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Facing the Problem

Introduction

Many parents coming into contact with the child welfare system are users and abusers of alcohol and other drugs (AOD), the effects of which can impair their parenting skills and threaten the safety of their children. Every child welfare agency in the nation has struggled with AOD problems among its caseload, and many have attempted to build more effective bridges between child welfare services (CWS) and AOD abuse treatment services. Those agencies that have been most active in addressing substance abuse have recognized that it is not a "stand-alone" issue, but rather is linked with delinquency, family violence,

Organization of the Guidebook

Chapter 1 describes the overall framework in which AOD-CWS policy issues are currently addressed, summarizing the underlying values and circumstances that affect practice and policy regarding the connection between child welfare and AOD services. Chapter 2 presents several models of CWS-AOD connections, as well as recent innovations within the CWS field. Chapter 3 examines the lessons emerging from the models and innovative practices, and Chapter 4 describes AOD treatment and special issues for children. Chapter 5 defines the role of assessment in linking CWS and AOD services. In Chapter 6, we discuss the need for child welfare reform efforts to understand the roles of other service systems in addressing AOD-related problems. In the final chapter, we present recommendations for strengthening practices and refining policy. Throughout the guidebook, the experience from Sacramento County, California, is used as a case study of the issues and is highlighted in the report.

welfare reform, mental health, and the need for a stronger community role in supporting families. This guidebook focuses on understanding and improving approaches to AOD problems among child welfare clients, but also calls for a recognition of the several other problems beyond substance abuse that afflict many families.

Evidence drawn from numerous studies across the nation produces estimates that 40 to 80% of families in the child welfare system have problems with alcohol and other drugs and that those problems are connected with the abuse and neglect experienced by their children. Children are affected by their parents' alcohol and drug use in several ways, as illustrated in the chart on the following page. While prenatal exposure has received a great deal of attention in recent years, Table 1 shows that many more children can also be exposed through the behavior of their parents and through the environment in which they grow up. The underlying premise of this guidebook is that *all* of these forms of exposure to children are harmful and that child welfare agencies and AOD treatment agencies must increasingly work together to reduce this harm.

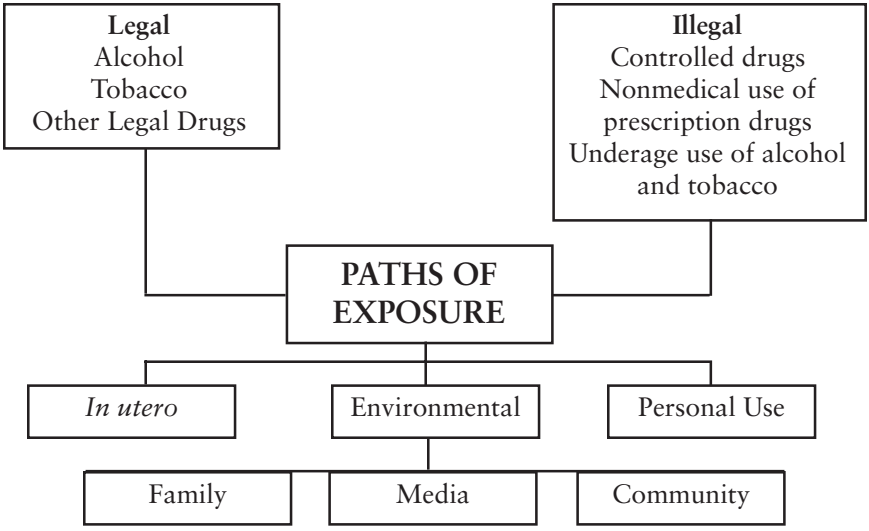
The Scope of the Problem

Problems related to the use of alcohol and other drugs impact the child welfare system in a number of ways—by increasing CPS caseloads, contributing to the number of children entering foster care, and interfering with the ability of families on welfare, some of whom are also in the child welfare system, to secure employment.

The Overlap: Parents in the Child Welfare System with AOD Problems

With an estimated 13 million children living with a parent who reportedly has used illicit drugs in the past year and some 28.6 million children living in alcoholic households [Colliver et al. 1994], a significant number of children may be at risk of maltreatment. But not all of these children will become victims of child abuse or neglect and, obviously, not all of those who are victims will be reported to public agencies.

Table 1. Paths of Exposure to Alcohol and Other Drug Use



Though researchers have yet to accurately document the prevalence of substance abuse problems among families within the child welfare system, most have come to agree that 40 to 80% of parents with children in the child welfare system have AOD-related problems serious enough to affect their parenting. Below are just a few of the studies documenting the overlap:

- Of the nearly 1 million children found to be substantiated victims of child abuse and neglect in 1995, at least 50% had chemically involved caregivers [CWLA 1997].

