

CHILDREN AND FAMILY FUTURES
STRATEGIC PLANNING AND EVALUATION

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**Bridge-building:
An Action Plan for State and County Efforts
to Link Child Welfare Services
and
Treatment for Alcohol and Other Drugs**

A report for the Stuart Foundation
by
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INTRODUCTION

This report summarizes a series of structured discussions between two sets of county officials in five California counties: child welfare leaders and their counterparts in drug and alcohol treatment. These five sets of county officials were joined by state officials from the Department of Social Services and the Department of Alcohol and Drug Programs, in an exploration of the current and needed links between child welfare services and drug and alcohol treatment.¹ The meetings began in December 1996 and were completed in May 1997.

The initial premise of the effort was stated in the invitation letter to the attendees:

With a large majority of the families coming into the child welfare system affected by AOD (alcohol and other drug) issues, we believe that this exploratory effort can help counties and service providers to consider a wider range of options for more effective services needed by families.

The data on the overlap between CWS and the need for AOD treatment services are extensive and continue to grow; a recent (1997) study of states by the Child Welfare League of America documented that:

- Studies of the link between parental substance abuse and child maltreatment suggest that chemical dependence is present in at least half of the families known to the public child welfare system;
- 80% of states report that parental substance abuse is one of the top two problems exhibited by families reported for child maltreatment;
- Substance abusing families with young children are placing an enormous burden on medical, social and educational systems which is reflected in the 72% increase nationally of out-of-home care placements between 1986 and 1995;
- At least 52% of placements into out-of-home care were due in part to parental substance abuse;
- As many as 80% of drug exposed infants will come to the attention of child welfare before their 1st birthday.²

¹ This report and its recommendations do not reflect the official positions of any of the participants' agencies; this is a summary of the discussions developed by the group's facilitators, Dr. Nancy Young and Sid Gardner. This report seeks to report on the consensus achieved by the group; on some items, the consensus did not include every member. Participants are listed in Appendix 1.

² Child Welfare League of America (1997). "What is the Link between the Child Welfare System and Chemical Dependency?" Washington, D.C.: Child Welfare League of America.

As a means of organizing the discussions, five cross-cutting topics were used as the subject of each of the meetings, drawing upon an earlier background paper on CWS-AOD issues.³ These topics, in the order they were discussed by the group, were:

1. Daily Practice (discussed in December 2 session)
2. Information Systems, Evaluation, and Outcomes (discussed in January 13 session)
3. Budget and Finance (discussed in February 25 session)
4. Training and Staff Development (discussed in March 21 session)
5. Alternative Delivery Systems (discussed in March 21 session)

The Current Policy Environment For CWS-AOD: The Key Leverage Points

Participants emphasized throughout the sessions that the present time is an especially opportune period to address these issues, in view of several action-forcing events and opportunities for leverage on current policy and practice:

1. The proposal for a new Infant Health Protection Initiative which addresses CWS-AOD links for a portion of the most severely impacted children, infants born to mothers who test positive for drugs or alcohol, combined with an effort to develop new risk assessment tools for CPS;
2. The development of new information systems and data collection in both the Department of Social Services (the CWS/CMS) and the Department of Alcohol and Drug Programs (linked in the case of ADP to managed system of care reforms);
3. Several federal initiatives, including the Chaffee-Rockefeller proposal for use of Title IV funds for AOD treatment and training, the proposals for Performance Partnership Grants as a replacement for the Substance Abuse Prevention and Treatment Block Grant, revisions of federal information systems, and welfare reform;
4. The re-constituting of a national task force on chemical dependency issues by the Child Welfare League of America;
5. The convening by the California Department of Social Services of a series of regional hearings on the future of the foster care system; and
6. Tragically, the recent high-visibility deaths of children in which AOD abuse was a part of the case.

³ This paper, "The Implications of Alcohol and Other Drug-related Problems for Community Partnerships for Child Protection" was developed by the authors as a part of the John F. Kennedy School's Executive Session on the Future of Child Protective Services, which met from at Harvard University 1994-97 and was funded by the Annie E. Casey Foundation and the Edna McConnell Clark Foundation. It discusses in more detail the issues of treatment effectiveness and the causes of weak links between the two systems.

The acronyms CWS (child welfare services) and AOD (alcohol and other drugs) are used in this paper to refer to the two major systems which are its focus. CPS (child protective services) is the legally mandated system responding to allegations of abuse and neglect within the child welfare services system.

The action steps and recommendations in this report are designed to respond to these key leverage points, and to provide the basis for both an action agenda of steps that can be taken immediately and for an advocacy agenda that needs to be addressed over a longer period of time. The group strongly urged that both a short term agenda— things that could be accomplished over the next 12-18 months— and a longer-term agenda be developed from the recommendations of this process.

Context of the Findings

The discussions were lively and wide-ranging. At the initial meeting, participants acknowledged that both “sides” to the discussion—child welfare and AOD treatment agencies—have equal enough responsibility for their lack of connection that there is no need to apportion blame for the problem. The goal of the discussions was to understand the basis of the barriers between the two systems and to propose mutually accepted solutions, rather than to attribute responsibility. This “no-blame” tone prevailed throughout the sessions.

Two additional “ground rules” were proposed at the first session, and the group adhered generally to both. The second was an assumption that:

resources matter but something other than funding is also important...the [funding] problem is critical, but if everything that comes up is impossible without more funding, then we should all just go home. Some important things are going on other than resources, some of it is about a redirection agenda of better uses of today’s funding... not everything is a funding issue.

The third proposed ground rule was that the discussion should focus on building on some of the excellent pilot projects already under way and deal with the question of :

how do we move from projects to systems change to redirect funding to affect a larger number of clients? We know we can do projects, but we need to move on to demonstrate what we can do to work in at scale in the larger system...to move beyond projects into the larger system.

This issue is especially important in moving beyond the excellent pilot projects for perinatal services to mothers and infants, to the much larger group of children in the CWS system affected by AOD problems in their families.

State staff involvement in the discussions was very important and very constructive. The state officials from both sets of agencies were active participants, presenting new budgetary information, setting out the logic underlying current and past state policy, and reviewing changes in information systems, especially the new child welfare information system.

State and local participants from both sets of agencies agreed that they needed better and ongoing information about the other agencies than they had at present. The funding systems were the most bewildering, but frequently in the discussions participants said that they were learning things about

“the other side” that they had not understood before. This underscored the infrequency of sustained contact between the two sets of agencies. The difficulty of penetrating the terminology and jargon used by each side was also evident, as members of the group gradually came to understand each other’s references, but only after six meetings.

Philosophical differences

The depth of the differences in philosophical outlook between the two systems was a recurrent theme, which participants agreed should not be understated for the sake of a vague consensus. While better communications and referral agreements will help considerably, the fact remains that if the central missions of the two agencies differ—as they still seem to, in some important respects—the level of cooperation which is possible will remain below what is needed to respond to the overlap in clients. The primary areas of difference in philosophy remain:

- who is the client: children, parents, the family, or the community?
- which timetable should apply: child welfare law, the new welfare reform law, AOD treatment timing, or the developmental needs of children at different ages?
- how can we reconcile zero tolerance, harm reduction, child safety, and family preservation as contrasting philosophies in protecting children and stabilizing families?

The emerging CWS-AOD consensus

At the same time, a consensus among participants from the two systems did emerge from our discussions. Simply stated, participants agreed that better-connected CWS and AOD systems could achieve four purposes:

1. Provide more effective services to more children and parents than the current fragmented systems (the effectiveness goal);
2. Do so in a way that preserves more families with greater child safety than today’s system (the family stability goal);
3. Assist in making decisions about removal of children from those parents and caretakers whose addiction remains a threat to their safety and well-being (the child safety goal); and
4. Combine resources from the two systems which would serve more children and families than either system could do separately, while working more actively to enlist other community agencies and organizations for families with less intensive needs (the resource mobilization goal).

These four goals are contrasting, but not inconsistent. As summarized in an earlier report from the Child Welfare League of America:

...efforts to support children within their chemically dependent families must attempt to address chemical dependency in the family while meeting the developmental and safety needs of the children.⁴

At the same time, this consensus should not be overstated. Important differences remain, notably a reluctance on the part of AOD providers to accept responsibility for children and families beyond their current resources, which are significantly earmarked by federal requirements. On the CWS side, the consensus was least firm in accepting the need for additional emphasis in the risk assessment process on screening and assessing the extent of substance abuse problems in the family, as long as state policy does not find that substance abuse is child abuse. CWS participants noted that the IHPI proposal focuses upon substance abuse for a only small percentage of the total CPS caseload, and then only in severe cases.

Where Do the Barriers Come From?

The problem of inadequate connections between child welfare and AOD agencies arises in five major differences:

1. Differences in purpose reflected in different laws and regulations
2. Differences in education and training of staff
3. Differences in the timetables for carrying out the two sets of programs
4. Differences in the definition of who is the client
5. Differences in funding which reflect the above differences

There was a consensus that the two systems found it difficult to work together as a result of these differences. In discussing front-line workers' reactions to AOD issues, one member of the group said "For years the workers have been saying it [substance abuse] isn't on the form and it usually isn't in the allegation—so I don't go looking for it." Another participant summarized the reaction from the treatment agencies by saying "We have just not seen children as part of our responsibility."

The "Four Clocks"

This phrase came to be the shorthand used by discussants to refer to the fundamentally different timetables required by child welfare legislation, welfare reform, the process of recovery, and the developmental needs of children.

