clients need more detailed AOD assessments and treatment planning, parents' first level of contact is with a worker who is not trained and often not encouraged to make an in-depth judgment about clients' AOD problems. In addition, if child- and family-focused assessment tools are not combined with current AOD practices, both the immediate and the long-term risks to children are missed in the treatment plans. Most women's AOD treatment programs of the past decade are an exception, but these programs serve only a fraction of the parents who are admitted to publicly funded treatment programs.

Unless these tools are fully integrated with CPS assessments, however, a "layering" effect results in which each discipline or problem area demands its own assessment by its own workers, leading to multiple layers of assessments for such issues as CPS risk, TANF work readiness, the severity of substance abuse, and the developmental stage of the child—each treated separately and assessed categorically. This places a burden on both workers and clients that makes the system much less likely to be able to address problems in a unified manner. In some settings, this layering has caused frontline workers to react negatively to proposals for expanded use of screening or assessment tools, which inevitably appear to present them with more work without increasing their time or pay.

The Training Response

Workers in the three systems are typically trained in different disciplines, use different definitions of professionalism, and emerge from pre- and in-service training with disparate ideas about who their clients are. In responding to these training barriers, a group of CWS and AOD officials recently developed and proposed a set of priorities for new training that would enable workers to work across systems. Several training modules have been suggested to work across the two systems, including how each system operates; the distinctions among use, abuse and dependency; treatment methods in AOD agencies and their effectiveness; resources in the child welfare system; AOD abuse as a family disease; the special needs of women and parents; and the development impact of parents' AOD abuse on younger children.

Sacramento County's Alcohol and Other Drug Training Initiative, supported by the state of California and The Annie E. Casey Foundation for the past three years, is the most comprehensive effort to change the training of health and human service workers at the county level to include significantly more AOD material than workers have received in pre- or in-service training in the past.

Alternative Service Delivery Options: Managed Care and Community Partnerships

Trends in CWS and AOD systems—which include major shifts toward managed care, privatization, and community-based reforms—promise to alter the delivery system significantly. The fact that the welfare reform legislation permits the for-profit operation of portions of the system (and the fact that some states and counties already contract out substantial portions of their welfare systems) is further evidence of these trends. These changes are being driven in part by a concern for behavioral health outcomes, which some observers believe to emphasize fiscal outcomes over client outcomes. Some officials fear that managed care may make it harder to cooperate across CWS and AOD systems, whereas others point out that the approach used by managed care may build better links between CWS and AOD because it emphasizes the combinations of agencies that can produce better results for clients. Results will improve, however, only if "scorecards" are developed to monitor managed-care
reforms that emphasize the results for clients. Few states or counties have yet developed such scorecards for monitoring managed-care changes in their communities. When a state or county shifts to private or managed-care providers, its service delivery role changes, but its regulatory and monitoring roles become much more important. Several counties and states have begun to review the millions of dollars of contracts they have with local providers and to develop more outcome-driven monitoring of the effectiveness of contracts for both CWS and AOD treatment.

The second major service delivery change already under active discussion and implementation in some communities is a shift toward neighborhood- or community-level partnerships that expand the role of community organizations and natural helping networks in providing front-end services to families who are not yet in the CWS system but who appear to have problems that may worsen. Under the heading "community partnerships" and encouraged by family preservation and family support funding made available to states three years ago, these efforts have been highly visible at several sites, including those in Cedar Rapids, IA; Cleveland, OH; Jacksonville, FL; Louisville, KY; Los Angeles, CA; and St. Louis, MO. This trend has been further strengthened by the movement toward school-linked services, full-service schools, and family resource centers. As neighborhoods become more adept at using community asset mapping, including some inventories of total public resources coming into their neighborhoods, they have begun to demand a wider role in service delivery reform. In neighborhoods that can mobilize informal networks of recovering parents—as Cleveland, OH and Nashville, TN, have done—this community role includes support for both CPS monitoring and AOD aftercare.

Models of New Practice

The models in Table 1 summarize some of the most current trends in programs that weave together CWS and TANF systems' concerns for their clients' AOD problems. Some of the models have been in use for two or three years; others are in the early demonstration stages. The range of options included here, however, shows how different states and communities have approached the task of building new links across systems.

Outlines of a New System

A newly linked CWS-TANF-AOD system would operate differently with regard to frontline workers, client contacts with both children and families, assessment of risk, referrals for services, accountability for results based on outcome-driven information systems, and training for workers. The community would support families at the front end of CWS and TANF support services. The new system would be capable of assessing and providing a differentiated response to children and families, responding to a more sensitive and detailed assessment of both family issues and substance abuse issues. This new partnership among CPS, TANF, and AOD would have to be comprehensive, negotiated among equals, carefully staged in its development, and driven by results-based accountability. Above all, the new system would have to have new partners, primarily at the community level, who could accept responsibility for families who need help, be it aftercare in the AOD system, support in finding transportation to work in the TANF system, or respite care from reunification responsibilities in the CWS system.

The new system would also include more than bilateral bridges between CWS, TANF, and AOD agencies, since many clients need more than these services and supports. Community-based aftercare, family support, mental health, job training, and literacy training are among the many services and supports that go beyond the CWS, TANF, and AOD services that are needed by families in the three systems. As one participant said during a session of officials from CPS and AOD agencies, "AOD treatment is not a stand-alone service.

Agencies should give special attention to the problem of domestic violence, given the specific references in the welfare reform legislation to domestic violence and the substantial overlap between AOD use and domestic violence. Policymakers should carefully review the extent to which these two problems affect an overlapping group of both TANF and CWS clients. Both battered women and their abusers are significantly affected by AOD use; several studies have found that over 40 percent of homeless women report both physical abuse and AOD abuse (Bassuk, Rubin & Lauriat, 1986). In a study of domestic assault incidents in Tennessee, 94 percent of the assailants and 43 percent of the victims had used alcohol or other drugs in the six hours prior to the assault (Brookoff, 1996).

We believe the overlap among TANF, CPS, and AOD problems to be important. Although we are not arguing that this factor alone will determine the success of TANF or of recent efforts to reform the CWS system (Farrow, 1997), we do believe that the issue intersects profoundly with the needs of poor children in the welfare and child welfare systems. Domestic violence, child care, and mental health are among the issues that affect parents' work readiness as well as their parenting, making it essential for policymakers and frontline staff to address them in a unified way rather than categorically, based on the resources that they have set aside for each of the problems. Child welfare and welfare reform are inextricably woven together, and the existence of AOD problems within a substantial subset of each client group argues powerfully for continued efforts to build on the models and innovations outlined in this article.

— Nancy K. Young, Director, and Sidney L. Gardner, President, Children and Family Futures, Irvine, CA

REFERENCES


Child Welfare and Substance Use: Findings from a Collaborative Services Initiative in Illinois

In 1995, the Illinois state legislature established an innovative collaborative initiative between the state child welfare agency—the Department of Children and Family Services (DCFS)—and the state substance abuse agency—the Office of Alcohol and Substance Abuse (OASA). This DCFS/OASA Initiative was designed to reduce interagency barriers which can prevent mothers involved with child protective services from succeeding in substance abuse treatment. Findings from a recently-completed evaluation suggest that the Initiative services were successfully implemented and that Initiative participants were less likely than recipients of regular treatment services to continue using substances. The findings also provide valuable insights into the challenges faced by mothers involved with child protective services due to substance use and into the potential for state agency collaboration to address some of these challenges.