- For two consecutive years, more than three-fourths of states (76% in 1996 and 80% in 1995) reported that substance abuse is one of the top two conditions assessed as problems for families reported for maltreatment [Wang & Daro 1997].

- Famularo and his colleagues found that more than two-thirds (67%) of child maltreatment cases involved a substance-abusing parent [Jaudes et al. 1995].

In addition, studies indicate that parental substance abuse is associated with *recurrent* reports of child abuse and neglect. Wolock and Magura concluded that parental substance abuse of any kind results in an increased likelihood of a subsequent report to CPS, and the effect of drugs and alcohol combined is particularly strong. Here are some additional findings:

- Children who are prenatally exposed to drugs are two to three times more likely to be abused than other children. In their study of more than 500 infants exposed prenatally to illicit substances, reports of abuse were subsequently filed for close to one-third (30%) of the children, two-thirds of which were substantiated. Of the substantiated cases, 51% were abused once, 37% twice, and 12% three or more times [Jaudes et al. 1995].

- A study of families reported to CPS who were followed for an average of two years found that in 55% of the families, one or both caretakers were identified as having a substance abuse problem. One or more recurrent reports were reported in just over half of these families [Wolock & Magura 1996].

"In the Best Interests of the Child"

A couple attending training for prospective foster parents were impressed when the trainer wrote "best interests of the child" on the board early in the session, thinking that the literature on parent-child interactions would be discussed. However, throughout their four training sessions, there was no further discussion of what the phrase meant in practice.

What *does* "best interests of the child" mean in AOD cases? There seem to be three levels of answers to the question:

- What the child needs in terms of immediate safety: who is competent right now to serve as caretaker on a daily basis?

- What the child needs him/herself: what level of intervention or treatment will best strengthen the protective factors needed to break the cycle of AOD abuse for that child?

- What the child needs in the longer term: what is the best possible relationship with his/her birth parents that will lead to family stability in later life?

The Effect of Substance Abuse on the Foster Care System

As Cole and her colleagues point out: "Whatever the prevalence of children exposed to drugs and alcohol in the general population, there can be little doubt that the vast majority of children entering foster care are affected by living in substance-abusing families" [Cole et al. 1996]. And the number of children entering foster care continues to skyrocket—in 1996, the figure topped 500,000, a 47% increase from the 340,000 cases in 1988 [DHHS 1997].

It is estimated that substance abuse is a factor in three-fourths of all placements. Children under 5 are the most vulnerable to abuse or neglect by a substance-abusing parent and represent the fastest growing population in out-of-home care [Day et al. 1998]. Several studies highlight the prevalence of AOD-problems among foster care cases:

- The U.S. General Accounting Office recently found that parental substance abuse was a factor for 78% of the children entering foster care in Los Angeles, New York City, and Philadelphia County [GAO 1994].

- In a recent CWLA survey, state child welfare agencies estimated that parental chemical dependency was a contributing factor in the out-of-home placement of at least 53% of the child protection cases [CWLA 1997].

- In that same survey, more than two-thirds (67%) of state child welfare agencies said that AOD-involved families are "much more likely" or "more likely" to reenter the child welfare system over a five-year period, compared to non-AOD-involved families [CWLA 1997].

- In Washington state, 41% of infants placed in out-of-home care in 1995 were born to mothers who abused alcohol or other drugs during their pregnancy.

Effects of Alcohol and Other Drug Abuse on a Parent's Ability to Care for Children

Use of alcohol and other drugs can seriously compromise a parent's capacity to protect a child, and such use interferes with the individual's general functioning in a number of ways. Bays [1990] stated that up to 90% of drug abusers have mental, emotional, or personality disorders that can compromise their ability to care for their children and influence poor parenting skills. More specifically, AOD use, abuse, and dependence can have the following effects [Besharov 1992]:

- Interfere with thought processes and thus consistent parenting processes—a parent's mental functioning, judgment, inhibitions, and protective capacity may become impaired.

- Interfere with the ability to respond consistently and sensitively to a child—a parent may be less sensitive, responsible, and accessible to infants. This can decrease the development of secure attachments between mother and child.

- Leave the parent emotionally and physically unavailable to a child—caseworkers may have difficulty getting a parent to focus on needs of the child.

- Lower a parent's threshold of aggression toward children.

- Result in a parent spending household money needed for food, clothing, and other basic needs on alcohol and other drugs.

