2
Seeking Solutions

Models of Current CWS-AOD Links

To understand how child welfare agencies are responding to AOD problems, we need to examine the progress made in each of the five core areas of the policy framework. The successes and impressive pilot projects described in this section represent a substantial body of work in the decade or more since the interrelatedness of CWS and AOD problems first attracted national attention. We have sought to distill the essential knowledge from hundreds of practitioners, policymakers, and advocates; their voices can be heard throughout this guidebook.

Based on the policy framework that we have described and on nine model strategies, the matrix shown in Table 2 (on page 28) summarizes the state of the art in efforts to address AOD problems among child welfare cases [Young & Gardner 1998]. Some sites that have employed a particular model have been operational for three or four years, while others are in the early demonstration stages. But the range of options shows how different states and communities have approached the tasks of building new links across systems and with communities.

The noted sites are examples of programs based on these models; these are not the only sites where these approaches are being pursued. Some of the innovative projects and initiatives described in this chapter focus on only one of the features included in the matrix, while others have been designed as comprehensive initiatives and incorporate more than one facet of the framework.

Following our discussion of these model approaches that work across CWS and AOD systems, we turn to several innovative practices *within* the child welfare field and examine how these innovations interact with the growing effort to respond to AOD problems. Because of the great importance we attach to *assessment practice* as

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Table 2. Model Strategies and the Policy Framework

Model Strategies	Elements of the Policy Framework				
	Daily Practice	Training	Outcomes & Info. Systems	Budgets	Service Delivery
Paired AOD Counselor & CWS Worker (DE)	Joint family visits and case planning	Formal cross-training	Separate assessment and MIS, evaluation in place	Title IV-E waiver	Joint case planning and management
AOD Counselor Out-stationed at a CWS Office as Technical Assistance (NJ)	AOD worker as resource in CWS office	Informal and formal cross-training	Separate assessment and MIS	Joint-funded AOD/CWS	Provides immediate access to AOD assistance to CWS
AOD Screener in CWS/Welfare Office; CWS & Welfare Staff on Loan to State Office (OR)	CWS worker makes referral to screener who refers to treatment	Informal and formal cross-training	Separate assessment and MIS	Joint-funded AOD/CWS/welfare	Establishes gatekeeper to AOD treatment resources
Multidisciplinary Team for Joint Case Planning (women's treatment programs, multiple sites)	Parallel workers with families who meet for joint planning	Informal cross-training	Separate multiple assessments	Separate funds from each partner agency	Joint case conferencing opportunities, sometimes "overall case manager"
Paired CWS Worker & Person in Recovery (Cleveland, OH)	CWS worker & PIR joint family visits, PIR provides support	Informal training of CWS	Joint assessment; only CWS MIS	Foundation grant and CWS funding	Increases the use of peer leaders as experts for CWS workers
Infusion of AOD Strategies through Training (Sacramento County)	CWS worker trainer to conduct "mini-interventions," assess for treatment, make referral & expand AOD capacity	In-depth formalized training leading to treatment capacity expansion	AOD assessment for problem severity and initial match to level of care by trained CWS workers	Foundation grant and CWS funding	Attempts to create systemic change within CWS to recognize, intervene, & expand capacity for AOD problems
Community Partners of Recovery & Treatment Staff with CWS (Nashville, TN)	CWS worker can call for assistance from person in recovery or treatment staff	Informal cross-training	Separate assessment when families enter either system	Primarily AOD funding	Changes reporting requirements, foster family regulations
Community Partnerships for the Protection of Children (Jacksonville, Cedar Rapids, Louisville, St. Louis)	Community, CWS, and AOD joint problem solving	Cross-training and technical assistance	Self-evaluation protocols supported by technical assistance	Attempts to blend funding across systems	Governance through new community entity
Family Drug Court (Pensacola, Reno)	Frequent contact with judge with graduated sanctions	Judges seek own training	Separate assessment and MIS	Family court	Uses authority of court to increase compliance with AOD treatment

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the process that bridges the CWS and AOD systems and that promotes interaction among and across all five of the framework elements, we also include a separate section that discusses innovation in screening and assessment of AOD problems as they affect referral of CWS parents to treatment.