The timing barriers

The timing differences were seen as a very powerful driving force that underlies system incompatibility. The phrase "the four clocks" was used to refer to the four different timetables that may be affecting a family's response to CWS-AOD problems: (1) the CWS timetable of six-months reviews of a parent's progress and the timing under state

and federal law governing termination of parental rights, (2) the timetable for treatment and recovery,

⁴Children at the Front, The CWLA North American Commission on Chemical Dependency and Child Welfare, Child Welfare League of America, Washington, D.C., 1992.

which often takes much longer than AOD funding allows, (3) the timetable now imposed for TANF (former AFDC) clients who must find work in 24 months,⁵ and (4) the developmental timetable that affects children, especially younger children, as they achieve bonding and attachment—or fail to.

The client targeting barriers

Identifying which children and families should be targeted is also an issue. In the view of some of the participants in the session, there continues to be disproportionate emphasis upon the problems of children who are born prenatally exposed to alcohol and other drugs, relative to the much larger number of children affected by AOD problems *after* birth. With the dominant emphasis upon prenatal exposure and adolescent drug use, the years between birth

and adolescence are under-emphasized, despite the obvious evidence that risk to children and youth from AOD problems occurs during these years due to family and environmental exposure which has lasting effects in ways that *in utero* exposure does not always have. The substantial evidence that this is true includes the thousands of children in this age group who are reported to CPS units, despite never having come to the attention of these agencies as result of prenatal exposure. Some estimates place the total percentage of all children affected by AOD at fifty times greater than those testing positive for exposure to drugs at birth.⁶

Yet the birth of a child who tests positive for drugs is so traumatic and so clearly an occasion requiring intervention that this critical juncture has been rightly perceived as an opportunity to take decisive action in a family which is undeniably high-risk. In response, the group felt that the IHPI was an appropriate entry point for broader systems reforms that go beyond one more demonstration

“Denial is not a river in Egypt.”

We are also in denial; we want to close the cases. We are only looking at the tip of the iceberg because we have a responsibility to serve cases that are open....It keeps the system from collapsing.

CPS official

⁵Although the focus of this project was the child welfare system as it relates to substance abuse, not the welfare system as such, the connections and overlap among the three systems came up repeatedly in the discussions. Participants frequently noted the likely impact of welfare changes on child welfare practice. On the day that legislative hearings addressed the absence of adequate funding for AOD treatment for welfare clients, the IHPI proposal was being discussed in the same committee. See also Young and Gardner, Implementing Welfare Reform: Solutions to the Substance Abuse Problem, Children and Family Futures and Drug Strategies, 1997, and Kammerman and Kahn, editors, Child Welfare in the Context of Welfare Reform, Columbia University School of Social Work, 1997. This issue is discussed further below.

⁶Derived from Young, Nancy K., “Effects of Alcohol and Other Drugs on Children,” Journal of Psychoactive Drugs, 1997. The estimate is based on the percentage of all prenatally exposed cases which were referred to the county CPS agency in Los Angeles County in 1993, compared with estimates of the wider incidence of effects on children affected by alcohol and other drugs in these other categories, using national figures drawn from a variety of sources.

project which sits on top of an unchanged system. The group felt strongly that this population—the 69,000 estimated positive tox births in California each year—was a classic case of “pay me now or pay me later,” given the likelihood of these children requiring subsequent public costs.

If I have to serve clients from the courts and mental health, when do I get to serve the individuals I want to serve?

AOD practitioner

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 work 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 California 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. A reality stressed by those from the AOD systems was that there are currently 7,000 people on the waiting lists for AOD services statewide—and thousands more who have been discouraged from signing up for a waiting list.

Remaining Controversies

The question of the appropriate legal response to a mother who gives birth to an addicted baby remains a major controversy which spans the two systems. Related questions have been raised by the inclusion of drug testing options in the welfare reform legislation, along with a prohibition against providing services to welfare clients with felony drug convictions. Whether treatment or punishment is the right response is still debated actively in both systems. In the group’s discussions of the Infant Health Protection Initiative, some of these philosophical differences emerged. At the same time, in the sessions there was general agreement that with better CWS-AOD connections, it should be possible to be more demanding of clients because broader treatment options would be available.

Free will, public health, and brain chemistry

Child welfare practitioners, like the general public, are part of a continuing debate over the fundamental nature of addiction as “bad acts by individuals with free will” (in the language of the 1992 National Strategy report) or a public health problem caused by a medical condition that changes brain chemistry once clients have progressed from use to abuse and dependency. As a result, the public debate is often conducted in polar extremes, ranging from medicalization and legalization on one hand to zero tolerance and punitive strategies on the other. This argument from extremes often rules out middle-ground options such as treatment on demand for all clients willing to comply with a treatment and aftercare plan.

Participants in the sessions appeared to believe that both brain chemistry and motivation matter. Clients can and should be held responsible for their actions, especially once consequences have been

clearly set out and treatment services clearly offered. And offering services does not mean simply giving clients a list of phone numbers, which is an all-too-typical response of the two systems. Participants in the discussions pointed out that research in the addiction field shows conclusively that coerced clients are no more or less successful in treatment than “voluntary” clients. “Coerced” and “involuntary” are words sometimes used loosely in child welfare and AOD treatment; is a parent who has been told he/she will lose parental rights acting voluntarily when checking into treatment—or being coerced? Either way, such a parent has been held personally responsible, given a clear message about treatment, and offered help—which are essential preconditions for successful treatment—but no guarantees that success will follow.

The differences between how the CPS and AOD systems respond to licit and illicit drugs was mentioned several times in the meetings. As one member put it “CPS focuses on illegal substances and overlooks alcohol abuse and the consequences on the family.” Members of the group felt that to the extent that the CPS system does pay attention to substance abuse issues, it is far more disproportionately focused on illicit than legal drugs, given the overall damage done to children both prenatally and environmentally by alcohol.

The political environment

The political context of CPS and AOD cannot be over-stated in terms of its importance in influencing policy. Yet the messages are not uniformly punitive, some participants argued, with the passage of Proposition 215 and similar legislation in Arizona—which included tobacco taxes for education purposes similar to Proposition 99 in California—and the growing recognition that incarcerating every user would have vast fiscal consequences. National publicity on the ineffectiveness of some school-based prevention models, notably DARE (and a similar California study published in 1996) gives further emphasis to the important link between treatment and prevention: “effective treatment for a child’s parents is the best kind of prevention for the child” was how one participant put it. The strong community reaction against some initial presentations of the harm reduction philosophy was also discussed as an unavoidable part of the political environment of CWS-AOD reform. A final dimension of the political environment was the emphasis given in recent allocations of drug treatment funding to incarcerated males, as a response to the wide public concern about crime and the evidence that prison-based treatment has been cost-effective. “We need to remember that we are competing with prisons” was the comment of one participant.

THE FIVE AREAS OF POLICY AND PRACTICE: WHAT HAVE WE LEARNED?

In each of the five areas of the policy framework, the group reviewed current practices and options for reform. The need for greater clarity about a consensus on values was felt to be a prerequisite to these changes in practice. This section will review these, highlighting major conclusions and the group’s concerns.

The Need for an Underlying Consensus on Values

Participants emphasized repeatedly the need for the two systems to resolve their philosophical disagreements on values—or at least to have more open discussions in each county about those differences and base policy on a consensus that is negotiated between both agencies with an impact on children and families. The group felt that the most important of those values differences were

The need to develop more middle-ground roles for parents

The typical argument from extreme positions—either parents’ rights are terminated and parents disappear from their children’s lives or children are reunified with parents—ignores a range of more intermediate options. Some parents who are clearly incapable of being the primary caretakers for their children can still play a role in their lives. For African-American families, participants noted, kinship relationships meant that aunts and other relatives often acted as primary caretakers while parents remained in their children’s lives as significant persons, but without the responsibility for daily caretaking. Some members of the group felt that this arrangement offered a better hope for both children and parents to come to terms with what the parents were and were not capable of providing as parents, and to keep open the possibility of parents who are working at recovery but not able to achieve it in the short timetables. As long as child safety remains preserved in the arrangements for parents’ roles, such flexibility seemed to some members of the group an important alternative to either extreme of current policy: removal or reunification.

Harm reduction and zero tolerance

The community view is still that when we go in with evidence of AOD, they want a ‘two strike’ approach: take the kids away after the second offense, with no realistic balancing of other options.

This comment by a CWS worker underscores the differences between different communities, since there are definitely some communities of interest that would still regard CPS as too hasty in removing children, and would emphasize the multi-cultural factors that are at times ignored in CPS criteria.

Both in its attitudes toward AOD use and child abuse, “the community” is sometimes very hard to define—and sometimes equally hard to please. Both drug abuse and child abuse can be polarizing topics, and values-driven discussion of anything other than zero tolerance in the AOD arena can quickly degenerate into a debate about why addicts should be protected from the consequences of their actions. Yet, as one AOD staff member said, “part of being clean and sober is relapse. We are talking about addicted people.” As difficult as reconciling these attitudes will be, without full and public discussion of these issues the polarized extremes will be *all* that is discussed.

Zero Tolerance— in a Drug Culture?

The thing about clean and sober is that we have a society built around drugs being all around— a drug culture— yet for our clients we expect zero tolerance. I don’t see how we reconcile these.