- Be associated with criminal activity that may jeopardize a child's health and safety.

- Lead to the neglect of a child's routine health care needs, including well-baby checkups and immunization schedules.

Changing Practice and Policy

In recognition of the growing scope of this problem, policy reflected in recent federal and state legislation and in innovative practice in several communities shows a new emphasis on working with AOD services and agencies to help achieve the goals of the child welfare system. Efforts to strengthen the connections between these agencies have taken several forms:

- Set-asides from each system to work with children and families served by both systems,
- Federal waivers in one state (Delaware) to work with AOD-affected families in CWS* caseloads,
- State efforts to develop new and blended AOD-CWS risk assessments,
- State action to include AOD treatment in supportive services for welfare clients under Temporary Assistance for Needy Families (TANF),
- Proposals (in federal legislation not yet passed) to expand the use of CWS funding for treatment services, and

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* Throughout this document, we refer to CWS (child welfare services). This is intended to mean the full range of child welfare agencies that address issues of out-of-home care, including foster care, adoption, and other forms of permanency planning. Child protective services (CPS) are mandated to address child safety issues, while CWS agencies have larger concerns with child well-being and family functioning. When we are discussing the narrower concern within CPS units for risk assessment and the actions taken by CPS units to ensure child safety, we will shift the focus of the guidebook from the larger CWS arena to the CPS units within it.

What's the Payoff?

The stakes in building bridges between CWS and AOD systems are significant: using the mid-point estimate of 60% of parents in the child welfare system affected by AOD problems, it is clear that a substantial net savings results from AOD treatment, even if it is assumed that treatment is effective for *only a portion of these parents* (detailed numbers are set forth in Chapter 4).

- An in-depth, federal study of how child welfare and AOD treatment services can connect more effectively (required by the Adoption and Safe Families Act of 1997).

Efforts by several prominent organizations, including the Child Welfare League of America (CWLA), have spotlighted these issues in the past few years.* CWLA's Chemical Dependency and Child Welfare Task Force, first convened in 1990, was reestablished in 1997 and continues its work at present. With funding from the U.S. Office of Juvenile Justice and Delinquency Prevention and as part of Secretary Shalala's National Initiative on Youth Substance Abuse Prevention, the CWLA task force is developing several projects to strengthen services for children and families experiencing AOD problems in child welfare. (This guidebook is one of those projects.)

At the same time, in several innovative sites around the nation, child welfare practice has been changing through new training curricula, out-stationing staff in such other settings as schools and family resource centers, links with juvenile justice agencies and the courts, community partnerships that bring AOD and CWS staff together with

* Some of these organizations include the Children's Defense Fund, the American Humane Association, Drug Strategies, the American Public Welfare Association, the National Association of State Drug and Alcohol Directors, Legal Action Center, and the Center for Substance Abuse Treatment in the U.S. Department of Health and Human Services. Funding for AOD-CWS demonstration projects has come from the Edna McConnell Clark Foundation, the Robert Wood Johnson Foundation, the Annie E. Casey Foundation, the Stuart Foundation, and others.

neighborhood residents in decentralized service models, and negotiated agreements for referral to and assessment by treatment agencies.

In recent years, the concern for the children affected by substance abuse has broadened well beyond the most visible examples of the need for connection between CWS and AOD: infants born with evidence of prenatal drug exposure. While tragic, these children represent fewer than 5% of all the children significantly affected by their parents' substance abuse [Young 1997]. Many of the innovations described in this guidebook began with a focus on prenatal drug exposure but moved to embrace the full range of problems among children and youth affected by alcohol and other drugs.

There has also been a growing recognition of the cumulative effects on children of the combination of AOD abuse and child abuse or neglect [Levoy et al. 1990]. The juvenile justice system has devoted particular attention to the relationships between child abuse and delinquency, focusing in several recent studies on the correlations between earlier child abuse and later delinquent behavior. Some studies have concluded that parents' AOD problems are especially powerful risk factors for youth, making it more likely that they will have problems in adolescence and later life [Rivinus 1991]. Several demonstration projects are targeting children who are most likely to "age into" the juvenile justice system from their earlier exposure to the CWS system, or those who have already become known to both systems.

