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What Addiction Professionals Need To Know About Welfare Reform and Child Welfare

By Bart Grossman and Laurie Drabble

Editor's note: The following is an excerpt from a talk presented by Bart Grossman, Ph.D., at the Pacific Southwest Addiction Technology Transfer Center conference, "Child Welfare and Addiction Services: Working Together for California's Children and Families," held in San Diego on November 9 and 10, 1998. Grossman is an adjunct professor of social work and director of field instruction at the University of California Berkeley School of Social Welfare. Laurie Drabble, Ph.D. (Candidate) at the University of California Berkeley School of Social Welfare, provided research assistance in the preparation of the paper.

Families Involved With Drugs

The general Temporary Assistance for Needy Families (TANF) population is about 13 million nationally, which translates to about 4 million adults. It is estimated that around 10 to 15 percent are drug and alcohol involved. The child welfare population is much smaller, with about 450,000 kids in care. Maybe twice that number come into contact with the child welfare system at some point. But statistics reveal that between 60 to 80 percent of these families are substance involved.

Both of these groups are increasingly considered priorities for Government-supported drug treatment. Meeting their needs will require some significant departures from the ways in which alcohol and drug services have been provided resulting in some different models of interaction between the drug and alcohol system and other public and private social services.

When they are trained, addiction professionals must be taught to serve new populations, to work in new contexts, and to manage new realities. The growing emphasis on services, and therefore funding, for substance-involved families creates opportunities. But these opportunities aren't without costs. The costs will include significant change in the organization of services.

Many of the models and approaches that have been central to drug treatment will need major revision. Instead of serving individual adults whose energy can be completely harnessed to the tasks of recovery, the Alcohol or Other Drugs (AOD) system should more effectively serve families with multiple problems and demands. Those families—primarily single mothers and kids—bring a broad

array of problems and pressures such as housing, employment, mental illness, crime and delinquency, physical illness, development delay, learning disabilities, family conflict, domestic violence, and others.

To address these problems, drug and alcohol treatment professionals will increasingly need to function as members of multi-system, multi-professional teams. It won't work to dig a moat around the therapeutic community or to see the other agencies—welfare, child protective services (CPS), and county mental health—as a bunch of incompetents who just don't understand addiction. If you are in the drug and alcohol field, increasingly the problems of these other systems will be your problems, their constraints will limit your freedom, and their resources will pay your salary.

So what do AOD professionals need to learn to be effective in this new climate? What do AOD professionals need to know about CPS and TANF and about substance-involved kids and families?

CPS and TANF

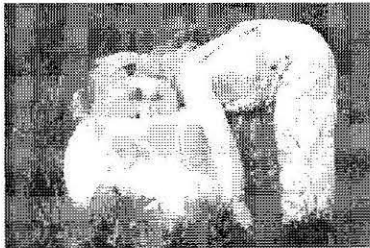
Asking what AOD professionals



need to know about TANF and CPS might be seen by some in the field as unfair. After all, what do CPS and TANF workers know about drugs and alcohol? Unfortunately, the answer to that is generally "not much."

But that situation is changing rapidly. State and county social services administrators all over the country are moving to require that their workers receive pre-service and in-service training on drugs and alcohol. The quality, the scope, and the objectives of this training vary widely.

In those communities in which AOD workers have a basic understanding of the child and family agency, the existence of this training may foster more effective collaboration between these systems. However, where AOD workers are not prepared to understand and respond to the needs of the child welfare and TANF systems, clients will experience an



accelerating squeeze between the assumptions of treatment and the demands of the social services systems. Clients will get hurt and the potential contribution of the AOD system will be blunted.

Child Protective Services

The first thing AOD professionals must understand is that CPS operates according to a rather rigid legal clock. Workers have some discretion but not a great deal, and they have to answer directly and continuously to family and juvenile courts. When CPS workers say a



family visit is needed or a client needs to be evaluated for reunification, they aren't just being difficult; they are following the law and usually a judge's orders.

Current child welfare practice is driven by the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272), as modified last year. The goal of this act was to correct the longstanding problem of foster care drift by getting children out of placement and into a permanent family as quickly as possible.