Characteristics of the Models: Strengths and Concerns

Nine model strategies are included in the matrix. Salient features and issues of each model are summarized below:

Paired AOD Counselor and CWS Worker. The model relying on an AOD counselor paired with a CWS worker has the advantage of multiple staff resources, which is also its obvious disadvantage—its cost. The model also operates from an assumption which some practitioners question—that a specialist orientation is essential to working effectively with the family, rather than teaching each professional enough about the other set of functions to be able to make connections without dedicated specialized staff.

AOD Counselor Out-stationed at a CWS Office as Technical Assistance. The model based on AOD staff out-stationing brings the advantage of line staff expertise immediately available to work on a case, which may reduce the pressures felt by CWS workers or neighborhood workers dealing with substance abuse for the first time. However, AOD out-stationing by itself doesn't change the home institution from which the worker is out-stationed. Moreover, out-stationed workers can become isolated from the "home office," unable to command its resources beyond token levels.

AOD Screener in CWS/Welfare Office. When an AOD screener is added to the service unit, the screener functions as a gatekeeper for current AOD resources and may trigger more slots for CWS clients. CWS staff still function as intake screeners for referrals. AOD workers then screen clients, but they may refer on to an unchanged AOD system in which no new priority for CWS parents has been negotiated. In an interesting variation on this approach, Oregon has placed CWS and welfare staff on loan to the AOD office to deal with policy issues. This puts CWS and welfare expertise inside the AOD agency, rather than vice versa.

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Multidisciplinary Team for Joint Case Planning. Multidisciplinary teams are perhaps the most thorough staff-level reform possible. But implementing this reform at more than pilot project levels demands a "theory of resources" (discussed in Chapter 3), since it is difficult to sustain such teams beyond the pilot project phase which may become a "Cadillac model" that is hard to support. Such pilot projects tend to drift into a system maintenance role because they are so costly, in contrast to promoting system change that permanently redirects staff resources toward institutionalizing such teams as a part of the normal staffing pattern.

Paired CWS Worker and Person in Recovery. Staffing a team with a recovering person provides strong rapport and access to clients, enabling the CWS worker to perform the sanctioning role while the recovering staff member can play a more supportive role. Relying on the unique expertise of a peer from the community can reduce the client's denial and avoidance problems, as the worker both empathizes with and challenges the client. The risk of this approach is role confusion and the difficulties of building an effective partnership with an uncredentialed lay person who may face the problems of adjusting to a system that does not value lay experience as much as professional credentials and time in service.

Infusion of AOD Strategies Through Training. The AOD infusion approach (used by Sacramento County and other sites) is, in our view, by far the most appropriate way to achieve genuine reform, working across the five core elements of the framework and going outside the CWS system to other systems, such as criminal justice and public health. But it is hard to sustain and is susceptible to external events and leadership changes. It is also difficult to get workers under normal or greater pressures to adopt new behaviors, especially new assessment tools, without careful advance planning and strong top- and mid-level leadership. Infusing the AOD perspective in a CWS agency requires a level of information systems and results-based accountability that many agencies are unlikely to have yet achieved. The infusion approach also expands the capacity of the AOD treatment system by moving away from treatment services narrowly defined as residential treatment, broadening the base of services to pre-

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treatment and community support models. This approach can and should be combined with networks at the neighborhood level.

Community Partners of Recovery and Treatment Staff with CWS. The community partners approach draws community support in the form of active buy-in from local residents, but it is not clear that it seeks to change the system. In some sites, it has led to system changes to the extent that informal community support and interim caregiving have reduced the need for formal CWS filing, enabling the placement of children in safe environments while parents are enrolled in treatment.

Community Partnerships for the Protection of Children. The advantages of community partnerships include all the advantages of the prior approach, plus the advantage of a new governance entity that can address the need for a broad constituency base for systems change. However, decentralized pilot projects often reflect an initial preference by neighborhood groups for a gradual community-building effort that focuses primarily on "microprojects." Such projects may provide a foundation for larger, more strategic efforts, or they may lead to less emphasis on opportunities to affect the larger system's resources through a formal policy agenda. The effect of such partnerships in making these choices remains to be seen.

Family Drug Court. The Family Drug Court approach uses the impressive authority of the court, which is a substantial force for reform and can also mandate participation in treatment. However, reforms that are restricted to the court system may ignore the rest of the CWS-AOD systems and thus lack the resources to make court powers effective. Court systems have also found it difficult to divert scarce program funding to evaluations of the effectiveness of court-mandated programs to which their clients have been referred.

