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Beyond the Boundaries of Child Welfare:
Connecting with Welfare, Juvenile Justice, Family Violence, and Mental Health Systems

As noted in the Introduction, several service systems outside the parameters of child welfare affect and are affected by AOD problems among children and families. Agencies in the domains of welfare reform, juvenile justice, family violence, and mental health are, at various stages, participants in the identification, assessment, and prevention/treatment of problems among children and families affected by substance abuse. CWS practitioners have also emphasized the importance of school systems, primary health agencies, law enforcement, and housing agencies in meeting the needs of CWS families with AOD problems. Child welfare officials must acknowledge that these other systems are essential players in addressing AOD problems faced by children and families. This section describes the existing overlap of cases among these systems, highlighting the interrelated nature of these problems and their solutions, which often require services from systems other than AOD and child welfare.

The Link to TANF

The overlap of AOD problems with welfare caseloads underscores the importance of addressing poverty as well as the other underlying factors in child welfare caseloads [Young & Gardner 1997]. A recent work that has masterfully woven together the three policy arenas of human services reform, community organizing, and community economic development is *Building Community*, by Bruner and Parachini [1997]. Many practitioners would add a greater emphasis upon community or neighborhood development to efforts to build community partnerships for child welfare services, following the conclusions of a

massive study of community prevention programs commissioned by the Office of Justice programs in the U.S. Department of Justice:

> ...community prevention programs address none of [the] causes of community composition and structure, which in turn influence community culture and the availability of criminogenic substances like guns and drugs [Sherman et al. 1997].

Predictions in some states that welfare cuts will affect CWS caseloads have led to efforts to look more closely at the effects of the 1996 welfare reform legislation on children. A series of federally and foundation-funded efforts based in a select group of states are monitoring the impact of welfare changes on the children of TANF recipients, including assessments of child welfare impact [Christian 1997]. With the recently announced decline of welfare caseloads to below the level of 10,000,000 for the first time since 1970, information on the effects of these reductions on CWS caseloads becomes critical, especially those for child neglect. Judith Gueron of the Manpower Demonstration Research Corporation, which is conducting studies in Minnesota and Florida, stated in January 1998 that "about half of the people leaving welfare are employed, and half are not" [Pear 1998]. The second group is the portion in which monitoring child neglect would seem critically important, since neglect is already making up a majority of CPS cases in most states.

A possible problem arises from the traditional separation between income support and child welfare programs. Though often placed within the same agency, the two systems have tended to seek different goals: the welfare system seeks the removal of parents from welfare and the child welfare system focuses upon children who may be endangered. With different eligibility rules, and now with different ideas of entitlement and time limits, the two systems will only work together effectively if these barriers can be overcome in family-centered approaches that take a wider view of clients' needs and strengths.

As noted in our earlier work on TANF, it appears likely that as caseloads decline in number, clients with more severe barriers to employment will be encountered more frequently, requiring a wider array of assessment and support services.

The Juvenile Justice Connection

The problems of substance-abusing parents of children are not confined to the domains of child welfare and welfare systems for some families—they extend further to impact the juvenile justice system. As CWLA notes: "The courts, like the child welfare system, are in crisis—overwhelmed by ... increasing numbers of cases involving alcohol and other drug abuse" [CWLA 1992: p. 97]. Yet, there exists a major disconnect between the child welfare and juvenile justice systems.

Recognizing the need for stronger linkages, participants at a recent Office of Juvenile Justice and Delinquency Prevention (OJJDP) conference concluded that "one large system" was needed to meet these families' complex needs. The conference summary captures the essence of the problem:

> Because abuse and dependency have root causes in dysfunctional families and unfavorable environments, and because being abused engenders the mental and emotional turmoil likely to lead to delinquency, child welfare and juvenile justice professionals end up working with many of the same kids [OJJDP 1997].

Why the Juvenile Justice Connection Is Critical

Research on the relationship between childhood maltreatment and subsequent adolescent problem behaviors provides clear evidence of the need for child welfare services and juvenile justice to work in tandem. Findings from the Rochester Youth Development Study, for instance, indicated that children who were abused or neglected were significantly more likely to engage in serious and violent delinquency. Forty-five percent of maltreated youth, compared to less than one-third (32%) of nonmaltreated youth, had official records of delinquency. Maltreated children were also at increased risk of other interrelated problems in adolescence including drug use, poor academic performance, teen pregnancy, and emotional and mental health disorders [Kelley et al. 1997].