Under the law, where possible, removing children from their homes is to be prevented by offering services to strengthen families and prevent continuing abuse and neglect. Where children are at risk they are to be removed to foster care.

The CPS agency is responsible for making a reasonable effort to reunify the family, offering a variety of services including drug treatment. But the goal is to get the children permanently settled as soon as possible. Last year, Congress decided that in too many cases the emphasis on family preservation was resulting in kids staying in foster care too long. As a result, the child welfare agencies now face tighter time frames, essentially 1 year—a 6-month

initial hearing and then a 12-month permanency hearing.

So the event horizon for child welfare is 6 to 18 months. This child welfare clock is often at odds with an AOD timetable sometimes described as "one day at a time for the rest of your life," according to Nancy Young of Children and Family Future. Addiction is a chronic, relapsing condition that is not quickly or easily overcome.

The course of treatment can easily be exacerbated if the drug treatment agency and the CPS agency become involved, as too often occurs, in a soccer game with the client as the ball. Struggles over confidentiality, over visitation, and over drug testing may be disturbing for workers but they can have devastating consequences for a family. The AOD professional working with a mother in the child welfare system has to see that the client is a family and the intervention has to be far faster and broader in scope than traditional drug treatment.

Constraints and Consequences of TANF

TANF represents another set of constraints and consequences. TANF replaced the old Aid to Families With Dependent Children (AFDC) program after the long welfare reform struggle. The



assumption of TANF is that financial assistance is a temporary thing until people are put to work. While the Federal law allowed 24

months of assistance each time with a lifetime limit of 5 years, California established a one-time limit of 18 months.

Because the goal is to get people to work—there are both penalties and rewards for the State and counties based on their success with this goal—the California legislature recognized that substance abuse would be a problem. With the skillful intervention of California Assembly member Dionne Ahroner, funds were earmarked specifically for drug treatment for TANF parents, and the welfare agency is authorized to stop the TANF clock for 6 months on top of the 18 months for a client in treatment.

Now 6 months may not seem like much, but in the context of this rather punitive law, it is a very big deal. Many TANF parents face tight time constraints—they get 6 months to recover enough to look for work and then 18 months to find a job or lose TANF supports such as medical care, child care, and a housing allowance. Child welfare parents get 12 months to recover sufficiently and to be eligible to be reunited with their kids, and for most of these the TANF clock will also be ticking.

Service Implications

What are the service implications? The old standard, individually-focus residential program just isn't going to be enough, in most

instances, for this population. If addicted moms are to be successfully reunified, they will need to be separated from their kids for as short a time as possible. And we will need programs that can house and treat whole families.

If TANF recipients in recovery are to be given the support they need to find and keep jobs, they will need support that is sensitive to the special issues and pressures they face as substance abusers. In short, addiction agencies that serve this population will need to see the client not as just an individual addict, but as a substance-involved



family. Moreover, they must be prepared to offer or broker a wide array of services including employment searches, work skills, housing, education, childcare, and health services.

Only a handful of settings exist where an addicted mother can take her kids into treatment with her—where she won't have to choose between her identity as a mother and her identity as a substance abuser. Kids from poor, substance-involved families can do well, but

they may bring a wide range of medical, emotional, and behavioral problems. They need structure, health care, treatment, education, stability, and continuity. Getting a mother into treatment, offering a friendly smile, and providing some crayons just won't cut it.

Making Leaps

The leaps that will be required of the AOD system and its workers in responding to the needs of poor families in the TANF and child welfare system are prodigious. There is an immediate need for more autonomous AOD professionals who have a firm grasp on their expertise and who have the ability to communicate effectively across the jargon gaps between our various systems.

Although their specialty area is drugs and alcohol, we need professionals who can see addiction and drug involvement as part of people's stories and not as the only thing that really matters.

The AOD system needs to learn how to create and sustain programs that meet the special needs of women and children, that can adapt to the child welfare and TANF time clocks, and that are family-friendly in structure and communication.

The opportunities for AOD professionals to be involved to be part of the solution for poor families in the public services are opening quickly, but they can also close quickly if AOD is unable or unwilling to respond.