These summary comments on the nine models should make clear that these are evolving approaches. Some of the concerns we have expressed may not apply to all the sites that have adopted an approach, but we have sought to reflect what practitioners have said and what our own experience has shown about the advantages and drawbacks of these approaches. Described below are a few of the projects that are spotlighted in the matrix.

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The Clark Community Partnerships

The Edna McConnell Clark Foundation's Community Partnership sites (Cedar Rapids, Iowa; St. Louis, Missouri; Louisville, Kentucky; and Jacksonville, Florida) are implementing a four-part strategy:

- Develop an individualized course of action for each child and family identified by community members as being at substantial risk of child abuse or neglect;

- Organize a network of neighborhood and community supports, including a neighborhood site for agency CWS staff, as well as neighborhood "helpers";

- Establish new policies and practices within the CWS agency, including consulting with partner agencies and intensifying focus on families with a recurrent pattern of child maltreatment; and

- Develop a collaborative decision-making capacity to sustain the partnership.

The strategy plan for the Clark projects explicitly emphasizes that both substance abuse and family violence have been included in the policy changes sought in the child welfare system:

> **Community Partnership Plan:** Sites are asked to ensure that as part of the development of each plan, assessment is made of whether substance abuse and domestic violence are problems for the family. If they are, the family's action plan is expected to include activities that will alleviate these problems. ... CWS agencies will establish close working relationships (and possible joint operating procedures) with domestic violence service providers and with substance abuse providers ... Substance abuse prevention and treatment programs must be immediately available within the network and to the CWS agency [Center for the Study of Social Policy 1997].

Each sites' assessment and action plan is to include a response to "reports of abuse and neglect with a *differential response* based on the severity of the situation and the future risk to the child." These

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efforts are expected to go beyond the formal agency networks to natural helpers and the staff of community-based agencies, such as child care providers, schools, faith-based organizations, and recreation agencies. CWS staff are being relocated into neighborhood locations, not only as a new work site, but to enable deeper family assessments and become familiar with and tap into local services and supports for families.

In Louisville, meetings have been held at the neighborhood level among providers and neighborhood residents, planning for "sober housing units" has begun in the target neighborhood, and a substance abuse coordinator has been hired for the project. In Jacksonville, community meetings have led to a set of proposals for neighborhood-level initiatives that are being prioritized for implementation in 1998. AOD treatment providers have joined CWS staff and neighborhood residents in an active planning group that has been addressing AOD issues.

The Delaware Title IV-E Waiver

Delaware is the only state that expressly targeted AOD problems in its application for a federal Title IV-E waiver. Granted in June 1996, Delaware's waiver was one of the initial 10 state waivers for child welfare agencies authorized by P.L. 103-432. (The Adoption and Safe Families Act legislation of 1997 authorizes DHHS to grant an additional 10 state waivers.) Under the waiver, the state is using foster care funds (Title IV-E) to fund substance abuse counselors and to co-locate them with child protective staff. A component of the evaluation is to ensure that the project is cost neutral to the federal government.

Listed below are the objectives of the project:

- Prevent or delay entry of children into out-of-home care because of parental substance abuse, or reduce the time in care in 50% of the families receiving multidisciplinary team services;

- Reduce the amount of time between identification of a substance abuse problem and completion of an evaluation and subsequent treatment; and

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- Ensure permanency for children by verifying that reasonable efforts have been made to prevent placement and that appropriate reunification services have been made available.

The staff use a team approach, with the child protective worker focusing on child protection and safety issues and the substance abuse counselor identifying the extent of the AOD problem and its impact on child safety. The substance abuse counselor assists the family with linkages to treatment resources and provides support and treatment during the early stages of the AOD intervention. An extensive evaluation is being conducted using random assignment of cases to control and demonstration sites.*

The Starting Early/Starting Smart Program

The Casey Family Program, in conjunction with federal agencies (the Substance Abuse and Mental Health Services Administration [SAMHSA], the Health Resources and Services Administration [HRSA], the Administration on Children and Families [ACF], and the Department of Education) began an effort in 1997 to support five primary care and seven early childhood integrated service sites. One of these sites emphasizes child welfare populations: in Cook County, Illinois, foster parents for a group of children who have been removed from their families because of substance abuse will be provided extensive support while birth parents will be in treatment The demonstration's evaluation is conducted through a data coordination center that is studying two questions: (1) Will integrated services increase access to substance abuse and mental health services for children and families? (2) Will integrated services improve outcomes for the children and the families?**

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* The contact person for Delaware's program is Candace R. Charkow, Treatment Program Manager, Division of Family Services, Department of Services for Children, Youth and Their Families, 1825 Faulkland Road, Wilmington, DE 19805; 302/633-2601.