Contrasting Approaches

While professionals and policy makers in both child welfare and substance abuse have taken action against parental substance use, professionals in the two areas have typically worked independently of one another and used different approaches. Substance abuse professionals, recognizing the motivating capacity of children, have often sought approaches which enable mothers to maintain custody of their children while participating in treatment. Child welfare professionals, on the other hand, often remove children until treatment has been successfully completed, or use the prospect of reunification as a motivation for treatment participation and recovery. Moreover, whereas substance use workers expect recovery from drug addiction to be a lengthy and erratic process, child welfare workers, aware of permanency deadlines, often require abstinence within fixed timelines. Despite the acceptance among substance use professionals of relapses as an expected part of the recovery process, child welfare professionals often interpret relapses as resistance to the recovery process or as willful noncompliance (Azzi-Lessing & Olsen, 1996). Thus, "the same clinical wisdom that applies to the general population of addicted people often does not apply to substance-abusing parents who find themselves involved with the child welfare system" (Azzi-Lessing & Olsen, 1996:17). As a consequence of the different perspectives and independence of the two types of professionals, the combined knowledge of each field has been insufficiently incorporated into decision making and service provision for substance-affected families involved with child protective services.

The DCFS/OASA Initiative

Recently, Illinois took steps to bring together knowledge from the two perspectives by launching an enhanced services program for mothers involved with child protective services due to substance use. The DCFS/OASA Initiative involves interagency cooperation between the state child welfare agency and the state alcohol and drug abuse treatment agency. The purpose of the Initiative is to integrate the services of the two departments in order to provide accessible and effective substance abuse treatment to mothers involved with child protective services. The design of the program builds upon research and program experience indicating that women benefit most from drug treatment programs that provide comprehensive services for meeting health and social needs (NIDA, 1995). The Initiative particularly focused on three service enhancements: transportation, outreach, and child care. These service enhancements were designed to reduce substance use, improve mothers' health outcomes, and improve family and parenting outcomes.

The Initiative was implemented in community-based, women-centered treatment programs in areas of Illinois with relatively high numbers of child welfare clients. With Initiative funding, these programs can provide a substance abuse assessment and begin treatment within two days of receiving a referral. Once a client enters treatment, an outreach worker provides emotional and practical support to both encourage sustained treatment participation and to help the client integrate the treatment experience. Outreach workers also assist in arranging child care and transportation.

The Initiative Evaluation

Design

An evaluation of the Initiative was conducted to identify differences in substance use, parenting, child safety, and health outcomes between clients who participated in Initiative programs and clients who participated in regular substance abuse treatment. Clients were randomly selected from each program type. Between January and July of 1997, in-person interviews were conducted with 73 Initiative clients and 75 regular treatment clients. The evaluation survey included questions about current and past substance use, current and past experiences in substance abuse treatment, service needs, service receipt, social support, demographics, child custody and child health.

Findings

Demographics. As shown in Table 1, participants in regular and Initiative treatment services were very similar in age, race, education, employment, income and family characteristics. The average age of both groups was 33 years; the vast majority of both groups was African American. About half of each group had graduated from high school and about a quarter of

Continued on page 6...
each group was employed. All respondents had a child welfare case in the past two years, and about 80 percent from each group had an open case when they were interviewed. Over half of the members of each group had children placed out of the home. While it appears as if Initiative clients were slightly less likely than regular treatment clients to have an income over $10,000 per year, this difference is not statistically significant. The more important point is that only one fourth to one third of the respondents from either group had incomes over $10,000 per year. Clients in both treatment types tended to be very poor.

**Service use.** The survey respondents were asked which services were offered at their treatment facility and which services they personally received. As shown in Table 2, the evaluation findings suggest that for the specific types of services that the Initiative sought to provide — child care, transportation and outreach — Initiative participants were more likely to receive the services than participants in regular treatment. This evidence suggests that the Initiative programs were indeed successful in providing the services they were funded to provide.

**Recent substance use.** One of the most important questions addressed by the evaluation was whether involvement in an Initiative program resulted in reduced substance use. The evaluation focused on the four substances most commonly used among the evaluation clients: cocaine, heroin, marijuana and alcohol. Whereas essentially all of the evaluation participants had used one or more of these substances prior to receiving treatment, 27 percent of Initiative clients and 37 percent of regular clients reported use of any of these substances during treatment, specifically in the 30 days prior to being interviewed.

While these percentages suggest that the Initiative clients may be somewhat less likely than regular treatment clients to use substances following treatment, many factors in addition to program involvement might affect recent substance use. Other potential influences include: the severity of substance use prior to participating in the program, the length of time in treatment, and individual factors such as employment status, education level, and child custody. Because clients were not randomly assigned to the Initiative and regular treatment groups, it is possible that there were preexisting differences between the groups in some of these important areas. Therefore, a logistic regression analysis was conducted to look at the effect of Initiative participation while controlling for these other factors.

The analysis suggests that when demographic characteristics and service use characteristics are taken into account, participants in Initiative services were significantly less likely than participants in regular treatment programs to report recent substance use. In addition, evaluation respondents who were employed, and those who had children in the home, were less likely than respondents not having these characteristics to report recent substance use (see Table 3). The number of services used was also negatively

### Table 1: Demographics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Regular treatment (n = 75)</th>
<th>Initiative treatment (n = 73)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>33</td>
<td>33</td>
<td>.55</td>
</tr>
<tr>
<td>Race/ethnicity:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>81%</td>
<td>82%</td>
<td>.89</td>
</tr>
<tr>
<td>White</td>
<td>13%</td>
<td>10%</td>
<td>.47</td>
</tr>
<tr>
<td>Hispanic</td>
<td>0</td>
<td>3%</td>
<td>.15</td>
</tr>
<tr>
<td>High school or more education</td>
<td>47%</td>
<td>53%</td>
<td>.46</td>
</tr>
<tr>
<td>Employed</td>
<td>28%</td>
<td>26%</td>
<td>.65</td>
</tr>
<tr>
<td>Full-time</td>
<td>17%</td>
<td>12%</td>
<td>.39</td>
</tr>
<tr>
<td>Part-time</td>
<td>12%</td>
<td>14%</td>
<td>.75</td>
</tr>
<tr>
<td>Income &gt; $10,000</td>
<td>33%</td>
<td>23%</td>
<td>.15</td>
</tr>
<tr>
<td>Family characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Num. children &lt; 18 years old</td>
<td>3.6</td>
<td>3.6</td>
<td>.97</td>
</tr>
<tr>
<td>Current open DCFS case</td>
<td>80%</td>
<td>85%</td>
<td>.71</td>
</tr>
<tr>
<td>Any children in DCFS custody</td>
<td>57%</td>
<td>63%</td>
<td>.48</td>
</tr>
<tr>
<td>Any children at home</td>
<td>51%</td>
<td>48%</td>
<td>.74</td>
</tr>
<tr>
<td>Ever married</td>
<td>37%</td>
<td>32%</td>
<td>.45</td>
</tr>
<tr>
<td>Have a partner</td>
<td>56%</td>
<td>56%</td>
<td>.76</td>
</tr>
<tr>
<td>Partner is child's father</td>
<td>41% (n = 44)</td>
<td>46% (n = 41)</td>
<td>.61</td>
</tr>
</tbody>
</table>

