7

Building the Future: Recommendations

Some of the lessons gleaned from the model projects and from recent innovations are about the *external policy environment* of CWS-AOD linkages, such as the importance of community values and norms, the powerful impact of crisis and the media response to crisis, and the wide range of other initiatives going on outside the child welfare system that can influence it, such as welfare reform and community development efforts. But some of the lessons pertain to *internal*, agency-specific issues that bear upon implementation of practices; these include the importance of the conduct of leaders, the development and provision of training, and the prime issue of assessment across and within systems.

Some of the recommendations made in this chapter focus on *policy changes*, such as the budgeting shifts needed to blend funds from both CWS and AOD systems. Other suggestions involve changes at the *practice level*, such as the nature of the actual forms to be used in assessment and the training needed to ensure a connection between new practice and the attitudes and competencies of existing staff. In Table 14, we set out recommendations according to the corresponding element of our policy framework and the related observations.

The First Steps: A Recommended Action Agenda

With these summary lessons in mind, using the six-part policy framework makes it possible to develop a set of action steps that should guide child welfare agencies as they move toward broader CWS-AOD links. Ten steps can be outlined that are critical:

- Make a comprehensive statement of values and principles that goes beyond "motherhood and apple pie" generali-

Table 14. Recommendations for Policy and Practice Changes

The Lessons/Policy Element	The Recommendations
Values Matter	
External crisis drives the values debate at times	Frame the values choices for community-wide discussion, but first assess where the areas of consensus and disagreement are deepest (Collaborative Values inventory)
Diversity of communities; means one size won't fit all	Develop marketing and public education approaches as part of innovation
	Understand the leverage potential of a crisis; market changes in noncrisis times
	Design approaches based on community-specific data on needs and values
Daily Practice	
Assessment as the common bond; staffing options	(See assessment recommendations on page xx)
	Weigh pros and cons of each staffing model
Outcomes and Information Systems	
Innovation and results-based accountability	Make clear that results-based accountability needs a transitional period
Feedback loops increase accountability & threaten workers	Negotiate fair measures as gradual outcomes
Training	
Take staff seriously as partners	Develop explicit line staff and senior manager consultation efforts
Mapping change: find the allies and the blockers	Training reforms for line staff and senior managers
Dealing with senior managers	
Leadership matters	
Budget	
Scope and scale of reform: reversion to categorical pilot projects	Clarify boundaries and key partners, based on data and opportunities for collaboration
	Develop a theory of resources and a redirection agenda
Going from pilots to policy; the filters for choosing strategic pilots	Expand blended funding waivers and permissive legislation
Fragmented financing in categorical, agency-specific patterns	Collect and update annual spending inventories
Service Delivery	
The overlap of AOD and CWS with TANF, family violence, and juvenile justice and mental health	Negotiate specific interagency protocols and memoranda of understanding
	Monitor TANF impact and welfare reform evaluation as special concern area
Which external agencies are key partners?	Data-driven partnerships; get the numbers on overlap
Parallel reforms undermine or reinforce change	Map initiatives in collaboration matrices

ties and that reflects careful consideration of important values issues, such as the following:

- The state/county/city policy on harm reduction;
- The community policy on working toward treatment on demand for all parents who are seeking help and complying with treatment requirements; and
- The community response to the debate about responses to pregnant mothers with AOD problems, ranging from punitive prosecution to encouraging these women to enter treatment without fear of legal action as long as they comply with treatment requirements.

- Develop a public education plan which explains the innovations that will bridge CWS-AOD agencies and which provides substantiation for the actual need for these services—cite data on the parents seeking help and children who will be affected.

- Consider use of the Collaborative Values Inventory (see Appendix A) with key stakeholder groups as a means of assessing consensus and disagreements on values and community norms.

- Review and upgrade local data on the problem as needed. This requires the following:

  - Estimating the prevalence of AOD problems among the different categories of families in the CWS system, as well as the prevalence of TANF and CWS families among current AOD client caseloads, using data matching, case reviews, sampling, and other tools;
  - Documenting the resources—both staff and contract services—devoted to providing AOD services to CWS parents;
  - Reviewing and upgrading the outcomes and indicators used to monitor the effectiveness of AOD treatment for CWS parents; and

  - Developing a local "scorecard" of overall CWS-AOD conditions that could be monitored annually for community-wide signs of progress in addressing the overlapping populations.

- Review current assessment tools for their AOD content and the "layering" effect of different tools to develop blended approaches, with screening done by CWS staff and detailed, follow-on assessment done by AOD staff.