CWS official

The critical importance of multi-cultural competencies in dealing with families

As both of these topics make clear, it is impossible to address values in dealing with families without recognizing the profound effects of culture on family. In California, especially, with both wider diversity among multiple cultures and the seriously disproportionate representation of African-Americans in the CPS and prison populations, it is imperative to keep multi-cultural issues in the discussion. Child abuse and substance abuse raise very difficult issues of family boundaries and differences in accepted practices in supporting families, and a values discussion that omits these issues is not adequately grounded in the realities of clients or communities.

A strong resource in this area is the growing body of literature and practice that addresses and embodies the need for linguistically appropriate services combined with cultural sensitivity and skills in addiction treatment, child protection, and community-based family support (especially the work of the Family Resource Coalition and its African-American and Latino caucuses).

Findings: Daily Practice

Assessment was the area of daily practice which received the greatest attention in this discussion, and some participants felt it was the area with the most immediate need for change in links between the two systems.. There was general agreement that the efforts under way by the state and Los Angeles County to improve risk assessment were important steps forward that could combine AOD assessment with child safety and family functioning screening and assessment efforts. The current assessment process does not, it was agreed, include more than a cursory review of AOD issues. The threshold issue, then, is adding an explicit assumption that AOD abuse and dependency poses a risk and therefore should become a formal, deliberate, and expanded part of the screening and assessment process in child protective services. The importance of improved assessment, the group felt, was not only the need to determine more accurately the threat to child safety, but also the importance of making an early, accurate assessment of what *kind* of treatment would be most appropriate and most effective. As one member of the group put it, “we would see earlier and more accurately which children need protection and which parents are likely to succeed in treatment.”

The group reviewed the current practice in screening and assessment through the steps from the initial report to final disposition of a case. Four specific changes were suggested at different stages of this process that would improve the links between CWS and AOD systems:

1. the initial telephone screening could be improved to include AOD questions;
2. risk assessment tools could add AOD content, using adaptations of existing AOD screening and assessment tools;
3. both the initial assessment and ongoing monitoring of a family’s progress could use family functioning tools that look at the whole family as the client, with a service plan developed by workers functioning as a team from, both CWS and AOD agencies; and
4. treatment matching could do a much better job of assessing which kind of AOD treatment a parent would need.

A critical distinction made throughout is that screening would be done within the CPS system, while detailed assessment and treatment matching should tap what AOD systems know about treatment resources and modalities, rather than relying upon CPS workers acting alone to make the full range

of these assessments. Under emerging proposals for managing care in AOD contracting, screening and assessment are separated, with screening done within the CWS system as a first step to connecting across systems. The group felt that it takes an AOD expert to do an in-depth AOD assessment and set up the treatment plan for a client or family. However, there are risk assessment screening tools that should be added to the CPS risk assessments to determine if a client needs a more detailed AOD assessment and AOD treatment planning.

The Addiction Severity Index appears to offer the most concrete, widely used tool which could be adapted to the task of going beyond what is now included in risk assessment on AOD issues. Without such efforts to integrate tools from different fields and disciplines, a “layering” effect results in which each discipline or problem area demands its own assessment by its own workers, leading to layers of CPS risk assessment, TANF work readiness, the severity of substance abuse, the developmental stage of the child, and other issues— each treated separately and assessed categorically. This creates a burden on both workers and clients that makes the system much less likely to address problems in a unified manner. From the county perspective, the group discussed both the difficulty of achieving consensus about the best practices in risk assessment and the problem of how to deal with state requirements in the absence of such a consensus. As one member of the group stated, “if we don’t even agree among ourselves on common tools for AOD screening and assessment, how can we recommend what the state should do uniformly?”

But assessment is not treatment.

We assess clients and do no treatment. What are we doing to see needs and what are we doing afterwards? We act at times as if we do the SASSI and then we have solved the AOD issues. We need to cross the border between assessment and treatment.

CWS official

Participants also discussed the importance—and difficulty—of assessing clients’ motivations to comply with treatment. AOD officials noted that their providers have limited ability and willingness to work with mandated populations, saying “some providers do not want to touch it. We believe that

Assessment is also looking for strengths

Recent experience, both in the AOD field and in family support programs, documents the importance of using assessment as a way of identifying clients’ (and communities’) strengths, as well as their needs.

in order for people to get better they do need to say they have a drug problem— they must be willing to participate.” CWS staff responded that “We keep working with the individual in pre-treatment groups; usually they come around.” Again, it was emphasized that research suggests strongly that there are few differences between the outcomes for mandated or voluntary clients. The reality is that few AOD clients seek treatment voluntarily or “on

their own.” In fact, some people in recovery use the phrase “it was the nudge from the judge” as an informal explanation of why they sought treatment.

One member of the group noted that in recent pre-treatment sessions with CPS parents there appeared to be a new recognition that both the termination of parental rights and the impact of TANF meant the system was no longer “bluffing” when it demanded that clients comply with treatment or face serious consequences. This member felt that this change had helped some clients resolve to get serious about treatment. She added that having peer counselors involved in the process who could speak about their own experiences added further credibility which had proven very effective with CPS clients. Experience in other sites with recovering parents who worked as paraprofessionals in the AOD and CWS systems was also cited as a useful practice.

Another major topic in discussing assessment practices was the likelihood that better screening and assessment would simply lead to larger caseloads. While a consensus of the group seemed to feel that better decisions on removals of children would result, not necessarily more removals, there remained a concern that looking harder at AOD issues would increase the demand for levels of services that could not be funded. As one member put it “‘Don’t ask, don’t tell’ is a policy that protects the system from collapse.” The response, which the group agreed with but did not fully satisfy the concern about resources, was “You are going to get these kids anyway later and a lot more of them will be in need of intensive services.” Members also agreed that a broad range of prevention and early intervention services needed to be explicitly targeted on the children in the CWS system, since these are some of the highest risk clients of the AOD system.

The final topic discussed under daily practice was the importance of maintaining a front-line worker’s perspective in responding to all the reforms envisioned by the group. Members of the group urged paying attention to the realities of workers with caseloads far beyond recommended levels, as well as the burnout and turnover problems in some counties, especially those where CPS has come under public criticism after child deaths. At the same time, new mandates affecting AOD workers also create new externally-driven pressures on front-line workers. In both fields, the CWS-AOD reforms we are proposing ask both sets of front-line workers to make large changes in their daily practice in ways that challenge basic organizational culture, and the group felt that going beyond pro forma consultation to serious involvement of workers in these changes in practice was the only hope that workers would not view them as just another round of mandates without resources.

As examples of changes in daily practice affecting workers, participants cited the experience in some counties with assigning AOD case managers to Family Court (or Drug Court with a family caseload) to assess and coach parents who are entering treatment. In some cases these are county workers, in others they are employees of nonprofit providers.

Findings: Information Systems and Outcomes

Participants felt that improved information systems were a critical prerequisite for policy changes that addressed the overlapping populations across the two systems, since we still know less than we need to about the overlap. MIS improvements are also a prerequisite for results-based accountability reforms that would strengthen the CWS-AOD connections by focusing on the effectiveness of working across the two systems. Making investments in cross-systems tracking of clients was seen

as the best way to make better investments in treatment, in both the CWS and AOD systems. As one member of the group put it:

Accountability for spending is constrained because we do not know what works, so when a service gets more expensive we stop funding it, regardless of its cost offsetting effects. We could not respond today if legislators said let us fund the 80% most effective programs.

The group agreed that the real MIS issues are about shared target populations. Strategies are needed that link those clients to both systems, rather than referring the clients out of one caseload to the other.

Getting to outcomes within each system is hard. Getting to shared outcomes is much harder.
CWS official

Following state staff presentation of the outlines of the new CWS/MIS, both sets of county agencies reacted.

The response from AOD staff was mixed, with some participants feeling that while an increase in AOD-relevant information was possible, the new system would not produce as much added information as the cross-agency discussions have sought. Examples were concerns about the lack of information about services which were requested or ordered for which there were no resources and the fact that the new system does not really describe what the provider did, making it difficult to review client outcomes in different kinds of treatment. CWS members of the group asked if there was a place on the new forms to identify AOD-affected children. The response was that while AOD factors are noted *in those cases where AOD is recognized* to be significant, there would be no requirement to indicate in every case if there were an AOD problem or not. CWS staff asked if counties could add information if they were in compliance with the state system, and here the response was that a change process has been identified that might be able to add factors which counties agreed were needed. Counties are currently talking with the statewide change management board to decide on proposed changes. The most important of these may be incorporating the new risk assessment protocol and Infant Health Protection Proposal into the system, which it does not include at present, since the CWS/MIS system was developed parallel to new risk assessment proposals.

For ADP's information systems, the summary was that "information on children is not really collected in our system." Options for doing this which were discussed included adding an element, having it mandated by the legislature; or using a voluntary effort with each county deciding whether it wanted such data. Similar data gaps on children exist at the federal level, and conversations with the National Office of Drug Control Policy about revisions needed in the Treatment Episode Data System (TEDS) have thus far not been productive.

One member of the group said "the threshold question is fairly clear: shouldn't we collect data on the numbers of kids whose parents are in the AOD system?" It was pointed out that the AOD data collection draft currently being considered by ADP's managed care planning team would add child

numbers for the first time. The shift being considered to a different kind of intake, billing, and discharge system would accomplish this change. The new intake system includes the level of care that a client needs. The system is based on the American Society of Addiction Medicine (ASAM) criteria and is applied as the client comes into treatment. This may have direct effects on child welfare, which has tended to over-estimate the need for high-end residential care for all clients. If we only purchase residential services for people who really need it, then child welfare agencies must comply with the understanding that not everyone needs residential services and be willing to be more flexible in their service plans (and thus court orders) in seeking AOD treatment.