### Table 2: Services received at treatment center

<table>
<thead>
<tr>
<th>Service</th>
<th>Regular treatment (n = 75)</th>
<th>Initiative treatment (n = 73)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On-site child care</td>
<td>28%</td>
<td>27%</td>
<td>.94</td>
</tr>
<tr>
<td>Child care arrangements</td>
<td>1%</td>
<td>7%</td>
<td>.09</td>
</tr>
<tr>
<td>Parenting classes</td>
<td>49%</td>
<td>69%</td>
<td>.04</td>
</tr>
<tr>
<td>Health care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth control counseling</td>
<td>44%</td>
<td>41%</td>
<td>.72</td>
</tr>
<tr>
<td>HIV counseling</td>
<td>79%</td>
<td>79%</td>
<td>.96</td>
</tr>
<tr>
<td>STD counseling</td>
<td>64%</td>
<td>70%</td>
<td>.45</td>
</tr>
<tr>
<td>Reproductive health care</td>
<td>29%</td>
<td>27%</td>
<td>.80</td>
</tr>
<tr>
<td>Family counseling</td>
<td>24%</td>
<td>23%</td>
<td>.92</td>
</tr>
<tr>
<td>Domestic violence counseling</td>
<td>45%</td>
<td>30%</td>
<td>.39</td>
</tr>
<tr>
<td>Education/job training</td>
<td>13%</td>
<td>16%</td>
<td>.60</td>
</tr>
<tr>
<td>Housing assistance</td>
<td>04%</td>
<td>07%</td>
<td>.45</td>
</tr>
<tr>
<td>Legal services</td>
<td>08%</td>
<td>08%</td>
<td>.96</td>
</tr>
<tr>
<td>Transportation</td>
<td>37%</td>
<td>63%</td>
<td>.002</td>
</tr>
<tr>
<td>Outreach worker</td>
<td>48%</td>
<td>68%</td>
<td>.01</td>
</tr>
</tbody>
</table>
Respondent characteristics which were positively associated with recent substance use include having a psychiatric hospitalization and being a cocaine user prior to treatment.

Finally, as indicated in Table 3, respondents who used transportation and outreach services were more likely than respondents not using these services to report recent substance use. Where this finding may seem somewhat paradoxical at first, the reader should consider that this analysis is associational, not causal. We tend to assume that service use has an impact upon recent substance use and not vice versa. However, due to the unique nature of transportation and outreach services, recent substance use may actually promote the use of these two services. That is, clients having the most difficulty staying off drugs are those who are likely to be in most need of transportation and outreach. Moreover, because these two services are more likely to be available in Initiative than in regular programs, the association between recent substance use and use of transportation and outreach is likely to be strongest among Initiative participants.

Evaluation findings reported elsewhere (Marsh, D’Aunno & Smith, 1997) suggest that compared to regular treatment, Initiative participation is not related to improved health, employment or parenting outcomes. Differences in these areas may not result from Initiative participation, or such changes may become apparent over a longer period of time. Future evaluation efforts will monitor some of the potential long term effects of the Initiative program.

**Table 3:** Logistic Regression Analysis of Recent Drug Use

<table>
<thead>
<tr>
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<th>B</th>
<th>S.E.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiative program</td>
<td>-1.93</td>
<td>.59***</td>
</tr>
<tr>
<td>Service used</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach</td>
<td>1.35</td>
<td>.53**</td>
</tr>
<tr>
<td>Transportation</td>
<td>1.65</td>
<td>.64**</td>
</tr>
<tr>
<td>On-site child care</td>
<td>-68</td>
<td>.67</td>
</tr>
<tr>
<td>Off-site child care</td>
<td>2.08</td>
<td>1.26</td>
</tr>
<tr>
<td>Total number of other services used</td>
<td>-22</td>
<td>1.1*</td>
</tr>
<tr>
<td>Individual characteristics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug use prior to treatment</td>
<td>-02</td>
<td>.017</td>
</tr>
<tr>
<td>Days in treatment</td>
<td>-.001</td>
<td>.001</td>
</tr>
<tr>
<td>Employed</td>
<td>-2.6</td>
<td>.75***</td>
</tr>
<tr>
<td>High school education</td>
<td>.07</td>
<td>.51</td>
</tr>
<tr>
<td>Children at home</td>
<td>-1.35</td>
<td>.56*</td>
</tr>
<tr>
<td>Chronic illness</td>
<td>-78</td>
<td>.58</td>
</tr>
<tr>
<td>Previous psychiatric hospitalization</td>
<td>1.36</td>
<td>.62*</td>
</tr>
<tr>
<td>Alcohol use prior to treatment</td>
<td>.98</td>
<td>.57</td>
</tr>
<tr>
<td>Marijuana use prior to treatment</td>
<td>-88</td>
<td>.67</td>
</tr>
<tr>
<td>Cocaine use prior to treatment</td>
<td>1.39</td>
<td>.64*</td>
</tr>
<tr>
<td>Heroin use prior to treatment</td>
<td>1.33</td>
<td>.73</td>
</tr>
<tr>
<td>Lives in Rockford (vs. Chicago)</td>
<td>-07</td>
<td>.75</td>
</tr>
<tr>
<td>Ratio of met needs to expressed needs</td>
<td>1.18</td>
<td>.95</td>
</tr>
<tr>
<td>Constant</td>
<td>-.23</td>
<td></td>
</tr>
</tbody>
</table>

*** p≤001, ** p≤01, * p≤05

**Table 4:** Respondents' Use of Transportation and Outreach by Report of Recent Substance Use

<table>
<thead>
<tr>
<th></th>
<th>Percent Using Transportation</th>
<th>Percent Using Outreach</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Recent Substance Use (All)</td>
<td>54%</td>
<td>53%</td>
</tr>
<tr>
<td>Initiative</td>
<td>55%</td>
<td>60%</td>
</tr>
<tr>
<td>Regular</td>
<td>34%</td>
<td>45%</td>
</tr>
<tr>
<td>Recent Substance Use (All)</td>
<td>60%</td>
<td>69%</td>
</tr>
<tr>
<td>Initiative</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>Regular</td>
<td>43%</td>
<td>54%</td>
</tr>
</tbody>
</table>

**Conclusion**

Mothers involved with child protective services due to substance use face many challenges. Historically, the service system response to these challenges has lacked integration and focus. The collaborative DCFS/OASA Initiative has responded by offering comprehensive services to address some specific needs of substance-using women involved with child protective services. The Initiative evaluation demonstrates, first of all, that enhanced services were offered as planned. Early evaluation findings also suggest that Initiative participants were less likely than participants in regular treatment services to report recent substance use.

It appears as if the Initiative has been successful in improving access to treatment and in providing services which reduce drug use. Overall, the evaluation findings point to the value of integrated service approaches. Nevertheless, many obstacles continue to face the mothers who participated in the evaluation. Many are still working to regain custody of their children; most continue to be very poor; many struggle with inadequate housing, poor health and employment difficulties; many encounter violence in their homes and neighborhoods. Such challenges can be only minimally addressed by the Initiative or any treatment services program. The evaluation findings suggest, however, that the best treatment service programs will offer a comprehensive array of practical and concrete services such as child care, transportation, outreach, and housing assistance.