- Design organizational innovation and new staffing patterns based on detailed analysis of the pros and cons of each model as they relate to the specific community involved and the need to work effectively with other collaboratives and parallel initiatives.

- Develop a multiyear funding and staffing plan across agencies that reflects the prevalence (based on data from preceding steps) of AOD problems in caseloads for CWS, TANF, family violence agencies, juvenile justice systems, and mental health agencies. This plan should include the total allocations of AOD slots, if any, for each of these five overlapping population groups.

- Use results-based accountability principles to evaluate and fund provider agencies; accordingly, modify contracts to reflect results-based accountability, allowing for a gradual transition period to enable agencies to move toward results-based accountability with training and support as they do so.

- Review outcomes as they affect the capacity to redirect resources, in which the key question is: What outcomes would convince policymakers to expand pilot programs? Keep issues of scale visible and explicit by asking what percentage of community needs would be addressed by a proposed project.

- Develop a multiyear staff development plan. All Title IV-E funded training should be reviewed in depth to determine whether adequate AOD content is included in training provided during orientation of new employees, as well as "booster shot" training on an inservice basis and whether the training is likely to achieve new competencies sought. Court and law enforcement staff should be included in such training, as well as supervisors and departmental senior managers from both agencies.

Further Reflections on Training Models

If assessment is the key element that helps agencies respond more effectively to clients across the CWS and AOD systems, training is the ingredient that ensures that workers in both systems have the knowledge, skills, and attitudes needed to play such a role. But training is too often treated as a single injection, rather than an ongoing process that may require an occasional "booster shot."

It is critical to involve both line staff and their supervisors in training. As the Sacramento AODTI project team observes:

> The staff realized late in the process that an informational seminar should have been offered for mid-managers and supervisors first. They felt that the project was imposed on them. Although a management seminar was subsequently provided, some residual impact continues to affect change efforts. Significant time must be spent nurturing "buy-in" among supervisors and managers before attempting a system shift with line staff [Klopp 1997].

A sustained dialogue among county-level CWS and AOD officials in California produced a set of training agendas in which both "sides" specified what they thought the other needed to know, which are described in Table 15.

Again, training by itself rarely changes practice. But training as part of the bridge across systems can help agencies become clearer about what they are missing and where they can get it.

Table 15. Proposed Training Agendas

Training Content for CWS Staff	Training Content for AOD Staff
AOD issues: use, abuse, and dependence	How the child welfare system works
How to identify and intervene with AOD dependence	Trends in local CWS and out-of-home care
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 child welfare and other systems
The "four clocks"—different timetables in the other systems	The "four clocks"—different timetables in the other systems

Working with Other Systems: A Review of Recommendations

As discussed in Chapter 6, strengthening CWS-AOD connections is not enough, given the extent to which these clients need other services provided by agencies beyond either child welfare or AOD systems. The most important of these connections are with the TANF system, the juvenile justice system, the agencies that address family violence, and the mental health system.

In working with the TANF population, the two priorities for action must be (1) to document the overlap between the two populations and (2) to seek an allocation of the maximum amount of TANF funding for the CWS/TANF population that now overlaps—or that might overlap in the future. While negotiating these allocations and referral relationships, CWS and TANF units must also work with other agencies in defining the outcomes that will be used to evaluate the effectiveness of welfare reform, especially its projected impact on child abuse and neglect.

For the juvenile justice population, several recent assessments have set out the arguments about "what works." Two critical recommendations emerge: (1) increase the focus on services for children, especially for the middle group of 5- to 12-year-olds; and (2) develop family-focused interventions targeting younger children once they are identified as being at risk as a result of their first contacts with the juvenile justice system and following their identification in the child welfare system.

With respect to family violence, the materials presented in Chapter 6 describe the necessary kinds of assessment, training, and AOD-specific services. The similarities and differences between the two systems as they affect daily practice need to be reviewed in staff training. Again assessment is critical, since separate AOD and family violence assessments are likely to lead to clients and workers both reacting negatively to the duplication and time costs resulting from "layered assessment."

In the mental health system, what is needed is, again, documenting the local overlaps in caseloads. Then, CWS workers must cooperate with mental health agencies to ensure that AOD treatment and mental health services are provided in a complementary way by therapists and counselors familiar with clients with dual diagnoses. Difficult issues of funding streams, time in treatment, and the overlap with TANF clients all challenge CWS and AOD agencies as they try to build their own bridges to each other, while addressing the very real problems of those clients they share who also have serious mental health problems. The priority recommendation for a CWS-AOD-based effort to respond to mental health problems is to document both client needs and available resources in the community.