In 1997, Sacramento County planned the Community Intervention Project to link juvenile justice and child welfare service agencies. Sacramento implemented this effort in response to research conducted by CWLA that found the following:

- Approximately 2% of the 75,000 children age 9 to 12 in Sacramento County were known to the child welfare system,
- More than one-half of those children (56%) were arrested for juvenile offenses, and
- These youth were far more likely to continue committing serious offenses, based on the early age of their first involvement with the juvenile justice system [Morgan & Gutterman 1995].

The Sacramento initiative targets these high-risk youth and their families in an intensive effort to prevent their continued involvement with the justice system.

Early intervention with these preadolescents has become a clear priority for some innovative juvenile justice agencies. Yet as these children grow older, they obviously begin to be perceived, within their own community and the larger society as well, as more dangerous than endangered. As the OJJDP study on childhood maltreatment noted:

> When a child victim becomes a juvenile offender, legitimate concerns about protecting public safety and holding youth accountable for their behavior can overshadow issues of continued trauma from childhood maltreatment ... Punitive responses ... may exacerbate previous emotional and developmental problems resulting from maltreatment [Kelley et al. 1997].

The response of the juvenile justice system to the needs of these children has been mixed, like that of other systems for which AOD issues have been treated as a side current to the mainstream of services. Exemplary practice is visible in a few agencies and general dis-

regard for the problems of AOD abuse in many others. As stated in a recent CSAT report on AOD treatment for adolescents diverted from the juvenile justice system:

> Although juvenile courts historically have functioned within a network of community social service and treatment agencies, these networks' responsiveness to AOD-abusing youth has at best inconsistently met the needs of courts, youth, and families. Many AOD abuse treatment programs were developed to serve only those adolescents and families who seek help [McPhail & West 1995].

This report goes on to recommend a strategy for diverting appropriate youth from the juvenile justice system to AOD treatment agencies, capitalizing on three opportunities:

- The access of the juvenile justice system to AOD intervention and treatment when needed;
- The capacity of the AOD treatment agencies to use the authority of the court to encourage compliance; and
- The capacity of multiple agencies working together to provide a continuum of services to specific youths, including AOD treatment, physical health, mental health, and other social services, based on the youth's individual, multiple needs for treatment and other services.

The guidelines for these diversion programs emphasize the nature of AOD abuse as a family disease and thus require family involvement whenever possible. Conventional definitions of family may not apply in all youths' situations and at times a supportive adult, who may or may not be a birth parent, may be a critical factor. These guidelines also stress that adolescent clients may require different treatment services from those of adult AOD abusers, including specialized education, pre-employment training, leisure activities, and mentoring.

Finally, we cannot lose sight of the older youth who are, in effect, "graduates" of the child welfare system. In some cases these youth,

who were often abused or neglected as younger children, have become involved in dysfunctional and criminal behavior as users, distributors, and sellers of drugs, and thus represent disruptive forces within their own families. These youth are far less likely to be reported to the child protective system, and it is therefore the juvenile justice system that may be their last chance for any relevant AOD services before incarceration as an adult. Sadly, this group is also where the problems of substance abuse and family violence, to which we turn in the next section, most frequently overlap.

Family Violence, AOD Problems, and Child Welfare

The family violence problem overlaps child protective services caseloads in many of the same ways that AOD problems do. There are important differences between the two problems, but first we need to understand how family violence and AOD issues are similar:

> Many professionals traditionally viewed the presence of adult-on-adult family violence as a problem that was irrelevant to their goal of protecting the children, and therefore did not ask about it during screening, investigation, or assessment. As a result, effective child abuse interventions were often sabotaged by the ongoing occurrence and escalation of domestic violence over time, and the children remained in danger [Carter 1997].

If the words "domestic violence" and "family violence" were replaced with the words "AOD problems" in this selection, this quote would remain just as accurate. That underscores the extent to which both problems affect CWS caseloads and require changes in CWS practice to reduce the harm to children. Both problems are underemphasized in the typical CWS assessment, reflecting the limited training provided to CWS staff on the nature of the problems. Both problems undermine the effectiveness of child abuse interventions. For example, parent education courses may ignore the two problems in their curricula. Family preservation programs undermine efforts to

address family violence and AOD problems if they screen out these parents (as some have acknowledged in a recent assessment of child abuse treatment outcomes in California) [Rosenbaum et al. 1997].