— Brenda D. Smith, M.A., Jeanne C. Marsh, Ph.D., Tom D’Aunno, Ph.D.
The School of Social Service Administration
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**REFERENCES**


The Newark New Start Project (NNSP) is an AlA funded initiative within the Division of Youth Family Services (DYFS), the New Jersey state child protection and child welfare agency. NNSP has been in operation since October 1, 1996.

DYFS serves as the lead agency in demonstrating a model of interagency collaboration which incorporates peer services, home-based services and coordinated medical and social case management. The project design combines prenatal and post-partum intervention strategies which include drug abuse identification and treatment and home assessments. The goals are to facilitate the timely discharge of infants from hospitals, reduce medically unnecessary hospital days and expedite hospital discharges to the most family-like setting without the necessity of extended residential placement. To achieve these goals, the program integrates community and child protection resources to maximize family autonomy without jeopardizing infant safety through three main activities: (1) preventive intervention prior to the birth of the infant; (2) intensive intervention at the time of the infant’s birth; and (3) expedited permanency planning for the children who require foster care.

Coordinating Child Welfare and Substance Abuse Services

To provide these services, DYFS collaborates with two major hospitals and five community agencies. A contract with Easter Seals was established in an attempt to address the substance abuse and child welfare issues of infants born drug exposed. The Easter Seals component of the project consists of a Certified Alcohol and Drug Counselor (CADC) and a home visitor. The CADC assesses the clients and refers them to the appropriate substance abuse program. The home visitor provides all the outreach and transportation needed to engage the client in treatment.

All referrals to the CADC are made once a case has been accepted for supervision by DYFS. The CADC and home visitor are physically located in the division office which accepts referrals and acts upon them immediately. The goal is to assess mothers prior to discharge from the hospital in order to expedite the permanency planning process. During the assessment process a father may also be identified as needing a drug evaluation.

Once parents have been assessed to determine the level of drug treatment required, the DYFS case manager can begin to develop a viable case plan with the parent(s). A teamwork approach is used in the development of a case plan. The case plan can vary depending upon the severity of the drug problem, the cooperation of the family, additional services needed to stabilize the family, and the family’s resources.

Preliminary Outcomes

Since the inception of the program, the case plans developed most often are: infant placed with relatives/friends or voluntarily placed in foster care while mother attends inpatient drug treatment; infant returned home with support services and family support while mother attends an intensive outpatient program five days a week; or mother and infant placed together in an inpatient program. The latter plan is the most desired; however programs that take mother and children together are the most difficult to locate, and they are usually filled to capacity when they can be found.

In the first year of the program, 157 clients were assessed by the Easter Seals CDAc. Of that total, 95 clients (61%) entered some level of treatment following their assessment, and 47 clients (about half of those who entered treatment) completed treatment and continued in an ongoing support program. African American females made up 95% of the population served. The average age was 25 to 30 years old and the average length of prior substance use was 10 years.

Challenges and Lessons Learned

During the first year of the program, many challenges surfaced and lessons were learned. A major challenge for the program was the ability to assess mothers prior to discharge from the hospital. When mothers have a normal delivery they can be discharged from the hospital in less than 48 hours of delivery. Within this time frame a mother has spoken to a doctor who then places an order on the chart for the patient to be seen by the social worker. The patient is then assessed by the hospital social worker and a referral is made to DYFS, when appropriate. The DYFS case manager must first meet with the mother...
and assess whether a referral to the CADC is warranted. When possible, the CADC accompanies the case manager at the hospital so the CADC can immediately begin their assessment as soon as the child protection assessment is completed.

Only three mothers were seen prior to discharge from the hospital for the first year of the project. Within the first quarter of the second year of the project, three mothers were seen prior to discharge from the hospital. The majority of mothers are assessed within 72 hours of discharge in their homes or at the DYFS office.

The second major challenge is encouraging clients to accept a Level III (inpatient) program. Approximately 95% of the clients assessed by the CADC are determined to be in need of inpatient treatment. Many clients, however, refuse Level III or have child care issues that prevent them from receiving inpatient treatment.

When clients refuse this level of drug treatment, the home visitor works intensively with the client to engage them. There are several techniques used to engage clients including: weekly home visits; taking them to weekly NA/AA meetings; promotion of outpatient treatment to help them realize the need to remove themselves from their immediate environment for a period of time; and promotion of detox to cleanse their bodies. The home visitor acts as a peer counselor utilizing community based services when other needs are identified. The goal for the home visitor is to help clients reach a point in their lives where they are open to receiving treatment.

When clients express an interest in participating in a Level III program but have child care issues, the DYFS case manager will make every effort to locate a relative or friend to care for the children, provide limited financial assistance, and explore day care services for working caretakers. They will also secure appropriate community services to stabilize the family until the parent completes the program.

Case in Point

The case scenario described below is what we are striving to achieve with the clients who enter a Level III program:

Ms. Davis is a single African American mother of three children ranging from newborn to three years old. Ms. Davis is a high school drop out, living with two friends while her children reside with family because of her drug dependency. Ms. Davis was referred to the program by the local hospital after giving birth to a cocaine exposed infant in April 1997.

Two days after giving birth, Ms. Davis was assessed by the Easter Seals CADC and recommended for a Level III program. The client agreed to enter a 28 day inpatient program eight days after giving birth to her third child. Upon successful completion of the program, Ms. Davis is home for seven days before entering a halfway house approximately 45 minutes from her home. The halfway house is located in a suburban neighborhood. The halfway house does not allow children to stay with their mothers but they encourage ongoing visitation to take place.

While Ms. Davis is living in the halfway house she will receive assistance with furthering her education, seeking employment opportunities and securing housing for her family. The main focus of the program is to provide support in maintaining her sobriety. Ms. Davis graduated from the program in March 1998 and was rejoined by her children. She has decided to remain in the area where the program is located and will continue in their aftercare program.

Conclusion

We view the relationship between the child protection agency and the substance abuse program as a crucial element in the development of permanency planning for children. The Newark New Start Project will diligently attempt to work with mothers prenatally. However, if this is not possible our efforts will be directed toward assessing mothers prior to their discharge from hospitals. It is apparent that early and collaborative intervention results in viable and safe plans for our most precious population.

— Leslie Pollard, MSW, Project Manager
Catherine Griggs, Assistant Project Manager
Chemical Dependency Services for Parents Involved with Child Welfare in Washington State

Parental addiction impairs parenting and increases the risk for child abuse and neglect. As a result, substance abusing families involved with the public child welfare system pose significant challenges for child welfare workers. Children in these families seem to have high rates of out-of-home placement and long stays in out-of-home care, and their parent’s addiction is often a major obstacle to successful reunification.

While the need for linkage between child welfare and chemical dependency treatment is obvious, there are significant barriers to making such a partnership viable. This article discusses what has been learned in the State of Washington about creating an alliance between chemical dependency and child welfare systems, which operate under different legal mandates and with different missions and philosophies.