CASE STUDY

The Sacramento County Case Study. In 1993, Sacramento County's Department of Health and Human Services (DHHS) responded to the growing number of child protective cases in the County that involved AOD-related problems. With an estimated 2,000 drug-exposed infants born annually and requests for AOD services accounting for nearly 30% of all Family Preservation service requests, the DHHS leadership assessed the agency's capacity to meet these needs and concluded that at best it could respond to no more than 25% of the need. The Department, under the leadership of then-Director Robert Caulk, developed a multifaceted initiative focused on changing the child welfare and other systems through training and making AOD assessment and intervention part of the respon-

sibility of every worker. The clear and ambitious goal: to provide "direct AOD treatment on demand." The Department developed three levels of training for more than 2,000 employees, providing core information on chemical dependence in the first level, teaching advanced assessment and intervention skills in the second level, and building group treatment skills in the third level.

A rich set of lessons is emerging from several years of demonstration projects supported by private foundations as well as by state and federal governments. These include the Community Partnerships of the Clark Foundation, the Family to Family Projects of the Casey Foundation, demonstration projects sponsored and funded by the National Committee on Child Abuse and Neglect, studies funded by the U.S. Office of Juvenile Justice and Delinquency Prevention, and the "Starting Early/Starting Smart" project, a joint effort of the Casey Family Program and the Substance Abuse and Mental Health Administration, which includes grants for programs addressing the needs of children age 0-7 who are at high risk of developing problems related to the AOD or mental health problems of their parents.

This guidebook draws on the lessons from several of these demonstration projects. In many ways, however, some of the most instructive lessons emerge from a single case study: Sacramento County's four-year (and ongoing) initiative, which has addressed CWS-AOD issues in a larger context of other systems, including welfare, criminal justice, and health services. Thus, the Sacramento case study of CWS-AOD connections is featured throughout this guidebook, illustrating many lessons for other projects and other communities.

Interaction with Other Systems: TANF, Juvenile Justice, Family Violence, and Mental Health

Some of the urgency in recent bridge-building efforts stems from the potential impact on child welfare agencies of the 1996 federal legislation that created the Temporary Assistance for Needy Families (TANF)

program. While we lack comprehensive data as to how many clients are enrolled concurrently in TANF, child protective services caseloads, and AOD treatment, numerous studies have documented that these multiproblem families are the highest risk clients in each of these systems [Young & Gardner 1997].

Although this guidebook will focus primarily on CWS-AOD linkage, it will also examine the emerging models of TANF-AOD connections, since welfare reform changes are certain to affect child welfare caseloads in years to come. Substantial CWS impacts are predicted both by the welfare reform optimists (who believe that children will be much better off in families with parents working and free of welfare dependence), and by the pessimists (who believe that neglect cases will increase substantially as parents who are removed from welfare find they cannot hold jobs). Which of these proves true, and for which children and families, will depend upon implementation decisions made in communities throughout the nation. Understanding the impacts of welfare reform will also require that communities make serious efforts to monitor the effects of reform beyond simple measures such as caseload reduction.

Three other systems need to be considered in the process of enhancing the connections between CWS and AOD services: (1) the related areas of juvenile justice, delinquency prevention, and youth development; (2) family violence; and (3) mental health. In addition to TANF, these are the parallel systems, combined with the indispensable roles of parents and the wider community, that have the resources to promote family stability. If these separate systems cannot forge closer links, each will be forced to work within its own limited resources, when it is clear that the resources of more than one system are needed to address the needs of families with multiple problems. The practices and policies of other systems play crucial roles in the future of the child welfare system, leading to a powerful paradox: the well-being of many children and the future of child welfare is heavily dependent on decisions made *outside* the child welfare system, in the form of both daily practice and public policy.

The Need for a Policy Framework

In recent work in this area, a six-part framework has proven a useful way to organize discussion of the policy issues raised when CWS and AOD agencies and programs are brought together.* The policy framework includes values, daily practice, training, outcomes and information systems, budgets, and service delivery. The elements serve as a template for developing and assessing initiatives that go beyond pilot projects to attempt system-level change. It should not be applied as a simple checklist, however. These six elements are interdependent, as revealed in the Sacramento initiative described below and in several other model projects. Although it is obviously possible to launch projects that feature innovations in only one or two of these dimensions, the most important premise of the framework is that working *solely* within a single area will ultimately fail, because the other ingredients are missing or not addressed in depth. Innovation has to begin somewhere, and carefully choosing the correct entry point in each policy setting is the first step, which must be followed by working across all six areas.

These elements also help us understand why it is difficult to link CWS and AOD services, despite the excellent efforts undertaken by those agencies and communities (described on page 27 and following). In each of these areas, there are formidable barriers to connecting the two systems—and to working with other systems as well.