In addition to families in the CWS system, family violence and substance abuse also coexist in a significant number of other families. Both battered women and batterers are significantly affected by AOD use; several studies have found that more than 40% of homeless, lower-income women report both physical abuse and AOD abuse [Bassuk et al. 1986]. In a study of domestic assault incidents in Tennessee, 94% of the assailants and 43% of the victims had used alcohol and/or other drugs in the six hours prior to the assault [Bookoff 1996]. A 1997 Treatment Improvement Protocol issued by the Center for Substance Abuse Treatment, titled *Substance Abuse Treatment and Domestic Violence,* included persuasive evidence that linked these two problems, and concluded that "failure to address domestic violence issues interferes with treatment effectiveness and contributes to relapse" [Fazzone et al. 1991].

Similarities Between Responses to Family Violence and AOD Problems

In response to these problems, similar proposals for reform have been developed by providers and advocates in both areas. These include strengthened training, revised assessment and screening protocols, access to experts in the specific fields of family violence and AOD, collaborative links to other agencies addressing problems of families in the CWS system, stronger links to community-based organizations and informal supports, and changes in court procedures and legal requirements. A review of Table 2 on models of linking CWS and AOD activities (on page 28) shows the similarities in approaches with the linkages being forged with family violence practitioners.

As is the case for AOD problems, the issue of assessment has special significance in addressing family violence, since routine assessment practices do not seek information on family violence in sufficient depth to ensure that this condition is tracked over time to determine its impact on the family. Several articles on family violence and its impact on families have recommended more thorough assess-

ment practices, but without taking into account the "layering" effect discussed previously, in which each problem is the focus of another, entirely separate assessment. This problem of layered assessments also complicates making separate AOD assessments on top of current risk assessment procedures. An issue of added importance in assessing family violence problems is the need to conduct separate interviews with the victims of family violence, apart from the perpetrators of violence and their children.

Training is also an area of reform addressed by advocates for more attention to both AOD and family violence, with the models for AOD-CWS training described above as prime examples. Within the family violence field, training curricula have been developed by the Family Violence Prevention Fund and the University of Iowa for use in training CWS staff, as well as other human service intake workers, in several states and communities.*

In both areas, community norms are an important factor. On the one hand, there is still acceptance of family violence and substance abuse as "normal" behavior that is often viewed by law enforcement staff as a private matter within the family. However, the community can also serve as an important source of pressure on parents whose behavior endangers their children, as well as a source of support for parents who want help. Reforms aimed at law enforcement personnel and court staff have been undertaken as a means of improving the responses of both sets of critical agencies.

Specific language in the welfare reform legislation refers to family violence, and with the substantial overlap between AOD use and family violence, policy makers should carefully review the extent to which these two problems affect an overlapping group of both TANF and CWS clients.

Differences Between Responses to Family Violence and AOD Problems

In family violence situations, there are usually a clear perpetrator and a clear victim, as opposed to AOD problems in the CWS system,

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where the parents are abusing alcohol and/or other drugs or are chemically dependent in a way that affects their parenting. This difference in perspective regarding the target of intervention leads to a different focus for treatment and prevention. In the family violence situation, the batterer is the focus of treatment efforts and the victim is the focus for supportive services and advocacy. In the CWS system, the effects on children are the focus, but in the AOD system, the focus is on the AOD user.

Abuse is the typical problem for family violence victims in the CWS system, while neglect is a much more common problem for families affected by AOD (although some studies have found that alcohol abuse is correlated with physical abuse and illicit drug use is correlated with neglect) [Wilson 1996].

Sanctions are viewed differently in the two systems, with family violence agencies seeking heavier sanctions against perpetrators and AOD systems using sanctions to reinforce the behavior sought in improved parenting. Family violence personnel typically favor noncoercive intervention for victims and sanctions applied to perpetrators, with some important exceptions when children are endangered. AOD systems use both coercive and noncoercive treatment, since research shows little difference in the ultimate outcomes.

Working with Family Violence Prevention and Treatment Agencies

Unfortunately, these differences and the traditional tendency of the human service systems to take a categorical approach to all problems have meant that the majority of literature and training materials addressing AOD or family violence has almost completely ignored the other issue. As a 1994 review of child abuse and substance abuse stated:

> Experts have been identified in chemical dependency, child abuse, and violence, but cross-fertilization in these highly correlated fields seldom occurs [Blau et al. 1994].

There are important recent exceptions, however. Discussions sponsored by the Clark Foundation, both under the auspices of its Com-

munity Partnerships initiative and in an earlier Executive Session on the future of the CWS system convened by the John F. Kennedy School of Government at Harvard University from 1994 to 1997, have begun to frame the issues of the overlap more explicitly. Materials developed by Susan Schechter of the University of Iowa have proposed treatment programs that address both family violence and AOD problems of batterers [Schechter 1997]. But much remains to be done in this area.