**Barriers Between Child Welfare Services and Chemical Dependency Treatment**

Despite the clear overlap of child maltreatment and substance abuse, the following issues create challenges to coordination of child welfare services and chemical dependency treatment.

- Staff of the two systems have different philosophies, value systems, priorities and approaches. Treatment professionals use a language of treatment, recovery, and relapse that is not always well understood by their counterparts in child welfare. Likewise, treatment professionals often do not understand the language, priorities and procedures of child welfare workers, e.g., child safety, risk assessment, the dependency process, child placement, permanency planning, and termination of parental rights.
- Staff in the two systems do not always agree about the identity of the client. Should we be serving the recovering parent or protecting the child? The counselor may see the adult’s recovery as paramount, while the social worker’s priority may be going to court to have the children removed from the parent.
- Information about a clients’ chemical dependency treatment is protected by mandatory federal and state confidentiality statutes. Child welfare staff get frustrated when their requests for information on the status of an assessment or treatment is denied because a proper release of information has not been signed.
- Relapse can occur during treatment and recovery. Is relapse serious enough to warrant a decision to remove a child from the home or to terminate parental rights? Child welfare workers must sometimes decide when to “give up” on substance abusing parents. Treatment professionals are less likely to view relapse as an event warranting extreme action.
- What information needs to be transmitted when the social worker is making a referral for drug assessment and treatment, and what information does the social worker need from the treatment agency?
- There are clinical uses for urinalysis (UAs) as a part of treatment, yet some treatment professionals have concerns about the use of UAs in court as documentation of parental failure.
- Skepticism exits on both sides. Some child welfare staff are not sure that substance abuse treatment works, and chemical dependency staff sometimes see child welfare staff as overzealous and punitive.
- The personal experiences of staff colors perceptions. Social workers may have seen “treatment failures” or have personal or family substance issues. Treatment staff may have witnessed “negative client consequences” of CPS involvement, or had their own experiences with child welfare as children or parents.

**Washington State’s Approach**

In 1997, recognizing the high rate of substance abuse in child protective services, the Washington State Legislature passed ESSB 6251 to improve access to chemical dependency treatment for parenting adults referred for services by social workers with the Department of Social and Health Services (DSHS) Children’s Administration. The legislation specifically funds assessment, outpatient treatment and child care. Inpatient treatment can be obtained as part of the treatment continuum but is funded separately. The legislation brings the public child welfare and chemical dependency agencies into a working relationship to improve access to and increase use of chemical dependency assessment, outpatient treatment, and child care linked to treatment. The DSHS Division of Alcohol and Substance Abuse (DASA) is the agency responsible for implementation and funding.

To understand what has occurred in Washington, it is useful to understand how service delivery is administratively organized. Children’s Administration (CA) is the state’s child welfare agency which investigates reports of child abuse and neglect. The agency is organized through six service delivery regions which have a high degree of autonomy and a tendency to protect their independence.

DASA is the state chemical dependency agency which contracts for services through county governments and private community agencies. Counties are key partners in planning and service delivery because they coordinate chemical dependency assessment and outpatient treatment. (Inpatient treatment is contracted directly by DASA.)

**Problem Solving**

To determine the best approach to implement the state legislation, a work group of designated representatives from DASA, CA, and the counties was formed. This group developed the new system that would be used to refer clients for assessment and treatment at the county level. They also produced a document called
IMPLEMENTATION GUIDELINES FOR ESSB 6251, and they developed products needed for effective cross-system coordination. These products, which were disseminated statewide to the CA offices, as well as chemical dependency assessment and treatment agencies funded by DASA, include:

1. Guidelines for local inter-agency agreements between the county, CA, and treatment agencies on how referral, assessment, treatment, and inter-agency communication will occur.
2. Sample chemical dependency screening tools for use by social workers.
3. Guidelines for making referrals that ask social workers to provide information regarding court mandated time frames, the reason for the referral and the nature of the requested information.
4. Guidelines for the content of the chemical dependency assessment which reflects the information that social workers want to know, e.g., the effect of a parent’s substance abuse problem on his/her parenting ability.
5. Guidelines for expanded assessments which include an initial urine analysis and collateral contacts with community professionals and family members.
6. Sample forms for progress reporting for chemical dependency counselors.
7. Samples of confidentiality releases that meet federal and state requirements for chemical dependency counselors.
8. Overviews of both CPS/child welfare timelines and the chemical dependency treatment and recovery process.

**Cross-System Coordination in Practice**

Although these products address some of the barriers to inter-agency coordination, they are not solutions in and of themselves. The experience in Washington State is that the counties with the highest utilization of substance abuse assessment and treatment, and the highest rates of clients moving from assessment to treatment, have taken other steps. The most critical additional step is the commitment from chemical dependency and child welfare administrators to make the cross-system coordination work. Other basic and practical steps that can help cross-system coordination be successful include:

- Facilitate and make the process easy, e.g., fax referrals and consent forms to save time and expedite referrals; use phone calls to alert an agency that a referral is coming or that a client did not show for an assessment.
- Secretaries and support staff are critical. They need to be part of the team and understand how the referral process works. If a referral for an assessment is expected but doesn’t show up, they should know the next steps to inform key staff.
- Child welfare staff have many demands for their time but need training on chemical dependency. Package small training units that can be offered in regularly scheduled staff and unit meetings. Make training practical and responsive to the needs of the social workers.
- Organize training and meetings that bring together staff of both systems.
- Inter-agency staffing of cases helps to develop mutual understanding of a case when needed.
- Bring together the key local partners periodically to review the status of operations, problem solve, and acknowledge the joint effort on behalf of shared clients. Meetings can be used to individualize plans for tricky client situations. Workable agreements can unwind with staff turnover and neglect.
- Validate the good work by staff to make inter-agency service work for clients, e.g., a letter of appreciation in a personnel file or other method of recognition.
- Agreements on local procedures or standardization of paperwork take time initially, but they help to avoid later misunderstandings.
- Consider other staff (e.g., child welfare workers) as part of the treatment team.
- Use voice mail or e-mail to facilitate communication between staff.
- Standardize the forms used for making referrals and sharing information.
- Develop a tolerance for conflict over case plans and understand that most disagreements can be talked through.

**Conclusion**

There are no easy answers. Passivity is probably the biggest barrier to improving services. Solutions require a shared commitment to problem solving by chemical dependency and child welfare. In Washington, we are seeing increased utilization of chemical dependency treatment service. Additionally, referral rates for assessments are higher, access to treatment is quicker, and there is better retention as clients move from assessment through treatment. There is also a level of cross-system coordination that did not exist two years ago. Both parties have a role to play in coordination and delivery of service to shared clients. At the practical level, the parties must be willing to ALWAYS look for ways to say yes.

— Ken Guza, Department of Social and Health Services, Division of Alcohol and Substance Abuse

Dee Wilson, MSW, Children’s Administration

Cleve Thompson, MA, Clark County Coordinator, Association Alcohol and Drug Coordinator, and Association of County Human Services
Innovative strategies for strengthening systemic links between child welfare services and services for alcohol and other drug problems: The DHS IMPACT Program

In April of 1995, two public entities in Cincinnati, Ohio, the Hamilton County Alcohol and Drug Addiction Services (ADAS) Board and Hamilton County Department of Human Services (DHS) Children’s Services Division, initiated the IMPACT program (Interagency Managed Care Program for Alcohol and Chemical Dependency Treatment). This innovative new program was designed to better meet the substance abuse treatment needs of DHS’s child welfare clients, maximize the quality and quantity of services to DHS clients, and maximize Medicaid reimbursement for the program. Prior to this collaboration, DHS purchased services for child welfare clients on an individual basis from various service providers in the community.