CASE STUDY

Sacramento County Update. The AODTI remains a vital initiative that is still much more than a training initiative and that addresses several other facets of the CWS-AOD connection. In recent months (as of March 1998) the Sacramento project has moved into a more neighborhood-specific approach, working with two neighborhood service centers where there is a multidisciplinary team and active concern for the AOD agenda. In addition, the commitment to the training portion of the AODTI remains so strong that virtually all of the more than 170 new hires in the Department of Health and Human Services have gone through Level I training. A new "gatekeeper" role has been established in the Bureau of Alcohol and Drug Programs for the purpose of maintaining a current inventory on all treatment capacity throughout the AOD system, which enables all human service workers to contact one staff person responsible for providing accurate information about community providers and available slots. The gatekeeper will also reinforce priority slots for CWS clients. The implementation of welfare reform in the county has adopted several of the key features of the AODTI. Finally, the county has been selected as one of six counties in the state in which new risk assessment tools will be developed, although the degree of emphasis upon AOD issues within those instruments is yet to be determined.

Expanded Funding Versus Improved Systems: Different Kinds of Capacity

It is obvious that for some of the changes proposed in this document, more funding will be needed to increase the number of persons who can be treated and to reduce caseloads to a level where these innovations can be effective. With more than 50,000 specifically identifiable persons in state waiting lists at present, and an estimated 1 million more in need of treatment, compared with the 1.8 million total slots in current publicly funded treatment programs, there remains a fundamental resources question [NASADAD 1997].

Yet expansion of funding for the current fragmented, nonaccountable system, as desperately as these services may be needed,

will be less effective than working *at the same time* to improve the capacity of both CWS and AOD systems to utilize new funding in a newly connected system. As stated in Chapter 4, we believe that improved assessment is a primary prerequisite for system change, without which more funding for today's systems will simply create larger, but still disconnected systems. It is the balance between the system changes and the resource changes that is crucial; we should neither overwhelm today's fragmented systems with new resources nor try to improve capacity in a vacuum while ignoring how much new treatment resources are needed.

As important as they are, greatly improved assessment procedures and staff who are well-trained in their use and motivated to use them *cannot compensate for insufficient capacity and inadequate resources*. Assessment is not treatment. With waiting lists as lengthy as they are today—especially for the family-oriented programs needed for the clients who overlap the CWS-AOD systems—the resources agenda and the capacity-strengthening agenda must go hand in hand.

"Capacity," therefore, means two different things. Expanded capacity needed for implementation of TANF, for example, means that in some states millions of dollars of new funding for support services, including some funds set aside by state policy for AOD treatment, is now moving toward treatment providers whose ability to serve TANF clients has not yet changed and whose beds and treatment slots may not be readily expandable. That is the first kind of capacity: the sheer ability to provide services to more people.

But the second kind of capacity is what this report is about—the ability to work across the CWS and AOD systems (as well as the TANF, juvenile justice, family violence, and mental health systems). We strongly assert that those agencies that are making efforts to become more family-focused, community-based, and accountable for results are those whose treatment slots should be increased first—because they are working on both kinds of capacity improvements.

Once these critical prerequisites are in place, the funding itself must be as broad as the strategies that seek to combine CWS and AOD practice. Funding must be multiagency and multiyear in nature, rather than relying upon a single line item to support CWS-AOD links.

To support these needs with a new categorical line item, in fact, would be a major step backward, since it would divert efforts to blend existing funding toward another round of grant chasing and RFPs for much smaller amounts of money.

Sources that should be included in a serious multiyear, multisource funding strategy are listed below:

- Medicaid;
- The new Child Health Improvement Program legislation;
- Title IV child welfare funds (under federal waivers as appropriate);
- TANF support services—both those funded directly to states and those funded through Private Industry Councils and Family Preservation and Support funds;
- State-channeled formula and project grants under the Substance Abuse Prevention and Treatment Block Grant;
- Discretionary funding under both the Center for Substance Abuse Prevention (CSAP) and CSAT, where community-wide collaboratives are seriously engaged in strengthening CWS-AOD linkages;
- Safe and Drug Free schools; and
- Appropriate state line-item funding available for specific target groups or program modalities, such as adolescent treatment or home visiting linked to AOD services.