** The contact person for the Casey Family Program is Ruth W. Massinga, Chief Executive Officer, Seattle, WA; 206/282-7300.

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The Cuyahoga County START (Sobriety Treatment and Recovery Teams) Program

Having documented that 75% of child welfare intake involved alcohol and other drug abuse, officials in Cuyahoga County, Ohio, launched a program in 1996 that built on earlier AOD-targeted efforts to weave together the strengths of AOD treatment providers with the needs of child welfare families. The elements of the program are listed below:

- Expanded worker training in AOD issues;
- Random urinalysis as a motivation booster for parents in treatment;
- Safety plans that address AOD problems explicitly;
- Natural support providers and relatives;
- Referrals to four local AOD treatment agencies; and,
- An explicit message to clients that says...

  > We want you to understand now, at the beginning, that permanent custody of your child will depend on this success. You must stop your drug use if you are going to have responsibility for your child [Cuyahoga County Department of Child & Family Services 1996].

The target group is the estimated 150 women a year who deliver babies and show a positive toxicology screen for any drug. A key feature of the program is the use of "child welfare advocates," who are recovering AOD abusers recruited from local welfare offices and past child welfare caseloads.

CASE STUDY **The Sacramento County Alcohol and Other Drug Treatment Initiative (AODTI).** In response to the flood of AOD cases in social service and public health caseloads, the Sacramento County Department of Health and Human Services enacted in 1993 an ini-

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tiative to incorporate substance abuse services as an integral part of its service delivery systems. The program received full endorsement from the Sacramento County Board of Supervisors, the Human Services Cabinet, and the Criminal Justice Cabinet.

The training component of the initiative focused on three levels:

- Level I - Basic introduction to AOD terminology and identification,
- Level II - Advanced assessment and intervention skills including certification in administering the Substance Abuse Subtle Screening Inventory (SASSI), and
- Level III - Group treatment skills with substance-abusing clients.

Level I was required for *all* Department of Health and Human Services personnel. Level II was required for all personnel who "carry a caseload." Level III training was required for all County AOD counseling staff and was voluntary for all other staff who completed Level II and agreed to participate in facilitating AOD group services. The program's three levels of training had been completed by more than 2,000 health and human service staff members and other community agencies by early 1998. Sacramento currently requires that workers begin AOD training after their first three months on the job. (The lessons of this initiative are discussed in Chapter 3.) The training was evaluated with a pre- and post-training test that assessed participants' knowledge, attitudes, and beliefs. Post-training results showed considerable initial approval from line employees. The substantive areas of the training that produced the most positive responses to the pre- and post-training questions included the following:

- The awareness that alcoholism and drug dependence are diseases,
- The awareness that professionals can help clients in denial,
- The effectiveness of different modalities of treatment for different kinds of clients,
- The relevance of client measures of functioning in addition to abstinence,

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- Alleviating the misapprehension that the AODTI sought to make all professionals into drug counselors,
- Definitions and symptoms of AOD dependence,
- The potential for all human service professionals to conduct substance abuse interventions, and
- Awareness of phases of recovery as measures of parents' readiness for child custody.

Overall, workers gave highly favorable scores on the questions: "I think this training will result in a change in how I do my job," "I will recommend to my coworkers that they participate in this training," and "I think that it is important that the department is undertaking this training program." An important distinction emerged, as it often does in training, among changes in *knowledge, attitudes,* and *expected versus observed behavior*. In answer to the question "as a result of this training, the primary change that I will make in the way I do my job is...," workers responded far more often "feel more knowledgeable in dealing with AOD problems" than they agreed with "be more understanding and sensitive to clients with AOD problems." The least frequent response was "be more willing to confront and talk about AOD problems," suggesting the greater difficulty of turning new attitudes into new practices.