Program Design

The ADAS Board agreed to administer the DHS alcohol and other drug addiction treatment funds and to develop a broad continuum of alcohol and other drug (AOD) addiction services for its clients to remove addiction as a barrier to their successful parenting. The continuum developed for this program includes assessment, detoxification, residential and outpatient treatment, a strong aftercare component, and a variety of supportive services, depending on the individual needs of each client. DHS requested that ADAS also assist in determining the impact of recovery and/or continued use on the client’s ability to successfully parent. DHS’ goal was to minimize the amount of time required to determine the need for a child’s placement.

The ADAS Board saw this as an excellent opportunity to improve the effectiveness of treatment and to maximize funding for a very high risk population. To this end, a cornerstone of the IMPACT program was the implementation of a utilization management component, which had not been used before with this type of population or for any other publicly funded addiction services in Hamilton County. Through a contract with a local behavioral health entity, utilization management services are provided for all clients in the program. The utilization management component includes assessment, referral to a level of care and provider (based on Board approved Screening and Placement criteria), monitoring the length of stay in treatment levels, determining movement to different levels of care, training in the effective use of utilization management, reporting, and data analysis.

Another critical component of the program is the inclusion of an ADAS Board staff person who is permanently housed on site at DHS and acts as the liaison between the child welfare system and the IMPACT program. The liaison, a certified clinician, is responsible for maximizing the quality and effectiveness of alcohol and other drug addiction treatment services provided to DHS clients through the IMPACT program. The liaison closely follows cases with special situations or problems, or with individuals who have failed or are likely to fail to complete treatment. She also conducts training to providers and DHS staff.

Program Goals

The goals of the IMPACT program are to:

1. Encourage collaboration and partnerships among service providers in order to:
   - Increase the clients’ attendance in residential, outpatient, aftercare and other services that support the recovery process.
   - Show progress toward increased utilization of community based AOD addiction services including: outpatient, aftercare and support services. (The model includes services that clients will continue receiving even after DHS case management is terminated.)
   - Increase the quality and quantity of services provided.
   - Reduce or eliminate barriers to successful client and family outcomes.

2. Provide effective treatment and after care which contributes to a reduction in the overall number of times children are placed in foster care and a reduction in the number of times cases are reopened because the parent’s relapse places children again at risk of abuse or neglect. This will result in the reduction of risks to children that are due to parents’ use and addiction to alcohol and other drugs and result in their inability to nurture, parent and protect their children.

3. Provide same day access to any necessary services for adults and children, whenever possible.

4. Serve as a laboratory that can help ADAS and DHS learn more about effective strategies for serving families involved in the child welfare system due to parents’ substance abuse.

Selection of Provider Network

The ADAS Board established a review committee to select providers to work toward these goals. The committee consisted of a broad spectrum of entities interested in children’s welfare issues, e.g., the guardian ad litem program, DHS advisory groups, and the Juvenile Court. Through an RFP process, the committee selected a consortium of providers to implement the IMPACT Program.
Although the results of a formal evaluation of the IMPACT program currently underway are not yet available, several indicators of the program’s progress can be noted.

Collaboration
Improved collaboration appears to exist at three different levels: provider, intersystems and client.

Provider level: Through participation in the IMPACT Program, the treatment providers have greatly improved their capacity to work together. Prior to IMPACT, they tended to function as autonomous entities which attempted to serve all of the clients’ needs. The external utilization management, the high level of cross systems interaction and review, and IMPACT’s focus on the ultimate outcome of the client (regardless of provider) have necessitated much closer collaboration.

In addition, through a rigorous quality improvement process, which includes a comprehensive peer review of client cases that have not been successful, providers are much more aware of their own and other providers’ strengths and weaknesses. The underlying theme of this process is the determination of whether or not everything that could have reasonably been done to assist the client to attain successful recovery has been done. This standard, which had not previously been applied on a system-wide basis, is being applied to the entire network of providers, resulting in innovative new approaches to combining residential and outpatient services more effectively. One example is the use of shorter, more intensive residential stays followed by a broader range of intensive, outpatient services and case management.

Another standard that has been employed is the practice of identifying clients who are not progressing but continue in treatment. The imminent danger is that the child welfare system and the juvenile court perceive this to be progress and make determinations of child custody based on this incorrect assumption. To help prevent these situations, the care management entity probes treatment providers for evidence of client progress. When such evidence is lacking, the provider undertakes a deeper review of the case and the client’s history. The client is then reassessed and moved to a more appropriate level of care or, when appropriate, the child welfare system is notified that further treatment is not recommended at the present time.

Intersystems level: The IMPACT Program has required the alcohol and drug addiction service and child welfare service systems to work more closely together toward mutual goals. At the onset of the program it became apparent that usually the “client” of the child welfare system (the child it was seeking to protect) was not the “client” of the alcohol and drug addiction services system (usually the parent). This fundamental difference required systems to rethink program focuses and goals. For example, before IMPACT, it was not terribly unusual for a service provider (representing the parent) and child welfare worker (representing the child) to take an opposing stance in juvenile court. Since IMPACT’s inception, conflicts of this sort are identified early on and resolved through team meetings which can include the ADAS Board, care management entity, child welfare system, treatment provider, client and other interested parties. By bringing these entities together, possible conflicts can be avoided.

Likewise, IMPACT has spurred closer relationships between providers and juvenile court and between providers and other child advocates. All of the child-serving entities which participated in IMPACT’s inception meet regularly to review the program’s progress and work out problems. In this way, intersystems issues are dealt with much more expeditiously. Additionally, a considerable amount of training has been provided to DHS caseworkers (including all new staff) and alcohol and drug addiction treatment providers.

Client level: All IMPACT clients receive immediate access to assessment and treatment. This is a tremendous improvement. The ADAS Board’s oversight and monitoring in collaboration with the providers, utilization management entity and DHS staff has resulted in keen insight into how clients are served. The net result to Hamilton County is that addiction treatment on demand has been made available to parents of abused and neglected children referred by DHS.

Access to Effective Treatment
IMPACT seeks to strongly support the client’s treatment through geographically convenient community-based service locations, convenient service hours and the provision of child care. Most of the residential programs have the capacity for women to keep their children with them while in treatment. Since its inception in 1995, IMPACT has treated almost 600 clients in each year. All clients have had immediate access to assessment and treatment. (Immediate is identified as access for residential services within 24 hours and for outpatient services within 72 hours.) To assess the effectiveness of these services, all IMPACT clients receive utilization management services by an independent entity. Providers meet regularly to review the program’s progress and scrutinize cases in which clients did not achieve recovery. These findings are then used to restructure and improve service delivery. Individual case and aggregate data is scrutinized to call out improved treatment strategies and supports.