But what if the legislature says AOD agencies still do not know how many kids their clients have, so we are going to mandate that you put a box on your forms? If you can't make the change yourself it will be mandated."
Staff member

Findings: Budget and Finance

In reviewing finance options, the group developed a table with the major funding sources for both sets of agencies. Total spending in California in the two systems is nearly \$2.1 billion, with the CWS systems spending approximately \$1.7 billion annually, including federal, state, and local resources, and AOD totals reaching approximately \$450 million from all sources. On the AOD side, this total does not represent funds available for children and families, however, since the bulk of the AOD funds are currently allocated to other populations, in part based on federal earmarks and maintenance of effort requirements and in part based on the state's own priorities in allocating its general fund dollars. (These totals also include some prevention allocations on the AOD side.)

The group agreed that funding is a greater mystery than it needs to be in an era of information systems; no place in California has a current summary of the full range of funding streams for AOD services to CWS clients. A recent DADP inventory of every department in State government revealed that 32 different agencies offer some kind of AOD services. While the group reviewed the difficulties of determining the total inventory of funding available to counties, the consensus in the group was that it was impossible to hold counties accountable for coordinating their AOD efforts aimed at children and families if no inventory of these incoming funds is made available. Without such an inventory, uncoordinated efforts will continue and each set of agencies is likely to continue focusing its efforts primarily on its own funding, without recognizing the extensive funds already available in their counties from other sources.

The state AOD staff described in detail their approach to working with other state agencies to allocate AOD treatment funds through other agencies' budgets, as a means of insuring that the framework of treatment which DADP has built up over the years will be used and agencies would not feel they need to build up their own, duplicate system, which may purchase services from providers of lesser quality. Despite this overall policy goal, it appears that some counties are using their own funds (particularly for criminal justice clients) or Title IV funds to purchase some forms of AOD treatment in limited amounts, without any links to the county treatment agency or its standards for

providers of treatment. Concern was expressed that this “off-network” purchase of services could accelerate under TANF if counties do not feel they can link their purchase of AOD treatment services with ADP’s system and reporting framework. If, in contrast, counties operated as brokers of such services and tracked both the level and, over time, the effectiveness of spending by other agencies, a comprehensive picture of budget resources would be possible.

There was a consensus among a majority of the group that the state’s use of Medi-Cal (Social Security Act Title XIX) funds for drug and alcohol treatment in California was less effective than it might be and received less emphasis from both the state and counties proportionate to the size of the Medi-Cal-eligible population that could benefit from AOD treatment. Artificial legislative caps on AOD treatment for Medi-Cal clients, resulting from changes in Medi-Cal rates and eligibility for parenting women, created a powerful disincentive for AOD providers to serve women in the child welfare system. It was also noted that federal restrictions on the use of Medi-Cal funds beyond 60-days post-partum have been very limited, and that this further affected state allocations.

Budget allocations raise questions of federal earmarks and state and county willingness to set different priorities. The group discussed the tradeoff between federal discretion, as proposed under the Performance Partnership Grants, for states to set their own priorities for AOD treatment services, and new accountability for results that would accompany new discretion. Some members of the group were somewhat skeptical that either the state or the county would be able to resist two important forms of political pressure: (1) from providers for

continued allocations based on the current distribution patterns, without regard to either need or effectiveness, and (2) from elected officials for allocations to incarcerated populations. Others felt that the available data on needs and outcomes was becoming strong enough to insure that state and county decision-making would be more responsive to California’s needs than earmarks decided in Washington. The significance of this issue is that a higher priority for children and families would require changes in both state and county allocation levels that might be inconsistent with current earmarks. In response, the group discussed the possibility of the state’s seeking designation from the federal government for a special form of PPG that would emphasize services to children and families.

Can We Set Our Own Priorities?

Are we capable of and willing to set priorities at the county level or not? Providers are too strong now [for us to resist them] without enormous clout from state and feds. Can counties set true priorities if allowed to by the state and feds? Will they?

AOD official

There was also a brief discussion of “full cost accounting” as a way of adding up all the direct and indirect expenditures a state or county is forced to make in responding to the effects of alcohol and other drugs. This approach can help policymakers see where the off-setting costs are. It is a different way of thinking about budgets: “consequences budgets” as well as direct spending. It focuses not only on Medi-Cal coverage decisions, but on the number of people in Medi-Cal because of AOD. (San Diego County proposed such a budget analysis to its Board of Supervisors in mid-May 1997.) This kind of budgeting would lead policymakers to ask what funding do we get from AOD sources

and how does the total revenue created by taxes on licit drugs correlate with the total of what we need to spend. It addresses the revenue implications of budgeting, not just the expenditures side. Since this approach has become much more common in addressing the total costs of tobacco as a public health issue, some members of the group felt this principle—and the related principle that polluters should pay for the public costs of environmental pollution—should be stressed more in discussing AOD policy as it affects children and families.

We need to stop fighting over the same pots of money, and make our case that this problem is as legitimate an expenditure as building and staffing new prisons.
CWS official

Finally, the group agreed that even with a more effective budget inventory, better optimization of Medi-Cal, and blending of funds from both systems, it would require a net increase in the allocations for CWS clients with AOD problems to address the problem at scale, going beyond a pilot project approach to the problem. The county participants agreed that more funding than that requested in the IHPI was needed, whether through expanded line item appropriations in both systems for treatment services

targeted on overlapping clients or new line items that went beyond the IHPI in its coverage. A further suggestion was for more favorable matching requirements as an incentive to serve overlapping populations.

Findings: Training and Staff Development

In discussing current training in the two systems, the group reviewed current training across the two systems and credentialing and certification procedures in the two fields. In general it was agreed that workers in the two fields learned less than they needed to know about the other area. CPS workers who are entering typically have university training at B.A. levels, with a growing number with Master's-level degrees, but in both cases the only exposure they may have gotten to AOD issues would be in an elective—“AOD 101”—which is taken by a small minority of them. The AOD competency in social work curriculum is being reviewed by the statewide consortium which develops and monitors CWS training and in some of the ten social work schools in California.

In Sacramento and a few other counties a stronger emphasis is placed upon AOD issues as vital in-service training, with Sacramento currently requiring that workers begin AOD training after their first three months on the job. This training involves two levels of four-day training for a total of 52 hours. Statewide, workers are also given some in-service training on risk assessment training, which in many counties is based on the “Fresno model” of assessment; there is only a little AOD content in the Fresno materials, since only one line on the form used asks for AOD impact.

On the AOD side pre-service and in-service training vary more widely, with seven different bodies in the state that review and certify AOD training for different workers and providers. It was agreed that full compliance with AOD training requirements would almost entirely exclude impact on

children, as opposed to training in intervention on addicts and alcoholics, in the same way that CPS leaves out nearly all the AOD content. “We want to maintain our tradition that we treat the individual not the children” was how one AOD official stated it, adding that “clinically, the significance of the other person in the relationship is more relevant [than the child]...the AOD field’s goal is to get an adult into recovery.”

How trans-disciplinary can people be? How much can one person learn? We will have to have expertise in special areas. We can’t have a generic worker to do everything.
AOD official

The group set out its priorities for added training content that would enable both sets of workers to work across systems:

Desired CWS Training Content	Desired AOD Training Content
AOD dependency: use, abuse, and dependency	How the CPS system works
How to identify and intervene with AOD dependency	Trends in local CPS and out-of-home-care; safety issues and warning signs of abuse
Treatment modalities and effectiveness— what providers do and their capacity What local resources exist and how they differ	Local resources in the child welfare system: parenting education, shelters, foster homes
AOD as a family disease; the dynamics of AOD-abusing families; impact on parenting	AOD as a family disease; the dynamics of AOD-abusing families; impact on parenting
Confidentiality laws	Confidentiality laws
Matching level of functioning to levels of care	Resources available for family-oriented interventions and family support/aftercare
The special needs of women and fathers/significant others	Developmental impact of AOD use— both prenatal and environmental— on children
The language used in AOD and other systems	The language used in CWS and other systems
The “four clocks”-- different timetables in the other systems	The “four clocks”-- different timetables in the other systems

In reviewing these, AOD staff pointed out that they rarely get any mandate for fathers to be in treatment; CPS staff responded that in child death reviews, it is often the male in the house, not the mother, who is most involved in abuse. Both sides agreed that “the vast majority of women go back out and get involved with the man again,” arguing for a wider orientation to treating the family or de facto family.

In summarizing the group’s views on the need for training, several additional points were made:

- We need to train people for our vision of the new system, realistically presented, not just let them to adapt to today's status quo.
- We are seeking links between a generic child welfare worker with direct ties to and knowledge of AOD issues and an AOD worker who understands CPS, so that an AOD counselor and child welfare worker can work together, not so that one worker can do both jobs.
- Administrator and mid-level supervisor training is also needed, since some front-line workers are much readier to make these changes in the interests of better outcomes for their clients, while some supervisors protect traditional ways of doing things.
- Training only CPS and AOD workers will miss the other workers in other systems that need to know more about how these two systems can work with each other.
- Training needs to actively involve both AOD providers and CPS clients with AOD history. Academically-based training needs to recognize that front-line workers and clients should have equal standing, not second-class roles.