At the peak of implementation, around January 1997, approximately two-thirds of all child welfare workers (outside the permanent placement bureau where parents have already been assessed for risk) were submitting AOD assessments. Later in 1997, the CPS crisis (see box on page 39) resulted in a reduction of assessments to a point where few were coming in from workers.

The actual procedure for AOD assessment and referral under the AODTI involved three steps:

1. Classifying the client (use of the SASSI was at workers' discretion as a tool to assist in this classification) as falling into one of five categories:
   - Having no AOD problem,
   - Substance user,

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- Substance abuser,
- Chemically dependent not in recovery, or
- Chemically dependent in recovery.

2. Determining, among those clients assessed with an AOD-related problem, their level of functioning based on a Likert scale across seven domains that are commonly used in AOD assessment protocols:

   - Medical problems,
   - Social relationships,
   - Legal problems,
   - Housing problems,
   - Mental health problems,
   - Family problems, or
   - Employment problems.

3. Referral to one or more of nine treatment options based on a grid that indicates appropriate patient placement guidelines for referrals to a continuum of treatment programs.

During the period in which assessments were at peak levels, 63% of all clients assessed were described as having an AOD problem at some level, with another 14% described as chemically dependent and in recovery. As a finding from the most comprehensive AOD assessment process systematically applied to all CWS-entering parents, this statistic correlates with many other national studies, which find 40 to 80% of CWS-involved parents have an AOD problem.

An important intervention developed as a part of the AODTI makes clear that the effort was designed and implemented as much more than a training program; this was the use of "pretreatment groups" run by social workers and/or AOD counselors. In contrast to a frequent CWS agency practice of referring clients with AOD problems to a "waiting list" at a treatment program (which some have derisively called "referral on demand" in contrast with the policy of *treatment* on demand), the AODTI used these pretreatment groups as a means of immediately engaging the clients who needed AOD treatment. Clients are involved in a group setting that in-

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cludes parents with similar problems from whom they can receive support. In some cases, this may be the only intervention required. In the case of higher risk, lower functioning parents, the groups serve as interim services while waiting for an intensive treatment slot to open. Approximately one-third of AODTI clients with AOD problems were referred to such groups at the peak period of assessments.

The Sacramento CPS Crisis. With the deaths of two young children during 1996-97 whose parents were involved in drugs, the CWS agency within Sacramento County's Department of Health and Human Services became preoccupied with tougher enforcement. Under media pressure and criticisms from advocates for children, the district attorney's office, in collaboration with DHHS, the probation department, and law enforcement, conducted "sweeps" of neighborhoods to place children in protective custody. At one point in late 1997, the sweeps had increased the number of children "filed on," (i.e., on whom formal removal proceedings had begun in court) by seven times its normal rate in prior months. The AODTI assessment policy was suspended, and plans were implemented to reduce work loads as staff came under great pressure to remove children at risk, without devoting any resources to assessing their parents' AOD-related status. Submissions of AOD assessment forms dropped to very few by late 1997. By early 1998, a renewed effort to commit resources to a revised assessment process was under way.

The Pensacola Family Drug Court

After 15 years on the bench, Judge John Parnham has a vision of a Family-Focused Community Justice System. To achieve that vision, he has changed his approach in working with families with AOD-related problems and believes that the Dependency Court should serve the community as a form of "therapeutic jurisprudence, empowering families to be in a healthy environment." In a strong collaborative effort among the court; the district AOD program administrator, Dr. Paul Rollings; the district Family Safety and Preservation administration; and the staff at Pathways Treatment Center, the principles that

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have been used in adult criminal drug courts have been implemented in the family dependency court since 1997.*

The families brought into the drug court have generally had open cases in the Family Safety and Preservation Division for many years and have all been court-ordered to complete a treatment plan. Drug court families are from the family reunification and court-ordered family supervision programs. If the case worker finds that the family is not cooperating in their treatment plan and the parent(s) have AOD problems, the case is referred to the state attorney's office for filing contempt of court charges. The parent is ordered to appear in front of Judge Parnham and if the parent is in violation of the court order, has no psychiatric problems that would interfere with the treatment, and agrees to participate in the drug court services, the family can be accepted to the drug court program.