Conclusion
Along with these initial findings, the IMPACT Program realized DHS savings of $230,028 in the first year (1995) and $386,546 in the second year (1996). (Data for the third year has not been finalized.) Additionally, dramatic programmatic changes have been made as a result of what has been learned from the program, and IMPACT’s success has provided the impetus for several other collaborative ventures in the community. Undoubtedly, other changes will be made as the evaluation efforts reveal more information about improving services for addicted families involved in the child welfare system.

— Martha A. Walsh, MPA, Associate Director, and John J. Young, M.Ed., ACATA, Executive Director, Hamilton County Alcohol and Drug Addiction Services Board
Structured client satisfaction interviews with women participating in specialized perinatal substance abuse treatment in Rhode Island were used to examine the use of child abuse and neglect and custody laws to "motivate" women with drug problems to enter and remain in treatment. Interviews were conducted by the National Perinatal Information Center as part of its program evaluation efforts. Treatment programs included Project Link, a comprehensive outpatient program originally funded by the federal Center for Substance Abuse Prevention, which treated 269 women in 5 1/2 years of program operation, and SSTARBIRTH, a 12 month residential treatment program for women and their children (funded by the federal Center for Substance Abuse Treatment), which has had 63 admissions in 4 years.

**Rhode Island Child Welfare Policy**

In 1994, Rhode Island rewrote its laws regarding termination of parental rights, making them, at the time, among the toughest in the country. There is an "early warning" policy which encourages reporting during the prenatal period if a woman is known to have taken non-prescription drugs; a positive toxicological screen in a newborn is considered prima facie evidence of child abuse. If a parenting woman is identified as a substance user she is subject to involvement with the Rhode Island Department of Children, Youth and Families (DCYF). Termination of parental rights can occur within one year if the mother does not make an effort to comply with DCYF. Ideally, maternal drug use is decreased through drug treatment entry and retention, with the ultimate goal of family preservation.

**Conceptual Framework**

The conceptual framework for the interview was derived from the Health Plan Employer Data and Information Set (National Committee for Quality Assurance, 1993), which specifies four dimensions that impact on perceptions of the quality of services: access, appropriateness, outcome, and satisfaction. Questions included:

- What made you decide to participate in the program?
- Was there a point when you felt like "dropping out" of treatment? What helped you continue?
- How did you feel about the interaction between DCYF and program staff?

**Interview Participants**

Interview participants included 28 women from each program, 47 women identified by staff as a treatment "success" and 9 women identified as "unsuccessful". Most interviewees were European American (41%) or African American (33%); their average age was 29. Their drug of choice was primarily cocaine or crack (74%). Interviewees were single (82%) and low income; slightly more than half had a high school education or equivalent. Almost all of the women in residential treatment (93%) and most of the women in the outpatient program (75%) were involved with DCYF. The number of outpatient interviewees involved with DCYF was higher than in the total outpatient client population (48%); in other aspects interviewees were representative of the total client populations.

Interviewees were involved with the programs from six months to over two years. Each received individual counseling and case management services; almost all received group counseling, including parenting classes. Women were interviewed just prior to or shortly following discharge.

**Interview Findings**

Most women (86%) indicated that an initial motivation for participating in treatment was to either maintain or regain custody of their newborn. For other women (4%), the fear of DCYF becoming involved motivated them to seek treatment.

Many of the women (71%) had a positive first impression of the program and staff. They felt the staff person treated them well: "She didn't look down on me," and "She stayed on the phone with me for two hours when I first called — I was so scared I couldn't stop crying." Most women involved with DCYF had the hope that the program would help them regain or maintain custody. Other women had negative reactions initially and were suspicious that program staff were working with DCYF against them. As one said: "I went because I had to. I had no expectations in the beginning."

For some women, losing custody was "a wake up call". One woman said: "I wasn't giving up the addict way of looking at things until I lost custody. Then I had to decide which I could live without — drugs or my kids. It wasn't easy, but I was finally able to choose (to give up drugs for) my kids." Fear of the consequences from DCYF helped women remain in treatment: "I knew I couldn't drop out—if it wasn't mandatory, I wouldn't have done it." However, many were able to invest in recovery to make positive changes in their lives: "I kept going after I didn't have to. I loved the staff — everyone who worked there showed their interest and concern." Many women described this kind of "turning point" in their recovery: "I didn't like the sense of loss of control — I didn't realize until I was clean and sober how out of control of my life I had been." "After awhile I went because I knew I needed it. I had a lot of praise from staff about the changes I was making . . . and started to feel better about myself. I wanted to continue this—I started to go for myself, to make the changes for myself." This type of transition was critical to recovery, as another woman described: "I relapsed..."
because I wasn't getting it, I was only doing it to deal with DCYF and not for me.” The “unsuccessful” women were less likely to have made this transition; seven (of nine) women said they dropped out after DCYF no longer required participation.

Women in residential treatment were grateful that they could receive treatment while maintaining custody of their children: “My children had been part of my addiction, and I wanted them to be part of my recovery, too.” Almost all (95%) reported that they had received the help they had expected. The relationship that developed with a supportive counselor was often critical to recovery: “She listened to me cry for hours [when DCYF put a “hold” on her newborn]—if she hadn’t helped me through this I would have relapsed.” Many described the warm, non-judgmental attitude in the treatment programs as being instrumental in their finding hope that their life could improve: “I learned to accept what had happened in my life, to deal with my losses. The staff were supportive and caring—it was the staff and I against the disease.” One woman succinctly described her experience this way: “My nightmare turned into the best thing that ever happened to me.”

Almost all of the interviewees expressed positive attitudes about the relationship between DCYF and program staff, primarily because staff members were honest with clients about what they were reporting to DCYF (through providing women with copies of reports, and including program participants in case conferences with DCYF) and because women believed that their counselor advocated for what was best for them (even when this did not include reunification with older children). Many of the women who were anxious at first grew to trust the interaction between program staff and DCYF. One of the “unsuccessful” women described coming to realize that “Project Link was finding out what the problems were so they could help you, not so they could go tell DCYF.” However, four (“unsuccessful”) women never grew to trust this relationship.

Concluding Comments

The use of the child welfare system to intervene with mothers with drug problems is hotly debated. Program staff were able to take advantage of the external motivation provided by DCYF and the women’s investment in parenting to draw many women into recovery. These interviews, however, reflect primarily the experience of women for whom this type of intervention was successful. More research with women who were “unsuccessful,” and more research that uses different approaches systematically, is needed to clarify which practice is best for which women.

— Donna L. Caldwell, Ph.D., Program Evaluator

REFERENCES


Upcoming AIA Telephone Seminar

■ WEDNESDAY, JULY 29, 1998, 2:00 PM - 3:30 PM (Eastern Time)

Childhood Sexual Abuse of Adult Survivors — Betty Button, MA, Human Resources Consultant, Executive Director of Capital Area Mental Health Center, Austin, TX

Participants will learn about the impact of childhood sexual abuse on adult survivors’ relationships and the genesis and function of survivors’ coping behaviors, which often prove counterproductive for adults. Specific topics will include parenting by survivors, ongoing contact between survivors and their families of origin, sexual concerns faced by survivors, and various treatment modalities that have been effective with this population.