Findings: Alternative Service Delivery

The discussion of alternative service delivery options was based on an assumption that trends in CWS and AOD include major shifts toward managed care, privatization, and community-based reforms in both systems in ways that promise to alter the delivery system significantly. This assumption leads to a conviction, as noted in discussing training, that if we train workers in the two systems to work more effectively *in today's system*, they will still be unprepared to function well in the system toward which we are heading. The openness in the TANF/welfare reform legislation toward for-profit operation of portions of the system (and the fact that some counties already contract out substantial portions of their welfare system) was felt by some to be a harbinger of changes likely to come to both CWS and AOD services.

In both CWS and AOD services, managed care changes are proceeding at a pace that members of the group felt needed to be taken into account. These changes are being driven in part by a concern for behavioral health outcomes, which some participants felt was over-emphasizing fiscal outcomes instead of client outcomes. One concern is that managed care may make it harder to cooperate with both systems. Others in the group pointed out that managed care approaches may build better links between CWS and AOD *because* it seeks the most outcome-effective combinations of agencies under results based accountability. In this view, privatization and managed care may be beneficial for bridging if they produce results in terms of client outcomes, not just saving money. The new "Golden Rule," it was suggested, may come to be whoever gets the results gets the gold.

But what this trend demands, the group pointed out, is that we look at short-term cost efficiency and at long-term client results, making sure that we listen to client feed-back. This will also demand developing thorough "scorecards" on managed care reforms that emphasize what happens to clients, including both those that use the services and those dropped by managed care firms. It was felt that few counties have yet developed such scorecards for monitoring managed care changes in their communities. When a state or county shifts its service to private or managed care providers, its service delivery role changes, but its regulatory and monitoring role may become much more

important. One county discussed its pending review of \$7 million in contracts to local providers for a range of CWS services, and their efforts to develop more outcomes-driven monitoring of the effectiveness of these contracts.

The second major service delivery change already under active discussion and/or implementation in most counties 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 that are not yet in the CPS system but appear to have problems that may become worse. Encouraged by Family Preservation/Family Support funding made available to the state two years ago, these efforts have been highly visible in Los Angeles and other sites. The trend has been given further support through state Healthy Start (SB620) funding for school-linked services that has included out-stationed CPS workers in dozens of schools and strengthened the trend toward generic family resource centers. As neighborhoods become more adept at developing community asset mapping, including some preliminary inventories of all the public resources coming into their neighborhoods, the demand for a wider role in service delivery reform has followed.

Some members of the group argued that “it takes a partner to go out and engage with the family,” and that a wider array of agencies working with the families not in the CPS system are providing family support. In this view, these services should be triggered by prior reports that are not yet serious enough to open a CPS case but definitely have AOD involvement. This would provide a midrange response that neither ignores the case as “unsubstantiated” nor moves to file a petition. How community partnerships, with links to the CWS system, would develop their ties to AOD systems is a topic the group felt should be addressed in more depth in further discussions between the two systems.

A final comment made in discussing alternative delivery systems is worth repeating: “We need to be clear first on the basic principles of the system, then decide about the modalities.” Other members of the group also pointed out that the underlying values of policymakers and the general public will drive the move toward new delivery systems, if such a move takes place at scale, in the same way that reliance on prisons as a larger part of the response to crime has been driven by underlying values. That leads to the next section, in which we return to the issues of underlying values.

Summary of Major Recommendations

The primary recommendations on which the group achieved the greatest consensus are grouped under the five cross-cutting topics, with the elements of an early action agenda highlighted in bold. The group emphasized that some of these recommendations are prerequisites to others, such as changes in risk assessment, upgraded information systems, and a commitment to move more actively toward results-based accountability.

Daily Practice

1. Risk assessment tools that combine CPS and AOD perspectives must be developed; **a special opportunity exists to build on the current efforts within DSS (and in Los Angeles County)**

to design new risk assessment tools and to add AOD assessment to the tools being developed. AOD agencies need to be formal, equal partners in these discussions, which they do not appear to be at present. As noted above, some members of the group argued that this recommendation had the greatest urgency.

2. Counties, acting through their CWS and AOD agencies, need to determine whether working toward common risk assessment procedures is a priority for these two agencies in their discussions with the state.
3. Front-line workers need to be actively involved in discussing and designing any major changes in daily practice that affect intake and caseloads. The changes in practice required to take “the four clocks” into account more fully, the changes in training discussed below, the need for closer links between CWS and AOD staffs, and the prospect of a service plan that is jointly developed by CWS and AOD staffs and submitted to the court as a joint plan— all these are variations from current practice that would have a major impact on front-line staff of both sets of agencies.

Information Systems, Evaluation, and Outcomes

Many participants mentioned the need for a new and more serious investment in the information infrastructure needed to track clients and treatment outcomes.

4. **The implementation of a new statewide CWS information system is an opportunity to assess the depth of this system’s capacity to provide continuing feedback on AOD issues and to add features as part of the amendment process, since AOD information may not currently be adequate.**
5. **Pending revisions of AOD reporting systems in counties and at the statewide level both present an opportunity to add data about AOD-affected children to information systems.** This is the “missing box” issue— the absence on most AOD intake forms and aggregate data of information about family status and presence of children and a variety of other data that could provide a more complete profile of the families and children being served.
6. Continuing efforts should be made to revise federal data collection for AOD agencies to add information on children and families.

Budget and Finance

7. **An ongoing inventory of funding, with an explanatory glossary, should be developed as an overview of funding sources to be updated annually.** The Executive branch could help by updating its allocations to counties and compiling an inventory of direct funding as well. Sample surveys of providers would fill out the picture of funding sources. In addition, this review should

include the full costs of AOD problems across all state and local agencies, not just CWS and AOD, and compare total alcohol-specific costs to total revenues from alcohol.

The state should be responsible for the best possible summary of funding to counties, while counties should begin geo-coding their own allocations to get a summary of where funds are distributed.

8. **In California, the discussions resulting from the introduction of the Infant Health Protection Initiative (AB 1373) offer a genuine potential to reach a fiscal blend of resources in response to CWS concerns about children born prenatally exposed and the broader issues raised by the larger number of children affected by AOD. It would explicitly identify shared funding from two sources, rather than relying upon CWS-AOD connections to be funded by one “side” alone.**
9. At the federal level, the recent Chaffee-Rockefeller proposals for new legislation that would tap CWS funding for treatment and training that could span the gap between CWS and AOD agencies should be supported by state and local officials from both sets of agencies as a further bridge-building opportunity, with substantial resources potentially available, in this case from Title IV sources previously reserved for CWS funding only. Some estimates have suggested that this change could open as much as \$1.5 billion for use to fund AOD treatment services. While realistic timelines should be observed in building this data base for the first time, the group’s consensus was that this legislation represented a definite step forward. The group urged both sets of statewide organizations and their state counterparts to back this legislation.
10. At the national level, the proposals for Performance Partnership Grants provide an opportunity for California to seek designation as a pilot site for a PPG approach that focuses upon impact of results-based funding on children and families. (There was, however, some skepticism that federal flexibility would be adequate to assure a focus on children and families and that the state of the art in outcomes data was ready for such performance grants.)
11. California has a model piece of legislation (AB 1741 Youth Pilot Projects) applying to youth programs in six counties which allows those counties to blend funds from state sources in support of an outcomes-driven local plan. **The group suggested that this legislative tool could be applied to AOD-CWS links where state funding (and eventually federal funding) would be combined in comprehensive services packages funded from multiple sources. Blended waiver authority could be justified by showing that this would help counties stitch different funding sources together at the local level.**
12. The state and counties should jointly review Medicaid drug benefits and reimbursement rates coverage for AOD treatment to determine whether (a) cost-effective approaches are being fully utilized in California for high-risk families in which Medi-Cal “savings” are being offset by higher spending in other agencies’ programs for children and families with multiple needs and (b) whether the state is taking full advantage of federal reimbursements for treatment .

13. Both sets of agencies should strengthen their efforts to require and to build local capacity for results-based funding. The recent contracts from DSS to a statewide network of family resource agencies may be an opportunity for such capacity-building for a client group including some parents who are at the front end of the AOD treatment system. At the same time, a greater focus upon impact and effectiveness of ADP-funded services on children and families would strengthen results-based accountability in AOD allocations; the pending discussions about [managed care??] in DADP are a context for such a move to strengthen accountability for results at the provider level.
14. In the longer-run, expanded allocations for treatment services for overlapping clients must be considered as a means of going beyond pilot project-level funding.

Training and Staff Development

15. **Comprehensive training initiatives such as Sacramento County’s Alcohol and Other Drugs Training Initiative should be replicated and disseminated to all training organizations in both child welfare and AOD education.**

The Content of Training

A portion of the discussion on training focused on the most important content areas that needed to be covered. The primary topics which participants felt needed to be covered were

- the difference between use, abuse, and dependency
 - the differences among substances used, including symptoms and effects
 - a review of the different modalities of treatment
 - “hands-on” specifics about how to serve the whole family in a way that emphasized their strengths.
16. University and in-service curricula currently supported by Title IVE and other funding for training should be reviewed for AOD content and revised to incorporate detailed treatment along the lines of the Sacramento AODTI training. University and other training institutions working with AOD staff should add CWS content and infuse information on the family effects of AOD dependency throughout their curricula.
17. A special effort needs to be made to focus training on courts and judges, since their role is so crucial in directing and monitoring parents’ progress in treatment and their willingness to raise issues of programs’ effectiveness—both for parent education and AOD treatment— has been so limited, despite the thousands of referrals made to such programs.