The Importance of Bridging the Practice-Policy Gap

The policy framework proposed in this guidebook is based on a conviction that the worlds of policy and practice remain too far apart in both CWS and AOD arenas. Attempts to change daily practice *necessarily* require policy change, or they become isolated pilot projects that cannot be sustained or expanded. Practice can raise important

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* This framework draws upon a 1997 report that the authors prepared for the Stuart Foundation, *Bridge Building: An Action Plan for State and County Efforts to Strengthen Links between Child Welfare Services and Services for Alcohol and Other Drug Problems*. Irvine, CA: Children and Family Futures.

questions about the lack of CWS-AOD connections, but it requires a policy process to respond to these problems with more than *ad hoc*, crisis-driven, temporary fixes. At the same time, without changes in practice, the policy process often operates to ratify and protect the status quo, which is always the least disruptive policy to implement.

So, practice and policy must be considered together when attempting to effect meaningful change. But the usual relationship between the two worlds ranges from benign ignorance to outright disdain. Those more familiar with the policy world may perceive hands-on practitioners as too overwhelmed by their work to see "the big picture" of resources and legislation, while practitioners may regard those from the policy sector as hopelessly unrealistic, far removed from the realities of daily practice and the dynamics of working with challenging clients in troubled communities.

A closer, mutually respectful relationship is needed between the world of the "hands-on" line staff and the world of the policymakers and budget staffs. Bringing together these two worlds is essential to build the bridges between CWS and AOD, since many policy issues that cut across the two sectors need action in both policy and practice realms:

- The impact of state and local budget decisions about CWS staffing and caseloads;

- The need to develop a resource strategy that breaks out of the pilot project mentality to create and carry out a design for going to full scale—redirecting significant core agency budgets and neighborhood assets, rather than relying solely on external grants;

- The concentration of resources on specific neighborhoods in ways that may affect overall citywide or countywide allocations;

- The impact of assessment practice in changing policy to direct resources to clients who need help; and

- The potential for securing new resources from other agencies that can support community partnerships with AOD services, family violence services, child care, and school-linked services.

These are all policy issues, in the sense that policy consists of choosing a course of action and putting resources behind it. But these choices can and must be informed and shaped by the realities of daily practice undertaken by skilled professionals, helpers, and parents. Practice needs to inform policy; policy needs to provide a framework for rational decisions that support the best kinds of practice. Policy can institutionalize best practices, ensure that they can be sustained, and provide the resources to assess their effectiveness in helping clients and communities. Practice changes are unlikely to survive unless policy supporting those changes is put in place prior to their expansion.

Why Values Matter

It is impossible to think and work effectively on issues of child abuse, substance abuse, and poverty without understanding how deep-seated our underlying values are on these issues. Our attitudes about how to treat children are learned and taught in our cultures from the earliest days of family life. Our attitudes toward legal and illegal drugs are the product of centuries of public opinion in this nation, going back to Prohibition, the Puritan era, and beyond. And the ways we think about the causes of poverty are at least four centuries old, dating from the Elizabethan Poor Laws and coming down to the intense debates over welfare reform in the mid-1990s. Sometimes we stereotype when we think and talk about these difficult issues.* When we do, it becomes more difficult to make policy or change practice, because the ingrained ways of thinking about these issues in polarized language force the middle ground options out of the debate.

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* Children and Family Futures believes that the values framework in which we discuss these issues is so important that it must be addressed as a critical part of any community's efforts to work collaboratively. We have developed a Collaborative Values Inventory as a neutral tool used to reveal the underlying values that collaborations often submerge in their desire to avoid conflict. This tool is attached as Appendix A.

As we noted in the Winter 1998 issue of *Public Welfare* [Young & Gardner 1998], some individuals and some workers believe that society should take children away from their parents if the parents are abusing drugs. The subject becomes more difficult, however, when we recognize that millions of children live in middle-income homes where substance use—and substance abuse—are common occurrences that do not come to the attention of protective services agencies. The distinctions among *use, abuse,* and *chemical dependence* are crucial to understanding the interplay among dependence, neglect, child abuse, poverty, and a lack of job skills. Our ability to decide accurately when AOD abuse and dependence endanger children has not grown as fast as our recognition that millions of children are undeniably affected by their parents' AOD problems.

We believe that there is a middle ground in which both sets of underlying values—child safety and family stability—can be endorsed while designing systems that achieve a balanced set of obligations:

- Placing the responsibility on parents to do everything they can to provide a safe and supportive home for their children, and

- Placing the responsibility on society and its service systems to provide parents with the resources they need to end their chemical dependence and its harmful effects on their children.