Important organizational issues are also raised by the attempt to create new units that address family violence and AOD problems in the CWS system. Establishing a unit specifically to deal with family violence issues is an appropriate recommendation, although establishing a similar unit for AOD issues—and for child sexual abuse, mental health, and TANF liaison—is also appropriate. But a significant problem with forming a new unit is that it sometimes enables an organization to isolate an innovation and keep it away from the mainstream of the organization. The larger challenge may be *infusing the concepts* of sensitivity to both family violence and AOD problems throughout the organization. Recently, San Diego County, California, reorganized its health and human services agency to include an AOD focus in each of the new operating units, rather than in a separate, more isolated AOD unit. Massachusetts has used a separate unit to pilot interdisciplinary teams that include family violence expertise as well as other disciplines relevant to CWS. Service providers may not always welcome the infusion approach, as opposed to having their own identifiable unit. But at the very least, the trade-off between a new entity and the infusion approach should be addressed explicitly.

Finally, it is critical that efforts to improve the child welfare system's handling of both AOD problems and family violence devote adequate attention to documenting that such efforts will succeed in improving outcomes for children and families. As Aron and Olson note,

> It may be worthwhile to develop methods to justify these resources, such as documenting the number of families in need, tracking these families over time, and observing if they are more likely to reenter the child welfare system or use more

expensive services because of unaddressed domestic violence concerns [Aron & Olson 1997].

The same questions apply to AOD-targeted reforms, in which changes in clients, workers, and systems should all be the focus of serious evaluation designed to make the case for such reforms based on results, not just good intentions. These discussions about outcomes will get to the heart of some of the important philosophical differences in perspectives, including the issue of whether removal of children (and parents) from the home is an indicator of success or failure. In a serious discussion of outcomes across the boundaries of the fields of AOD, CWS, and family violence, the measures of success must be defined in ways that are clear to all three groups, while allowing flexibility for different perspectives on the needs of children and families (see Table 13).

The Link to Mental Health

Parents with substance abuse problems frequently have a variety of health and mental health complications. The increasingly common label "behavioral health" is usually intended to include mental health and substance abuse problems in the same broad category, suggesting the close connections between the two sets of conditions. In the total population, diagnosable mental health and substance abuse disorders are projected to affect 28% of the population; 22% of the population has a mental disorder, with anxiety (12.6%) and depression and other affective disorders (9.5%) the major categories. Substance abuse disorders are found in 9.5% of the population; thus, about 3.5% of the population has both mental health *and* substance abuse disorders [Goodwin et al. 1997]. A particular disorder among substance-abusing women with children who are victims of family violence is posttraumatic stress disorder, as documented by a wide array of studies and the experience of women's centers [Dansky et al. 1997].

These findings are a powerful reinforcement of the premise of this guidebook that the lines between these often-overlapping conditions, however categorically they may be defined at entry to the sepa-

Table 13. Similarities and Differences in Approaches to Family Violence and AOD Problems

	Family Violence	AOD
Values	Public attitudes tend to polarize Gender bias affects values Victim and perpetrator seen differently Perpetrator's personal responsibility is central to better outcomes Children seen as victimized	Public attitudes tend to polarize AOD stigma affects values Addict seen as focus of treatment Addict's motivation is critical factor in better outcomes Children rarely the focus of treatment (except in perinatal programs)
Screening Brief questions to trigger in-depth assessment	3-5 threshold questions widely accepted	Screening instruments widely accepted in AOD, but most often used in CWS are biological markers (testing)
Assessment	Five questions form core of assessment process Assessment needs to continue throughout contact with case; risk continues	Moves beyond AOD use to functioning in key life areas: health, crime, employment, psychological status, social/family relationships
Perspectives on Treatment	Wide skepticism about treatment outcomes among perpetrators Victim is not "treated," but provided advocacy/services Family needs protection from perpetrator	Growing reliance on treatment if well matched to client Addict is focus of treatment Treatment outcomes are better with family support, employment, and persons without mental illness
Training	Curriculum exists for inservice training	Curriculum exists for inservice training
Outcomes	Not widely used to assess services effectiveness yet	Growing use, especially in treatment outcomes in managed care settings
Budgets	Focus is upon categorical funding	Moving from categorical AOD-only funding to some wraparound and other sources
Advocacy Strategies	Close ties among national organizations	Rivalries sometimes exist among different modalities and constituencies
Links to CPS	Increasing linkages Mother sometimes seen as cause of "failure to protect" children at risk	Increasing linkages but CPS is primary actor to make linkage at this point Mother who has AOD problem is a risk factor and must satisfy court and fulfill service plan

rate systems, are far less distinct than current practice suggests. For those women who are multiply affected by poverty, mental illness, family violence, and AOD abuse, their own lives are often ample evidence that separate systems cannot deal with interpellated problems; when the focus shifts to the lives of their children, who have often witnessed the violence and other disruptive episodes that accompany these conditions, the impact can be even greater in long-term effects.