Alternative Service Delivery

18. Special efforts should be made to select prototype community organizations and multiservice centers which could be provided with training and technical assistance as a formal capacity-building effort, to insure that CWS-AOD ties are built at the community level, as well as in centralized agencies, and that the community support agenda is not imposed before adequate improvement of community groups’ readiness and willingness to implement this new role.

The Significance of the Infant Health Protection Initiative

The group spent considerable time discussing the Infant Health Protection Initiative, introduced as AB 1373 in February 1997, since the group felt that this initiative raises important issues about the long-term relationships between CWS and AOD systems. On the one hand, members pointed out that the children affected by the proposal were a small percentage of the total number of children affected by AOD problems, and some argued that inadequate resources were being devoted to even this small portion. On the other hand, members of the group pointed out that the IHPI would forge much stronger ties than now exist between the two sets of agencies that are the focus of this policy review, and might provide models of such cooperation that could benefit a much larger group of children and families than those included under the IHPI. Some members of the group felt that the strong emphasis on AOD treatment was a major step forward, given that the impetus for the reform was from the CPS side and the AOD dimension is rarely included as a co-equal partner in CPS reforms.

The IHPI definitely focuses on a small proportion of the total number of children affected by AOD issues. If one accepts the state's estimates of 69,000 children born annually with positive drug screens, combined with an estimate of \$2000 for the average drug treatment episode, the cost of responding *only to the AOD treatment portion*

of the problem which the state has identified as its highest priority in CWS-AOD issues would be \$138,000,000 (a total of \$35 million has been requested for funding the five county pilots). What this omits, of course, are all the births where children are living in families with AOD problems just as serious, but where the mother did not use a detectable drug 48 hours prior to birth. It also ignores the possibility that the birth in which AOD use was detected was not a first birth to that parent, with the near-certainty that older siblings have been AOD-exposed, at least environmentally, if not prenatally.

We are thrilled to see the tripling of funding— but it is still not enough....This is a fabulous idea that is under-funded.
County CWS official commenting on the IHPI

The IHPI would force all hospitals to report— today's it's only the public ones that do, and we're missing a lot of kids and moms who need help.
CWS official

In discussing the IHPI, the participants commented that it raised a number of larger questions:

- The issue of whether Medi-Cal funds would be used to increase the funding available for treatment;
- The benefit of the strong message requiring private as well as public hospitals to use the 2669 protocol for assessing infants and mothers;
- How credible the assessment procedure would be as a basis for reporting children by creating a new sub-section of the 300 section of the Welfare and Institutions Code

providing an additional basis for reporting, not removing, children born with a positive tox screen;

- The unquestioned value of expanding home visiting for parents in response to a positive tox screen, explicitly based on the extensive Hawaii model of home visiting.

Some members felt that the IHPI should be broadened considerably to a multi-county pilot project that would be conditioned on choosing counties where the CWS and AOD systems are working together effectively and develop an RFP that embodies our discussions about what good CWS-AOD practice should be.

The Significance of Welfare Reform

Throughout this document, there have been references to the importance of welfare reform. The members of the group felt that the issue of CWS-AOD links could be given greater emphasis by the greater visibility of the need of many TANF clients for AOD treatment services (a subject already debated at considerable length in the legislative hearings on welfare reform), but could also, in some ways, become an arena of competition for resources between TANF and CWS systems. Members stressed the importance of *knowing the extent of overlap between TANF clients and CPS clients* as a means of dealing with the potential competitiveness of the two systems in their efforts to secure treatment services. In some counties the overlap is extensive, with as many as 90% or more of CPS parents in the (former) AFDC system. A statewide data set on CWS clients currently being reviewed by University of California researchers was mentioned by one member of the group as a potential resource for clarifying this issue.

AN OVERVIEW OF THE NEW SYSTEM

The group called upon the staff to draft a statement of a new system at the intersection of both CWS and AOD. In its discussions, sites were mentioned where elements of that system were coming into being, or being planned and written about in clear terms. These included the Community Partnerships programs in Louisville, Iowa, St. Louis, and Jacksonville being supported by the Clark Foundation and the Center for the Study of Social Policy, home visiting programs as implemented in Hawaii, CWS-AOD practice models under development in Cuyahoga County, New Mexico, and Washington State, Sacramento County's AOD Training Initiative, the efforts in both Los Angeles and New York City to build a strong new role for neighborhood organizations, and efforts under ways in a number of states, including California, to strengthen ties between the single state agency for substance abuse and the CWS agency.

What Would A New System Look Like?

A newly linked CWS-AOD system would operate differently at the level of front-line workers, client contacts with both children and families, assessment of risk, referrals for services, accountability for results based on outcomes-driven information systems, training for its workers, and the role of the community in support of families at the "front end" of CPS services but not yet in the formal system.

The new system would be capable of assessing and providing a differentiated response to children and families, responding to more sensitive and detailed assessment of both family and substance abuse issues.

In the words of the earlier background paper,

A new partnership between CPS and AOD needs to be comprehensive, negotiated among equals, carefully staged in its development, and driven by results-based accountability.

Above all the new system would have new partners, primarily at the community level, who could accept a responsibility for those families who are not seriously enough engaged with CPS to merit formal investigations, but who undeniably need help. As one of the members put it, the reality test for the concept of community partnerships was that “somebody else would step up to the microphone” when a public explanation of child safety issues was needed, rather than the media solely holding the CPS system accountable.

“It’s Not Just CWS-AOD”

One of the participants made a repeated point: even with the best possible links between CWS and AOD agencies, what these children and families need is an integrated system of services and supports that goes well beyond CWS and AOD. A commitment to genuine services integration, this official argued, was needed instead of merely bilateral links between CWS and AOD that would still omit many of the resources needed by families in the two systems

The new system would also include more than a two-way bridge between CWS and AOD agencies, since for many of its clients more than these services and supports are needed. Community-based aftercare, family support, mental health, job training, literacy training— these are some of the many services and supports which go beyond CWS and AOD services that are needed by families in the CWS system. As one participant in an earlier session put it, “AOD treatment is not a stand-alone service.”

The new system would also address the realities of the four clocks head on; one county official stated this challenge this way:

Look at ways to adapt your system to the reality of the timetables: we can create sheltered workshops to stop the clock, we can put clients in work programs. Do not get so bounded by the categories of current programs that the timetables run our agencies.

TAKING THE FIRST STEPS

With these general principles, these are some suggested first steps that CWS and AOD agencies could take to begin forging a new relationship [the table at Appendix A summarizes recommendations for action and responsible parties]:

1. **First, identify the overlap and the need for AOD services:** The two agencies should pool the information they both have about clients who are already in each others' systems, or who need services from the other system. This can be done in some cases by a review of a small sample of child welfare cases through initial screening tools such as the SASSI, by reviewing information from case files which is not captured in data systems, or by a more rigorous use of a tool such as the ASI which could be administered for a sample (the original designers of the ASI are completing analysis of five states' welfare caseloads to assess the need for AOD treatment, and this same methodology could be used for a sample of the CPS caseload). From the other side, AOD caseloads should be reviewed and data matched against CWS caseloads, with samples of AOD treatment files reviewed for numbers of children. Confidentiality issues should be carefully observed, but it should be emphasized that what is needed most is data about the *aggregate number of cases which overlap*, not specific names.
2. **Based on this information about overlap, review current referrals to AOD treatment:** Here the information needed is which treatment agencies are used when a service plan for reunification calls for AOD services, and what results do the agencies keep on CPS clients, even if the CPS system itself does not monitor treatment progress.
3. **Change education and training for CWS workers on AOD issues— and for AOD workers on CWS issues:** How much do workers now receive in orientation to the differences between use, abuse, and dependency? How much do workers want to know that is not included in current training? What are the resources in the community— treatment agencies, universities, other non-profits—that could help improve training?
4. **Identify the highest priority overlapping clients**, i.e., those that both systems would agree should receive resources from both systems to test the effectiveness of new targeting efforts aimed at this group. This strategy adopts a pilot project approach, rather than trying to build strong links across the entire caseloads of CWS and AOD agencies, but it may be easier to justify as a first step and much less threatening to officials at the top of the two systems since the total budget impact would be smaller.
5. **Negotiate outcomes measures that both sets of agencies would agree to be appropriate measures of the effectiveness of initial collaboration.** Invest resources, through grant sources or internal redirection, to upgrade information systems to support these outcomes.
6. **Establish interagency monitoring bodies with oversight responsibility for insuring that these changes are carried out.** Without ongoing monitoring by a body made up with equal representation from both AOD and CWS systems, a flurry of interagency meetings may lead to little long-term effort and nothing that is institutionalized. An interagency group organized with the responsibility of monitoring progress toward a work plan developed by both CWS and AOD staffs offers a much more concrete hope for implementing a change process.
7. **Statewide associations of both groups should meet to continue these discussions in a structured way.** CWDA and CADPAAC should have overlapping meetings, with joint sessions

among CWS and AOD officials from all 58 counties, at which the recommendations of this report (as modified by the county and state participants in this process) should be reviewed. This review process would produce a package of legislative and administrative follow-up agenda items on CWS-AOD issues over the next three years, at which point progress should be reviewed in depth. The IHPI provides an arena for addressing some of these issues, but for a narrowly prescribed, high-priority group of children. (With its new staff assigned to work on integrated services issues, CSAC should also be invited to play a part in CWS-AOD discussions.)