Children's needs will not be met by either a strict demand for abstinence or, at the other extreme, the too-frequent practice of ignoring substance abuse problems until they become severe enough to move toward terminating parents' custody rights. Yet the public debate over these issues tends to swing from pole to pole, rarely confronting the hard choices necessary to ensure that parents are given a fair chance to recover and that children are given a fair chance to live in nurturing homes with loving caretakers.

The recent legislative history of AOD issues in social welfare and child welfare is instructive, revealing the preoccupation of some lawmakers with sanctioning clients who abuse drugs and punishing those

with past drug felonies. In the TANF legislation, references to drug testing and prohibitions aimed at clients convicted of drug felonies were the only AOD issues addressed in the law. But the federal law was silent on what to do about the estimated 1 million women who may need treatment to enable them to perform effectively at new jobs. In some states, however, more in-depth approaches to the issue included set-asides of specific resources for treatment of TANF clients.

The Adoption and Safe Families Act of 1997 signed by the President last November originally included detailed provisions and funding for building closer ties between child welfare and AOD agencies. But unable to agree on how to respond to overlapping substance abuse and child abuse issues, Congress removed all provisions to providing AOD treatment with child welfare funding and charged DHHS with conducting a study of the issue.

The Policy Framework in Action

The Element	The Impact and Trends
Daily practice	Assessment, caseloads, and incentives
Training	Working across agency boundaries with new AOD content
Outcomes and information systems	The shift toward client outcomes and results-based accountability
Budgets	Shifting from categorical funding to blended and linked funding
Service delivery	Alternative delivery methods, including for-profits, faith-based organizations, community-based partnerships, and managed care organizations.

Daily Practice

Ensuring the competence and thoroughness of daily practices of line CWS and AOD workers is critical to making lasting change. Some training initiatives have encountered problems because they did not recognize that without new incentive systems, newly trained workers would have little reason to use new practices in their day-to-day work

with clients. The fundamental connection between client and worker is at the heart of AOD diagnosis and treatment, and different approaches to that all-important relationship are described below. *Assessment*, the process at the core of how workers make judgments about their clients, is discussed in Chapter 5, since it constitutes and influences much of daily practice in both the CWS and AOD systems.

Training

Training is a crucial element in system innovations, but training alone cannot achieve system reform. Furthermore, most training today is categorical, operating as though the system in which it operates were the only system in which workers function. We frequently hear complaints by workers and supervisors in both CWS and AOD systems who state that they know far too little about the other systems with which they should be working more closely. (After the new training of more than 1,000 Sacramento County health and human services staff and others from community agencies and other county departments, workers strongly expressed their positive responses, as quoted later in this report.)

Outcomes and Information Systems

For good practice to lead to better outcomes, it must be accompanied by a move toward results-based accountability. The use of defined outcomes as client-level measures of a program's impact, rather than measuring the units of services provided or the number of clients served, has accelerated in the past decade as a critical management trend affecting both child welfare and the treatment field. Under pressure from managed care in general and behavioral health firms specifically, outcomes-based evaluation has progressed further in the AOD field than in the CWS arena. But to date, funding organizations (both government agencies and private foundations) have not fully adopted results-based evaluation or results-specific budgeting for either CWS or AOD agencies [Gardner 1996]. Agencies are collecting and using outcomes, but budget decisions are not linked to outcomes in any sustained way in most child welfare or AOD treatment agencies. Some of the most basic information about what happens to clients is not collected by child welfare agencies or by many treatment agencies.

CASE STUDY

Comprehensive Training. Sacramento implemented its training based on the fundamental belief that "department members from every level...must have the capacity to address alcohol and other drug issues." This basic premise should underlie all such efforts. The prerequisite to a serious commitment to training is a recognition that the great majority of workers in the child welfare system and in the treatment agencies do not know enough about "the other side" to work effectively across systems.

As CWLA summed up in 1997: "...a majority of state child welfare agencies are not equipped to deal with chemically involved clients. Many agencies do not have data collection processes, assessment protocols, policies, or programs that are responsive to youths' AOD needs" [CWLA 1997].

Budgets

Connecting CWS and AOD agencies must happen in a world of categorical funding. Despite growing familiarity with "wraparound funding," new legislation that enables blended funding, and the success of some well-funded demonstration programs in tapping dozens of sources from different state and federal agencies and private foundations, the world of daily practice remains a world of categorical policy making and categorical funding streams. That context eventually constrains all efforts to link programs funded from different sources and makes it far more difficult to assemble resources, train workers, and refer and treat clients across the boundaries of these separate systems.