There have been several recent assessments of the connections between AOD problems and mental health, including a review of behavioral health and other barriers to welfare-to-work transitions produced by Olson and Pavetti at the Urban Institute in 1996; a Treatment Improvement Protocol issued by the Center for Substance Abuse Treatment, titled *Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse;* and the California-specific guidebook *The Impact of Behavioral Health on Employability of Public Assistance Recipients,* issued by the California Institute for Mental Health [Pavetti et al. 1996]. While none of these places a spotlight on child welfare issues, their focus on the TANF population enables some generalizations about the CWS population as well.

Again, assessment issues are important in developing responses to mental health problems within the child welfare and AOD-abusing population. The standard instruments used for initial screening for mental heath problems are unique to the mental health field, as are those in substance abuse, CPS risk assessment, and family violence. So some parents in the TANF system may be screened five separate times for job readiness, parenting skills, mental health, substance abuse, and family violence.

As one means of responding to this problem, the CSAT protocol recommends use of simple screening techniques to detect the presence of psychiatric disorders, including both a CAGE-type tool for AOD problems and a brief mental status exam for mental disorders. The protocol recommends that "all frontline AOD and mental health staff receive detailed training in the use of a mental status exam and AOD screening tests" [Ries 1994].

Other issues raised by the connection between mental health, substance abuse, and child welfare are the extent to which Medicaid funds reimburse states and localities for mental health treatment, the availability of needed medications for parents with diagnosed disorders, the mix of different skills and training needed in treating substance-abusing and mentally ill clients, and the optimum organizational configuration of a set of services and supports that respond to the problems of clients with these overlapping conditions.

With regard to the last issue, several sources note that mental health and AOD treatment are often combined in state agencies, either in a single behavioral health unit as part of a health department or in a single "superagency" that includes mental health and AOD treatment issues (and sometimes even child welfare) under an overhead agency. One recommendation that emerges from this configuration is for common identifiers in data collection across AOD abuse and mental health treatment. This would obviously enable data matching of those clients with dual disorders with far greater accuracy than is usually possible in separate agencies with separate data bases.

Confidentiality Issues in Working with Other Systems

As CWS and AOD agencies reach out to work with agencies and providers in other systems, the issue of client confidentiality becomes a concern. Though both CWS and AOD agencies must adhere to confidentiality laws, regulations governing the disclosure of AOD treatment information are much more restrictive. Federal law (42 U.S.C. § 290dd-2) and its accompanying regulations (42 CFR Part 2) require federally assisted alcohol or drug programs to strictly maintain the confidentiality of client records. Furthermore, many states have their own confidentiality laws and regulations that also must be followed [Lopez 1994]. An excellent source in dealing with these issues is the publication *Glass Walls,* issued by the Youth Law Center in San Francisco [Soler et al. 1993].

No one disputes that these privacy laws are important to encourage people to seek treatment and protect the release of information that may be adversely used in their professional and personal lives. Yet, such laws and regulations also compound the distrust and lack of communication among the many professionals working with substance-abusing parents and their children. Despite 1986 federal regulatory changes intended to enable substance abuse programs to generate state-mandated child abuse reports, a treatment agency must still protect patient records from subsequent disclosures and not permit them to be used in child abuse proceedings against the patient—unless the patient consents or a court order is issued.

Under specific conditions, sharing of client treatment information is acceptable—for instance, if information is needed within a program to provide substance abuse services to the patient, or if a patient authorizes disclosure by signing a valid consent form. Increasingly, child welfare service agencies that are working as part of interagency collaboratives or case management teams are turning to the use of informed consent forms with their clients. Some providers work out informal agreements that operate as trust builds across agency lines. It should also be noted that sometimes what an agency needs most from another agency are not specific names of clients, but overall totals for purposes of data matching to assess the extent of overlapping—which does not violate anyone's confidentiality. In short, familiarity with confidentiality laws and regulations is essential to any agency working with families requiring substance abuse treatment and prevention.

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