AOD treatment services are provided in four phases by Pathways, a local AOD treatment provider. Although there are timelines set for each phase, the time limits are flexible and adjusted for each client's progress in treatment. The phases of treatment are:

- *Phase 1*. 4 hours per day, 4 days per week for 5 weeks;
- *Phase 2*. 4 hours per day, 2 days per week for 3 to 6 months;
- *Phase 3*. 1 1/2 hours per day, 2 days per week for 6 months; and
- *Phase 4*. Long-term case management for approximately 6 months.

There are weekly court appearances and random selections for urine tests during Phase 1. Court appearances and drug testing is less frequent as the structure of the program becomes less rigorous over time.

Each member of the drug court team believes that the key component of its success is the emphasis on linkages among the partners.

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* For additional information on the Pensacola Drug Court, contact Dr. Paul Rollings, Program Administrator, Florida Department of Children and Families Substance Abuse Program; 850/444-8366.

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There are weekly case planning meetings in which each team member has a voice in reaching consensus on rewards and sanctions to be delivered under the authority of the court. Most important in case planning is the view from each perspective on the treatment team on the client's "patterns of behavior." Even if a client is testing clean, if the AOD counselor or CWS social worker believe that the client is not demonstrating a change in his/her behavior patterns, they can request the imposition of sanctions. Sanctions used by the court include more frequent court appearances, daily urine tests, community service jobs, and when necessary, jail time.

Putting the Models in Context

In summarizing the state of the art of CWS-AOD relations in 1992, the CWLA Commission at that time said

> Currently, the child welfare and AOD service systems operate independently from each other, using different eligibility criteria, restrictive funding streams, and sometimes conflicting program requirements, creating a maze that severely limits access [CWLA 1992].

Today, in 1998, the practices and policies in the exemplary agencies we have discussed in this chapter have advanced well beyond this summary description. We have made progress, despite the large obstacles that remain. The "maze that severely limits access" is still there, arguably more confusing because of new categorical legislation and the lack of adequate data collection.

But the recognition of the problem of AOD abuse by parents in the child welfare system is much wider than it was in the early 1990s. Demonstration programs, as noted in this section, have shown that advances in AOD treatment can make a difference in child welfare outcomes. The 1992 judgment of inadequate community response is still true of many communities, but practice innovation is expanding the number of child welfare agencies that are trying to break out of this status quo. We turn now to an assessment of child welfare innovation, as it provides further evidence of the progress that has been made.

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Child Welfare Trends, Practice Innovations, and AOD-related Issues

Several recent trends and practice innovations in the child welfare field are closely related to the AOD problems addressed in this guidebook. Some are changes in child welfare practice that could result in more effective handling of AOD problems, but others may present barriers to closer links with AOD treatment agencies. The following material discusses these innovations as they influence and are influenced by AOD problems. Some of the common themes in these innovations and trends include *family-centered practice* and *strengths-based* or *solution-focused practice*. These approaches identify and build on the strengths of the families in the child welfare system, while recognizing that those strengths are challenged by the forces that cause and are affected by AOD abuse.

Kinship Care

While not a new innovation, kinship care has expanded in the past decade to a point where it makes up as much as one-half of new placements in some states and counties, and it can be seen as both a major resource and a challenge in weaving together AOD and CWS practice and policy. On the one hand, kinship care is undeniably a resource that has provided safe, loving homes for thousands of children whose parents were unable to care for them responsibly, due to their own AOD and other problems. As of 1994, approximately 2.15 million children–just over 3% of all children in the United States—were estimated to live in the care of relatives without a parent present [Harden et al. 1997]. Since "concurrent planning" (described on page 44) relies on kinship care as an early option, the use of this form of care is likely to increase rather than decrease in years ahead, as more restrictive time limits for both CWS and TANF begin to take hold.

At the same time, the intergenerational, genetic factors in AOD use and abuse, while not determinative, are highly correlative within families, and policy needs to take into account the possibility that the AOD issues may be present in the kinship setting in ways that can affect children. As Ivory Johnson has written, inadequate kinship care

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"can be another system of abuse and neglect for vulnerable children" [Johnson 1994]. The AOD issues in kinship arrangements are at least as important as they are in other caregivers' homes, and should be assessed as such. Johnson emphasizes that workers dealing with kinship arrangements

> must be skilled in family assessment to be able to understand the implications of chemical abuse and dependence on one's ability to provide adequate parenting and protection. The dynamics of chemical abuse and dependency must be part of the core training for kinship caregivers and staff members.