AN APPROACH TO GRANT STRATEGIES FOR FOUNDATIONS AND OTHER FUNDERS

A part of the original charge to the group from the Stuart Foundation was to think about possible funding strategies for foundations and other funders. The group discussed these issues briefly, and the following suggestions have been derived from this discussion:

1. Funders should make “bridge grants” that require equal participation by both CWS and AOD agencies (working through their statewide associations as described above) in innovative projects, as a means of building experience between the two sets of agencies in working with each other. These grants might be organized to support development or refinement of specific improvements in each of the five areas of reform discussed in this project : daily practice, information systems and outcomes, budget, training, and alternative service delivery approaches. These grants might utilize the following criteria:
 - a. The two systems (or their neighborhood counterparts) have to apply for funding jointly.
 - b. Each system has to use redirected funds from its own budget or base sources of funding to supplement/match the grant funding.
 - c. Projects must be based on an initial baseline assessment of overlap (however preliminary) so that the grantees share a common definition of the problem.
 - d. The courts involved should endorse the proposal.
 - e. Community groups need to endorse the proposal and have roles as active partners, with specific in-kind matching of volunteer time and community organizations’ staffing.
2. Funders should be clearer in requiring or encouraging results-based accountability in their RFPs in the areas of child welfare services and AOD treatment programs, as a means of assuring that outcomes affecting children and families are explicit in the responses.
3. Funders should support joint public-private grant-making as a means of multiplying the funds available for these innovative projects and providing wider incentives for public sector agencies to innovate across CWS and AOD boundaries. Staffing state interagency efforts of the kind that led to the IHPI could also be supported with joint public and private funding.
4. Funders should assure that adequate resources are available for grantees in the area of CWS-AOD innovations to have the opportunity to meet periodically and consult with each other as a form

of “horizontal technical assistance” among peers, enabling grantees to contribute to a continuously updated base of information.

5. Funders could provide capacity-building support for community-level partnerships between CWS-AOD agencies that sought new roles for community organizations and helping networks and gave such organizations that lead time they would need to prepare to play such roles and to secure the resources they would need to do so effectively. This could build upon the role of the Clark Foundation in its Community Partnerships project supported through the Center for the Study of Social Policy in Washington.
6. Funders should also avoid creating any new incentives for the two systems to work separately, either by funding CWS or AOD reforms separately without consideration of impact on the other set of agencies or by funding parallel initiatives (e.g. in welfare reform or public health) that largely ignore CWS and AOD issues while addressing the needs of this same population under different labels. In carrying out other reform projects, funders could request information from grantees about CWS-AOD overlap with these initiatives, and may want to consider adding a CWS-AOD component to them. Simplest of all, funders could ask a single question of all of their CWS grantees: do your programs document whether AOD problems affect children and families and how do your programs respond to these issues?

CONCLUSION

In its work over the six month period, the group addressed many issues, and this summary does not treat all of them in the full depth that was possible as they were discussed. An important shift appeared to take place as the group met; participants, who appeared daunted by the size of the problem when the sessions began in December 1996, felt that in mid-1997 these findings and recommendations reflect the strong potential that exists to capitalize on the special opportunities now available in California. We concluded that there is the will, the leadership, and a significant portion of the resources needed to forge much stronger and more effective links between the two systems, in the interests of both family stability and child safety.

The role of leadership should be emphasized. Both at the county level and at the state level, it will require policy leaders who work at levels above both CWS and AOD systems to give clear, unmistakable emphasis to the message that child welfare and AOD treatment services belong at the same table—that where clients overlap, agencies must overlap. At the state level, the Infant Health Protection Initiative provided an excellent opportunity for the two sets of agencies to work together; yet within recent weeks, state inter-agency meetings on the Chaffee-Rockefeller legislation have been called without even inviting DADP officials to the meetings. So leadership across and above the two systems is crucial.

Reconciling the goals and underlying values of the two systems will require sustained dialogue, skilled community-level facilitators, and, it seems likely, thick-skinned public officials. Not all of these are in ready supply. But the communities that have or seek such resources may be those that achieve the

greatest improvements in outcomes, compared with those in which the debate remains polarized and the programs remain categorical, narrow, and ineffective. If communities truly seek a results orientation to the needs of children and families, with the state's help, the pieces can be put together.

APPENDIX 1: MAJOR FINDINGS AND CORRESPONDING RECOMMENDATIONS:

Findings	Recommendations		
	State Action	Local Action	Action by Others
<u>Values:</u> Philosophical differences between the two systems act as barriers to serving families in the CWS system with AOD problems	Building upon the IHPI proposal, articulate a clear policy to work across CWS and AOD systems for the entire group of children and families affected.	Associations of county groups for CWS and AOD should meet regularly to address these issues and monitor progress	Funders should support such exchanges across CWS-AOD boundaries and staff monitoring efforts to build stronger ties
<u>Values:</u> Decisions are needed on the basic issue of the priority to be given to children and families with AOD problems in the CWS system	Progress made in developing the IHPI should form the base for expanded links between DSS and DADP on CWS-AOD issues. Health and Welfare Agency-level support is needed for other CWS-AOD initiatives at scale	Set clear priorities for CWS-AOD clients within the county budget process, reflecting the numbers of such clients in the county population and their costs	Funders and advocates should clarify the priority needed for CWS-AOD linkages and end categorical approaches that treat the two issues on separate tracks
<u>Practice:</u> Current CPS screening and assessment tools do not adequately focus on AOD problems, especially as they affect children. AOD assessment does not adequately address family functioning or child safety	Pending discussions in DSS should add AOD assessment issues to any revised risk assessment instrument that may be developed; consider blending ASI into new RA tool. AOD practice needs to develop and provide prevention services targeted on children in the CWS system.	Counties must assure that balanced teams of both CWS and AOD front-line staff are involved in their efforts to revise and implement risk assessment protocols. [See training recommendations]	Worker organizations should provide worker-level feedback on the reality of using new assessment tools.
<u>Practice:</u> The "four clocks" problem prevents CWS and AOD agencies from monitoring and supporting families' progress in a uniform way	Seek closer links between TANF and CWS implementation, and explore legislative and policy changes that may be need in timing for TANF and CPS based on family status and AOD impact	Consult with AOD staff on how to take recovery timetables into account more fully in monitoring progress. Track children and families' progress against all four clocks in the case plan. Assure that teams of CWS and AOD staff can carry out this practice [see training recommendations]	Federal policy should make the "four clocks" explicit in discussion of pending federal changes to reunification.

<u>Information Systems</u> : The new CWS system will provide some new data on services, including AOD treatment, to which CWS clients are referred, but lacks assessment data	Monitor the new CWS system as it comes on line and test its utility to AOD agencies; propose revisions as needed; refine system capacity to match clients across systems	Monitor the new CWS system as it comes on line and test its utility to AOD agencies; propose revisions as needed; refine system capacity to match clients across systems	Pending analysis of statewide CWS data by university research teams should include AOD issues
<u>Information Systems</u> : Existing AOD agencies' reporting and the state system's requirements do not account for children in the caseloads of AOD agencies ("the missing box")	"Add the box": revise state information system requirements to count children and assess families in AOD treatment caseloads	"Add the box": revise state information system requirements to count children and assess families in AOD treatment caseloads	Federal: revise TEDS to track children in more detail
<u>Information Systems</u> : Neither system monitors outcomes in a consistent way to shift resources for least to most effective programs	Based on improved MIS, use data to capture and track cross-system outcomes	Based on improved MIS, use data to capture and track cross-system outcomes	Federal and private: support results-based accountability efforts
<u>Budget</u> : Neither CWS nor AOD agencies have a useful understanding of the resources and constraints in the other systems	Both state agencies should provide annual totals of allocations from all CWS and AOD sources to local agencies	Local inventories of CWS and AOD resources should be updated annually, including CWS purchases of AOD services	Federal funding sources should annually break out all CWS and AOD allocations made by geographic areas
<u>Budget</u> : Categorical funding makes it difficult to blend funds across the boundaries of CWS and AOD systems	Examine the feasibility of using AB 1741-type authority to combine funds for CWS-AOD linkages	Develop blended funds options using all available flexibility	Health advocates and private funders should assess the impact of current drug Medi-Cal policies on children and families
<u>Budget</u> : California's use of Medi-Cal funds for AOD treatment does not serve the highest-risk Medi-Cal eligible CWS clients	In the long term, the state must go beyond TANF allocations to provide effective AOD treatment for TANF and CWS clients		
<u>Budget</u> : Federal proposals for Performance Partnership Grants offer an opportunity for a child- and family-oriented block grant	Seek pilot funding for outcomes-driven PPG for children and families		Federal: allow variations on PPG model with special impact on children and families