TELEPHONE SEMINAR REGISTRATION FORM

The seminar will be conducted through a teleconference call, at no cost to the participant, and will be limited to 25 sites on a first-come, first-served basis. To register, please complete this form and mail/fax it ASAP to the AIA Resource Center, 1950 Addison Street, Suite 104, Berkeley, CA 94704-1182, ATTN: Gwendolyn Edgar-Miles, Fax: 510/643-7019. For further information, please call 510/643-8390.

Name & Title: __________________________
Agency: __________________________
Address: __________________________
City, State & Zip: __________________________
Phone: __________________________ Fax: __________________________

You will receive confirmation of your registration and additional information prior to the seminar.
Practical Suggestions for Working with Substance Abusing Families

Substance abuse is involved in the vast majority of cases in which children enter foster care (Jaman-Rhode, McFall, Kolar & Strom, 1996). A child welfare worker is expected to assist the parent(s) in acknowledging and dealing with their substance abuse problem while simultaneously working to unite the family and protect the child from further abuse/neglect. Public Law 96-272 mandates the child welfare worker to make "reasonable efforts" to assure that a family receives services needed to maintain the child in the home or return the child as soon as possible. Although the Adoption and Safe Families Act (PL 105-89) more carefully defines the use of reasonable efforts, the considerations specified in PL 96-272 remain.

In this regard, many caseworkers find themselves in need of some basic guidelines for working with alcohol and other drug (AOD) affected families. Lack of training in substance abuse issues, as well as negative attitudes toward addicts, can interfere with a child welfare worker's ability to respond appropriately to the needs of substance abusing women and their children. Fortunately, as a result of addictions-focused education, many of today's child welfare staff have an increased understanding of, knowledge of, and perspective on the strengths a substance abusing parent can bring to a situation. Accessing these strengths and redirecting the burden of change from the professional to the substance abuser is a valuable process used successfully by many who understand this perspective. What follows is a compendium of suggestions for child welfare workers to consider in working with addicted clients and/or their families.

Relapse

Clients vary greatly in their motivation, chronicity of their illness, economic and social resources, and capacity to take the necessary measures to keep their children. Frustration with the occurrence of relapse, even among motivated substance abusers, further complicates the situation. It helps to remember that relapse is part of recovery from the disease of chemical dependency and often occurs several or more times on the road to sustained recovery. Some relapses can be useful if the client and worker view them as opportunities to make changes necessary for a more positive, long-term outcome.

Strengths Perspective

Noticing and responding to what a client is doing correctly before focusing on what they are NOT doing or doing wrong is the heart of a strengths perspective. It also makes it easier for a child welfare worker to be heard. Give good news first, whenever possible. As in the following example: "You are making noticeable progress. Attending a drug treatment program would give you a strong foundation. For the next six months why don't you try this. By that time you will be more likely to be given the benefit of the doubt when it comes time to being evaluated to have your child back. Until then, she'll be held in custody and we will work with you and the treatment team to arrange visits with her."

Safety First

By using the guiding principle of "safety first" to frame all interventions, a harm reduction model can be blended with other models of recovery. The following examples illustrate opportunities to frame options for clients in this way. "Using drugs is unsafe; abstinence is safer. Suicidal or self mutilating urges are unsafe; contracting for safety with a family member, sponsor or counselor is safer. Continuing to associate with individuals who use drugs or who are abusive is unsafe; attending 12-Step meetings and clean and sober social activities is safer. Moving into a shelter for battered women or going to a hospital for detoxification and stabilization are ways to be and stay safe. Failure to take appropriate medications, keep appointments with health care professionals, obtain adequate rest, or set appropriate boundaries with others is unsafe. Practicing good self care and learning to become assertive is safe. Staying clean and sober and getting support for managing intense emotions that arise when working on past trauma is safer than trying to manage 'controlled drinking' to cope with these emotions."

Encouraging clients to remain safe, asking them if certain choices are safe, prompting them to stay safe and inquiring if they feel safe are suggested reframes. A profound lack of safety, and an inclusive sense of failing to have both protection and nurturing was (and still is) the missing experience for many parents in the system.

Working with Distressed Clients

Flexibility and coordinated efforts are important with any approach. The use of non-judgmental, assertive communication when working with assaultive clients can aid in the de-escalation of conflict. When in crisis mode, some people over-react; some under-react. Both are attempts to cope with fear which may bring on feelings of helplessness. Often with bi-polar or amphetamine abusing clients, there can be a swift move from laughter to anger, or
other emotional liability. A rule of thumb is that when the observed affect is not reality based, be cautious not to escalate the situation.

Precautions

The following general precautions are prudent. In responding to a parent's distress and helplessness, it is seductive to become overly controlling and/or feel overly responsible. Don't. Whenever you are more anxious and emotional than the client, shift gears. This may be a sign you are taking on more than your share. The more control on the part of the child welfare worker, the less cooperative the client may become. Power struggles are useless, time consuming and the cause of burn-out. Self control on your part often promotes self control on the part of a client.

Planned Responses to Verbal/Physical Aggression

The natural reaction when one is attacked either verbally or physically is to counter-attack. Remember you have a choice to do something else. The following general suggestions provide alternatives:

- **De-escalation:** A way to prepare yourself for de-escalation is by doing practice drills or role-playing alternative responses ahead of time. Research indicates that people who are assaulted score higher on irritability and aggressiveness themselves (Brennan, 1998).

- **Vulgarity:** If a client uses vulgarity, don't go there too or try to silence them. Rather, shift your focus to why they may be upset. By exploring why they are expressing themselves in this irrational manner, you are more likely to move through conflict.

- **Task centered:** Sometimes there are other factors contributing to one's inability to reason with clients. Stay task-centered whenever you are confused. The most useful word when the situation feels out of hand is the client's name. Saying a person's name helps to ground them. Describing the reason for your work together may remind them of their own desire to accomplish specific tasks.

- **Style:** Defensiveness or aggression on your part in the face of their passive aggressiveness only escalates the situation. Remember to take a breath and start over. A person's reaction to threat usually has a pattern. Paying attention can make things easier for you.

- **Non-verbal Behavior:** It is important to be aware of the non-verbal behavior and general energy expressed by the other person. Often irritability, staring, or glaring may alert you to possible rebound behavior (drug withdrawal). If a client seems tense, tight or argumentative, disengaging can de-escalate power struggles.

- **Back Off:** Often strategic use of “I” statements can be helpful, but be careful of these kinds of statements. For example, “I need you to take this drug test,” can be more effective by eliminating the personal pronoun and simply stating, “Here's the drug test.”

- **Be Aware of Yourself:** Some clients have difficulty expressing their dissatisfaction with a simple “This is not ok.” Bypass their style and focus on the task of understanding why they are upset. Remember, intoxication often leads to a decrease in rational thought and impulse control. Becoming aware of your physical boundaries can be helpful. Most physical injury on the job starts with a staff person initiating the physical contact first, often with good intentions. Saying a person's name is safer. It not only helps ground them, it keeps the interaction task focused.

- **Parallel Process:** The importance of clarifying and continuing to clarify your role for yourself cannot be overstated when working with substance abusers. Clear limit setting for your own preservation, and modeling by way of parallel process, can help a recovering mom learn necessary limit setting for herself, as well as her children, family members and partners.

These practical suggestions can help to simplify and improve child welfare workers' relationships with substance abusing clients, and lead to more positive child welfare outcomes.

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