One recent assessment of kinship foster care based on a review of 77 cases underscored the difficulty of dealing with AOD issues when both the caregiver and the parent are experiencing AOD problems, as would be expected since they are both affected by the familial roots of AOD dependence [Gleeson et al. 1997]. The rationale for whole-family treatment is always strong, but addressing the intergenerational issues in kinship care is a special challenge, due to the greater likelihood that some of the underlying factors contributing to maltreatment could be present in the kinship setting as well as in the biological home. An especially difficult set of issues must be dealt with by caregivers and agency workers when birth parents are still actively abusing substances or are incarcerated [Crumbley & Little 1997].

The broad principles that appear to have the best chance of ensuring that kinship care will provide safe and supportive homes for children include the following:

- Screening and assessment of the families in sufficient depth to address AOD issues explicitly;
- Adequate resources for kinship families;
- A recognition by public policy and agency workers' practices that kinship care is different from family foster care and requires different services and supports; and

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- Clarity about how kinship care and permanency planning interact, both in policy and in individual case planning.

Racial and cultural issues are deeply ingrained in kinship care and must be explicitly and sensitively addressed. As Johnson and many others note, "the kinship care arrangement is a practice rooted in the African and American experience" [Johnson 1994], and is of great importance in Native American communities as well.

Concurrent Planning

The goal of concurrent planning is *timely permanency for children*. In contrast with *sequential planning* (which seeks reunification and then, if these efforts prove unsuccessful, introduces alternative permanency plans), concurrent planning provides for parental reunification and rehabilitation efforts while simultaneously developing an alternative permanent plan for the child. An agency using concurrent planning methods simultaneously offers services to families while exploring alternative permanent options. The agency reviews relative/kinship placement options and seeks foster/adoption placement as a backup plan if reunification is not possible in 12 or 18 months. All options are discussed, including active rehabilitation efforts, voluntary relinquishment, and relative guardianship. Frequent, consistent, and meaningful visitation is used as a high predictor of reunification in concurrent planning. Concurrent planning for children and families requires caseload adjustments to reflect the more intensive level of services delivered by child welfare workers.

AOD problems are critical to concurrent planning, since the "fork in the road" often comes when the agency makes a decision about whether parents are able to resume their responsibility for their children. Some child welfare practitioners have expressed the view that AOD problems are in fact the most important barrier to making concurrent planning work. In their view, without adequate means of referring parents to treatment, monitoring their progress, and making a well-grounded assessment of the risk of returning children, concurrent planning cannot succeed.

The State of Colorado, for example, uses concurrent planning to make early decisions on families needing substance abuse services.

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Concurrent Planning: Significance for AOD Issues

The pressure to deal with AOD issues increases when the "second track" of permanent placement outside the biological family is apparent from the start. Consistent with the goals of the 1997 federal legislation and some states' moves toward allowing shorter time periods for reunification services for parents with AOD problems, CWS agencies have accelerated their efforts to make judgments on AOD-abusing parents. But CWS practice may be unrealistic in assuming that a single episode of treatment will "fix" a parent with lifelong habits and a lifestyle in which AOD abuse may be only one manifestation of family problems.

Staff have new resources for AOD treatment slots and reduced caseloads that enable intensive reunification services combined with concurrent planning for adoption based on parental performance in treatment. At three months the case is reviewed and a recommendation is prepared for concurrent foster care or adoption. By six months, the agency feels it has adequate information from AOD treatment providers to determine whether reunification is likely and, if not, to accelerate termination of parental rights. "With few exceptions, permanent placements must be made by 12 months" [Barth 1997].

This speeding up of the "AOD clock" runs the risk that parents who need longer than 12 months to achieve parenting skills and personal stability will have lost their children by the time they get their lives together. But the alternative in this difficult set of choices is waiting for the parents, at an obvious cost to the children if the parents are not successful. In some cases, the CWS legal clock and the child's developmental clock will become a higher priority and may take precedence over the slower running AOD recovery clock.