Service Delivery

The final element of the policy framework is *how* services are actually delivered, whether through the efforts of CWS workers, nonprofit contractors, behavioral health firms operating managed care contracts, faith-based organizations, or neighborhood-based family support organizations. The shift to expanded use of both managed care and community-based networks of agencies needs to be taken into account in describing recent changes in the ways these services are delivered.

Don't Ask, Don't Tell

For all the progress made in recent years in both CWS and AOD agencies, it is important to recognize that the norm in many sites is still a gap between the two. To quote one California county administrator from a child welfare agency, "For years the workers have been saying [AOD] isn't on the form and it usually isn't in the allegation, so I don't go looking for it." In the same conversation, an AOD agency official admitted, "We have just not seen children as part of our responsibility."

Barriers to CWS-AOD Links

The barriers to CWS-AOD connections loom large in each area of the policy framework. Potential conflicts in values and philosophies held by each domain occur over such fundamental issues as, "Who really is the client, the parent or the child?" There are many other differences between the CWS and AOD systems that make it difficult to develop links, including differences in the style of daily practice by line staff, how they screen and assess clients' needs, the education and background of workers, how each system measures and defines success for its clients, what data it collects about its clients, the funding streams and the financial assumptions of the two systems, and ways in which the two systems are moving toward both managed care and neighborhood-based service delivery.

One AOD practitioner summarized the barriers between the two systems in strong language:

> I don't believe the substance abuse system has wanted to embrace responsibility for assisting in the determination of child placement and operationalizing the role of addiction and recovery in child protection ... I also think that most child protection workers don't believe that treatment works, and when added to the issues around difficult access, relapse, sequential case planning, treatment is just another variable to deal with in disposition of the case ... This results in con-

> secutive and incompatible case management rather than concurrent planning . . . As the substance abuse field has been able to assist the criminal justice system in making determinations between incarceration and treatment, so we must become more adept in assisting the child welfare system in the determinations for which they are responsible, when substance abuse is a factor [personal communication 1998].

All of these pose major challenges to the effort needed to bridge the gap between the two systems. Considering the many obstacles to coordination of CWS-AOD agencies, the achievements of states, communities, and agencies that we describe in Chapter 2 are all the more impressive; the models show how innovative practices and policies can work together to overcome barriers.*

Timing Barriers: The "Four Clocks"

A key barrier that needs specific attention is what we term the "four clocks problem"—the four completely different timetables that can affect children and parents in an AOD-abusing family:

- The child welfare system timetable of six-month reviews of a parent's progress, which the new federal legislation accelerates to a requirement for a permanency hearing at 12 months.

- The timetable for treatment and recovery, which often takes much longer than AOD-based funding allows, and which is often incompatible with child welfare deadlines for parents who may have relapsed but are still working at their recovery; some have summarized the AOD timetable as "one day at a time, for the rest of your life."

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* A full discussion of the barriers between the systems can be found in several previous works, including the following: Child Welfare League of America (1992). *Children at the front*. Washington, DC: Author; Gardner, S. L., & Young, N. K. (1997). *Bridge building*; and Gardner, S. L., & Young, N. K. (1996). *The implications of alcohol and other drug-related problems for community-wide family support systems*. Cambridge, MA: The John F. Kennedy School of Government, Harvard University.

- The timetable now imposed for TANF (former AFDC) clients who must find work in 24 months. (This is the federal maximum; some states have lower limits and thus some clients are already reaching the cutoff point.)

- The developmental timetable that affects children, especially younger children, as they achieve bonding and attachment—or fail to—as they pass through the period of the first 18 months, which new research on brain development has shown to be a critical period of time in a young child's life.

Barriers in Defining the Client

A further basis for the problems between the two systems arises in the competing demands for AOD services for populations other than children and families. In part due to the improving information base about what kinds of treatment are most effective for which kinds of clients, demands for AOD support services have multiplied from the criminal justice system, the mental health system, and now, notably, the overlapping welfare/TANF system. Treatment for inmates has been an area of increasing emphasis, given the number of drug offenders in state prisons and local jails. Resources in the AOD system are scarce in the short run, and the call for expanded responsiveness to the special needs of children and families in the CPS system conflicts in important ways with these other demands. With waiting lists for different kinds of clients, those with special claims in the eyes of their sponsoring agencies may not meet the same priorities in other agencies.