Action Needed at the Federal Level

For the most part, this report has focused on action at the community level, with some state policy changes specified. But the previous sec-

tion makes clear that the federal government remains a critical player in several areas:

- Federal budget policy in the area of welfare reform, the implementation of the new Adoption and Safe Families Act governing child welfare, the use of new Title XXI funds in the Child Health Insurance Program, and the future of the Substance Abuse Prevention and Treatment Block Grant all make up part of the financing landscape for CWS-AOD connections, determining the feasibility of blended funding and several of the other recommendations in this report. This includes the authority given to DHHS to grant up to 10 state waivers for child welfare demonstration projects.

- The terms of federal funding, especially funding conditions that require or encourage outcome data as part of reporting or evaluation, can provide major incentives for an accelerated move toward results-based accountability and capacity building among both CWS and AOD agencies.

- Federal research and demonstration programs, notably the currently expiring perinatal grants for treatment programs for pregnant and parenting mothers, have supported several of the models discussed in this report. These programs include some of the best models of CWS-AOD practice, and they should receive federal technical assistance in blended funding that combines CWS, AOD, and other relevant funding streams.

- Federal data collection activities through the several data sets maintained by the various agencies that address child welfare and AOD treatment issues determine a great deal of the available national data and whether they cover children and families in the AOD system or AOD issues in the CWS agencies.

The enactment of the Adoption and Safe Families Act in 1997 affords a unique opportunity to the federal agencies that affect the problems of CWS-AOD linkages. Section 405 of that Act requires the Secretary of Health and Human Services to work with both the Substance Abuse and Mental Health Services Administration and the Administration for Children and Families in preparing, in the words of the legislation:

> ... a report which describes the extent and scope of the problem of substance abuse in the child welfare population, the types of services provided to such population, and the outcomes resulting from the provision of such services to such population. That report shall include recommendations for any legislation that may be needed to improve coordination in providing such services to such population.

This reporting requirement is an opportunity for federal agencies and their interested partners to frame all these issues at a higher level of visibility and to set forth a federal agenda that is proactive and built on the best practices at state and community levels. The federal agencies could themselves model CWS-AOD linkages in developing and disseminating to selected states and communities the authority to blend several types of federal resources. Such funding, which some have called "bottom-up block grants," would enable states or communities to blend portions of categorical funding, as long as those funds are aimed at the purposes of the ASFA legislation and use outcome measures to assess annual progress. (A separate section of the legislation, Section 203(a), calls for further federal attention to CWS outcome measures.) In its work with several states and communities over the past four years, the National Performance Review (NPR) initiative has made efforts at repackaging federal grants and technical assistance. Linking the NPR with the new legislation would raise the priority given to the CWS-AOD agenda within DHHS and other federal departments.

A special mention should also be made of the capacity and responsibility of the federal government to improve data collection. The

Office of National Drug Control Policy, SAMHSA, and the National Institute on Drug Abuse have begun to address some of the weaknesses in current federal surveys and other data collection efforts that hinder accurate estimation of the prevalence of CWS-AOD problems. This is an opportunity to ensure that a particular focus on children is included in each of the surveillance and outcome monitoring systems maintained by the federal and state governments. We recommend wider collection within AOD information systems of data on the children of substance-abusing parents.

Conclusion

As stated previously, an obvious paradox in child welfare services is that working with service systems beyond the traditional parameters of child welfare has become the only hope for success in achieving the goals of the child welfare system. That paradox—that success for many of the children and families *in* the child welfare system can only come from working with services and supports from *outside* CWS—is at the heart of our recommendations for continuing the efforts to strengthen the links between CWS and AOD services. The success of those efforts will affect millions of families and their children, and the potential savings in resources will more than repay the investment needed.

But recognizing the importance of external players does not reduce the accountability of the child welfare system for its own actions. Nor does it reduce in any way the demands of leadership that the child welfare system itself must provide in rallying external resources. Seven years ago, the CWLA Commission on Chemical Dependency and Child Welfare concluded its report, *Children at the Front,* with this call to action:

> Child welfare and other health and human service agencies must become actively involved in our nation's efforts to prevent alcohol and drug problems and to better address problems when prevention efforts fail....The Commission challenges the policies and practices of current national and state

efforts and the policies and practices of many child and family agencies [CWLA 1992].

We must remain true to that challenge and work on both practice and policy in the child welfare system, as the 1992 report proposed. We must keep in view the lessons drawn from the best projects described in this report and the knowledge of the terrible losses we will suffer if another generation of children affected by alcohol and other drugs is left without the help they need. This is not optional work to be done after the basic operational tasks of child welfare agencies are finished; it *is* the basic mission of the child welfare system as it responds to the needs of millions of children and their parents.

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