Family Decision-Making Models

As documented in a recent publication of the American Humane Association, agencies have begun to use an approach to families called

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Family Decision-Making Models: Significance for AOD Issues

The skills required to facilitate a family's discussion of "undiscussable" issues that include AOD problems are not always present in CWS staffing. It is not clear whether facilitators consistently seek to assure, as AOD counselors sometimes do in arranging family-based interventions, "hearing the voices of those who have been victimized" and "holding those who have committed the wrong responsible for their actions," in the words of one presentation of FGDM.

Family Group Decision Making (FGDM), that emphasizes building on the strengths of families and using a solution-based approach to resolve family problems that may lead to out-of-home placement. This approach includes a family case conferencing model developed in New Zealand and the Family Unity Model developed in Oregon and based on the Family Group Conferencing model.

Both processes use family meetings as the central mechanism to develop a family resource plan, drawing on the resources of the family, the extended family, and community agencies. The family assumes responsibility for the plan and takes ownership of the steps needed to carry it out.

The Family Unity Model uses a trained facilitator to assist the extended family unit in developing the family resource plan. In the Family Group Conferencing model, a facilitator provides initial guidance to the family but the family develops the plan, with the facilitator leaving the room when the extended family deliberations are under way.

These models are quite appealing in the reduced intrusiveness they bring to families' lives and their ability to hold families accountable for their own actions. They also offer an approach that is effective with diverse cultural groups. A further advantage pointed out by some state officials is that FGDM models create a team for the worker to be part of, which can be a welcome support for a younger, less experienced worker who no longer needs to make all decisions by herself.

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While there is not as yet a significant body of evidence about the effectiveness of these models, the combination of an approach that is more respectful of clients and provides workers more resources has led a number of states and counties to adopt FGDM. As with concurrent planning, however, some practitioners would caution that implementing these approaches with social workers assigned their current levels of caseloads will not be successful. It remains to be seen if these added resources will be made available.

The Family Support Movement

Some of the programmatic and philosophical underpinnings of the community partnerships approach are firmly rooted in earlier ideas about family support, building on family strengths, the need for natural supports as well as public and nonprofit services, and respect for the cultural and community origins of families. Securing support from the community in helping parents in the CWS system is at the core of the community partnership approach.

Some documents produced by the family support movement have given AOD issues scant attention, but the field as a whole varies widely in the depth of its approach to AOD concerns. Yet there is extensive evidence that self-help approaches, both neighborhood-based and faith-based, can help families both in early intervention and in community-based aftercare support from networks of natural helpers that include other parents in recovery. In addressing the issue of whether a strengths-based approach makes it difficult to address a family's AOD problems, some practitioners would agree with the statement by one reviewer that

> ... In no case do we view "family strengths" as an approach that ignores needs—rather it is an approach that uses family and personal resources, successes, and capabilities as essential components of creating plans to successfully address *needs* such as AOD, violence reductions, improved parenting, etc. [Anonymous communication with author, 1998].

It is not difficult to see the conceptual links between family support practice and increased community involvement in AOD issues.

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Two of the core principles of family support, as set forth in a series of publications by the Family Resource Coalition of America, are especially relevant. If one defines "having control over important aspects of their lives" and "equitable access to resources in the community" to include addressing AOD problems as they affect millions of children, the family support movement can become an important part of the effort to strengthen community support to parents with AOD problems [Family Resource Coalition 1996].

Another source of family support is the **school-linked services** movement. Services for AOD-related problems among parents have been included in several efforts: in Florida's statewide efforts to develop "full-service schools," and in statewide efforts in New Jersey, Kentucky, and California. These initiatives go well beyond the pilot project stage to widespread innovations in which public and community workers are brought into and linked with schools in family resource centers.

A specific form of family support program is **home visiting**. In an increasing number of communities, home visiting programs have been linked to child welfare reforms. Lawrence Sherman's extensive survey of crime reduction programs for the U.S. Department of Justice included a review of "family-based prevention" initiatives such as home visiting, and concluded:

> Perhaps the most promising results in all areas of crime prevention are found in the evaluations of home visitation programs. While these findings are often combined with other institutional elements, such as preschool, there is a large and almost uniformly positive body of findings on this practice [Sherman et al. 1997].

Home visiting programs have at times included counseling and treatment for AOD problems, especially those that are revealed by a positive toxicological screen at birth. But many programs have emphasized referral out to treatment agencies rather than equipping line staff to screen or provide pretreatment services.

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