For a CPS worker, the client is both the child and the family, with the risk to the child as the primary short-term concern and the safety of the child the longer range priority. But for a worker in the AOD treatment system, clients are addicts and alcoholics, usually adults, and their status as a parent is generally irrelevant unless they are in one of the few perinatal programs or a special program for mothers and their children. In most treatment programs, the children of clients may not be seen as important; they may be cited as an incentive

for recovery, but are usually not involved in any active way themselves. The AOD worker also may identify with the client because she/he is likely to be recovering from addiction and more readily understands the client's problems and the mechanisms of denial and avoidance.

In contrast, a CPS worker dealing with a known substance abuser is generally frustrated and sometimes even angry at such a parent, because of the risks to the child. Depending upon the worker's own attitudes, the client may be seen as suffering from a powerful disease for which treatment must be sought—but is more typically viewed as a selfish, thoughtless parent with no regard for her or his child. Judges and the court system can accentuate these attitudes when they adopt a "zero-tolerance" approach that emphasizes solely punitive measures and reflects little understanding of AOD treatment or parental functioning.

The differences between the CPS and AOD systems' responses to licit and illicit drugs are also important barriers at times. Practitioners have pointed out how CPS focuses on illegal substances and overlooks alcohol abuse and its consequences on the family, despite the much greater overall damage done to children both prenatally and environmentally by alcohol.

Differences in agency perspectives on who is the client also lead to issues of confidentiality, which are discussed at greater length in Chapter 6.

Barriers of Different Training and Education

Workers in the two systems are trained differently and tend to have different educational backgrounds. The content of training in the two systems rarely addresses the connections between the systems or methods that could be used to work across systems in identifying and assessing AOD-related problems.

A recent review of CWS training in universities documented the lack of emphasis upon addiction issues as they affect children and the complexities of working across the two systems. Most of what is included focuses on perinatal substance abuse and the issues of the positive toxicology screen at birth. These "doses" of exposure to AOD

issues appear disproportionately small, compared to the importance of these issues in CWS work. As one trainer put it, while working in a program that provides an in-service orientation to addiction for health and human services professionals who work across CPS-AOD agency lines, "What we are doing here is remedial—they should have gotten all this in their preservice programs."

Workers in the AOD system are trained in a wide variety of fields. A significant percentage of them have come through the treatment system themselves. While some have advanced degrees in counseling and other fields, many frontline workers have little formal training. This is especially true when mutual aid programs are factored into the spectrum of AOD treatment programs. In these self-help oriented systems, the "helpers" are lay people who draw heavily on their own experience rather than on formal education.

Funding Barriers

The funding barriers that impair CWS-AOD connections include the complexity of categorical funding, the barriers to reimbursement for many of the treatment needs of parents and adolescents, and a tendency of each "side" of the CWS-AOD relationship to protect its own funding sources and seek allocations from the other. Representatives of the two groups would doubtless add a fundamental resources gap in total spending to the list of funding barriers. Waiting lists in some states and communities provide evidence of this barrier, despite the absence in most communities of any total inventory of AOD spending. Federal earmarks are cited by some AOD providers as funding barriers to working with CWS clients, although the national allocation of approximately 27% of all publicly funded treatment slots to women reflects state priorities for providing treatment to men, especially those in prison, rather than federal requirements for such a division of funding.

The funding barriers also lead to problems caused by the inability of either CWS or AOD agencies to control their own resources, due to two major external forces: the decisions of courts and the decisions of managed care firms in the behavioral health field. In both cases, resource decisions are significantly out of the hands of the CWS

or AOD agencies, which means that when the two sets of agencies do seek to cooperate, outside mandates may make it more difficult because of a requirement set by a court or a regulatory burden of proof created by a managed care firm that makes it difficult to arrange appropriate treatment for some clients. Without education and training aimed at these key external decision makers who affect CWS-AOD links, barriers from outside the two sets of agencies will continue to affect bridge-building efforts launched from within these agencies.

Is a Policy Framework Realistic?

It can be argued that policy making on issues as difficult as child abuse, substance abuse, and family violence is *unavoidably* crisis-driven, episodic, and incremental at best. In such an environment, innovation is difficult to launch and even more difficult to sustain beyond the level of pilot projects. But there are a sufficient number of states and communities that have developed such sustained innovation in recent years, under the pressures of rising caseloads and greater understanding about the problems of substance abuse, to justify the attempt to set forth and refine a framework that could better guide policy making in a more comprehensive, less fragmented fashion.

The quest is not for rigidly coordinated, fully rationalized policy; it is rather for policy that goes beyond reacting to symptoms and crises to address the underlying forces that affect child abuse. Such policy can emerge from a framework, as described in this guidebook, that views inevitable crisis as an opportunity for reform, rather than a demand for quick fixes with more regard for media spin than the lives of children.

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