<u>Training</u> : Court staff and judges have little familiarity with treatment effectiveness and addiction issues			Use judges and legal officials as trainers for blended CWS-AOD training
<u>Training</u> : The Sacramento AOD Training Initiative has been effective in orienting a large number of county and community-based staff to AOD issues and should be replicated	[See table in text on content of proposed cross-training for CWS and AOD staffs]	[See table in text on content of proposed cross-training for CWS and AOD staffs]	Universities should review the Sacramento curriculum and other models for use in redesigning IVE training
<u>Alternative Delivery Systems</u> : Privatization is proceeding without clear standards for both fiscal and client outcomes		Clarify standards by which local managed care firms will be assessed, including CWS-AOD links	
<u>Alternative Delivery Systems</u> : Managed care firms providing AOD services may not have the tools or desire to link with CWS agencies		Localized approaches to managed care for AOD treatment should build in CWS linkages	
<u>Alternative Delivery Systems</u> : Community partnerships are being designed without full consideration of impact on AOD services	Build in AOD services and agencies from the first in redesigning CWS systems for wider community support and partnerships	Design new county- and community-level child welfare reform projects with CPS-AOD links built in from the first	Funders should support stronger links between CBOs and CPS-AOD services in community partnership models

APPENDIX 2: WHAT ARE THE ATTRIBUTES OF A COMMUNITY PARTNERSHIP THAT TAKES AOD ISSUES SERIOUSLY? ⁷

In developing recommendations for a reform of child welfare services that would move in the direction of community partnerships designed to expand community organizations' support for the CPS mission now performed largely by CWS agencies acting alone, the question arises as to what steps would constitute a serious approach to AOD issues by such a community partnership. The most important of these steps would include:

Preparation for a New Role/Readiness

1. Estimates of the percentage of the CWS caseload requiring AOD treatment services, based on review of a sample of the population, data matching, or case file review
2. Identification of available AOD treatment resources and any useful information on the capacity and effectiveness of such programs
3. Identification of natural helping networks and other community assets through a community asset mapping approach, which needs to include an environmental scan of the immediate neighborhood, to determine how that community's climate toward AOD use and abuse affects individuals and the entire community
4. Beginning efforts to improve information systems to provide data on both #1 and #2 on a regular basis
5. Training efforts for both CWS staff and community organizations' staff that would incorporate AOD concepts, especially (a) the distinction among use, abuse, and dependency, (b) skills in assessing and referring clients to appropriate levels of care and modalities of treatment, (c) multi-cultural competencies in responding to different cultures' views of family strengths, and (d) awareness of environmental influences on children and families.

Development of a Consensus on Values and Priorities

6. In view of #1-5, frame and discuss the values choices which the CWS-AOD-Community Partnership collaborative would need to make on:
 - a. a philosophy of services toward parents with AOD problems and community norms, along a continuum from zero tolerance to a policy emphasizing family stability and harm reduction;

⁷“Community partnerships” is a term with very different meanings in the two systems. In the CWS system, this term has been used in the past few years to refer to neighborhood- and community-based activities aimed at deeper involvement of community organizations and natural helping networks in the mission of the child welfare system, especially its “front end.” In the AOD field, however, community partnerships refers to more than a decade of federal and local investments in community coalitions organized around AOD prevention issues, with an emphasis upon master planning and community mobilization. Some community partnerships in the AOD field have sought to involve CWS agencies in their efforts as part of a broad community coalition to address substance abuse.

- b. a philosophy of services toward children and parents in the CPS system which balances family preservation and child safety.
- 7. Agreement on the appropriate measures and indicators of progress for clients in the two systems, including selection of 5-10 indicators of community-wide progress and program effectiveness

Changes in Services and Front-line Practice

- 8. Use of a risk assessment approach that combines child safety, family functioning, and the risk of substance abuse and enabled the partnership to make a differential response to families in different stages of need and readiness for services.
- 9. Expanded outreach to parents through both informal and formal organizations, as a means of providing family support to parents at an early stage of family problems
- 10. Use of self-help, peer support, respite care, aftercare, and mentoring approaches through natural helping networks in the community, in concert with environmental strategies that create a broader constituency for change in the community conditions that affect AOD problems.

“Reality Tests” of a Community Partnership in Addressing AOD Problems

- 1. Substantial numbers of new people from the community would be spending measurable time working with families and viewing themselves as part of the community’s family support system;
- 2. A consensus on values would be achieved across agencies and community organizations that addresses family preservation, parents’ responsibilities in dealing with their addiction as it affects their children, and community responsibilities for setting and defending norms regarding AOD use and abuse;
- 3. New allocations of staff would be presumed to be assigned primarily to community-based sites, rather than central offices;
- 4. Community leaders would join local CPS officials at a press conference to explain an incident of child maltreatment.

APPENDIX 3: PARTICIPANTS

[import from mailing list]

A Dialogue among the County Administrator, the AOD Director, and the Child Welfare Director

For two weeks the local media had been criticizing the county government in the wake of the second death in four months of a child in the county's protective services caseload. Two weeks ago, a child who had been returned to her family after reunification services had been provided had been found beaten to death in a filthy home with obvious signs of drug abuse. Citizen groups had been clamoring for removal of the CWS leaders "from top to bottom," as one activist had put it in an interview in yesterday's newspaper.

"We have to quit meeting like this," said the County Administrator with a wry look on her face. "I'm not trying to be funny," she added, "I know you hate these aftermaths as much as I do. How can we keep this from happening again?"

The CWS director spoke up first: "The two of us and our staffs have been meeting together, as you know, in an interagency working group for the past several months. We think we're about ready to be able to present you and the Board with options for some big changes."

The AOD director joined in. "We recognize now that we're going to have to work together much more closely on these families that need help from both our agencies. The numbers we've got suggest that more than two-thirds of the families entering the CPS system have serious substance abuse problems— just like the tragic case that brought us here. My agency has never seen these kids as our problem in the past— but we've finally realized that if we hold to that position, CWS is going to have to set up its own parallel treatment system. That would completely undercut our efforts to build a solid system of effective providers who are accountable for results. And the welfare reform task force just recommended an expansion of its own AOD services, so that helped us see what was going to happen."

"I'm glad you're finally getting it together," said the CAO. "But how are we going to know which of your services work to keep these families out of trouble?"

The CWS director responded, "Right now we're spending \$5 million a year on services in support of the CWS mission. We're doing what we can in both our agencies to get a handle on which services are effective, but the courts just keep assigning people to parent education and drug treatment without any sense of what works. They've never even asked us which programs are most effective. The good news is that we're finally beginning to know, because we've been monitoring their results for the past two years, not just how many clients they see."

The AOD director warned, "You know, you're going to get some flak if you shut down some of these programs. They have been funded for years, and have built up pretty strong constituencies with the local boards and city councils."

The CAO answered, “If you’ve finally got some standards that we can measure these groups against— and they’re fair ones— I’ll give the Board strong recommendations to move the money from the worst ones to the best ones. But both of you have to be willing to tell me which is which. Make sure that the Judge stays involved,” she added. “If she isn’t part of this, it just isn’t going to happen. Be sure to keep her and the other court people informed of everything you’re doing.”

The CWS director added, “The best of these agencies are a great potential asset for us. We’ve been trying to do the job all by ourselves, and at the same time there are thirty-five neighborhood-based groups in the county that work with kids and families— many of them funded by us. We’ve got some of the best community organizations and neighborhood-based programs in the state. What we want to try to do now is to get them to work together more than they have been . We want them to help us with the families we know have problems but are not yet serious enough to file formal charges. That way we can pay more attention to the most serious families, instead of having this rotten choice between taking kids away or letting the family disappear because we can’t document the charges against them.”

“That makes sense,” said the CAO. “It gives you a middle range response— sort of like community policing, where we don’t ignore the problem but we don’t automatically lock everybody up, either. We get in and work with the neighborhood on the causes of the problems.”

“Right— and we make clear that they share some of the responsibility for what goes on— it’s not just up to CPS to watch families after the harm is done.”

The AOD director spoke up. “The other area where we’re making some big changes is how we screen and assess these kids and families when they first come into the system. Our risk assessment from the CWS side is supposed to catch the families where the kid is most at risk of some kind of physical abuse. But we’ve never looked very hard at the drugs and alcohol issues. The workers have said it’s not part of the charges, and they feel it’s futile to identify drugs as a problem because it’s a problem in nearly all families. What we’ve got to start doing is a kind of assessment that combines the CWS assessment with a serious look at the family’s drug and alcohol problems if they appear to have any based on the initial screening.

“How can you catch that early?” asked the CAO

“We’ve got some very good screening tools that can be combined with the risk assessment that the CWS people do. Our people have revised these instruments so they fit into the CWS process, and it seems to be working,” said the AOD director.

“Are your two staffs on board with this?” asked the CAO.

“The AOD director answered first: “We had some mid-level supervisors who were starting to undermine these discussions, but I explained that we were going to be tracking individual workers’ and supervisors’ caseloads and what happens to those cases, and a few of the diehards decided they wanted to transfer over to another agency. We found we had some workers who had a few clients

who came in once or twice a month to get counseled, with no followup whatsoever, while others had formed pre-treatment groups of more than twenty regulars.”

The CWS Director added, “The best workers really like this new accountability and the chance to work with the neighborhood agencies to get more help; the ones who are threatened by it probably should be— and we expect that some of them will transfer out of CWS.”

“Go to it,” said the CAO, “and stay out of the headlines.”

CHILDREN AND FAMILY FUTURES
STRATEGIC PLANNING AND EVALUATION

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**Bridge-building:
An Action Plan for State and County Efforts
to Link Child Welfare Services
and
Treatment for Alcohol and Other Drugs**

A report for the Stuart Foundation
by
Nancy K. Young, Ph.D. and
Sid Gardner

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