

# Reaching Out

CURRENT ISSUES FOR CHILD WELFARE PRACTICE IN RURAL COMMUNITIES

FALL 2006



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## The Growing Problem of Alcohol and Drug Abuse in Today's Child Welfare System

By Susan Brooks, Director, Northern California Training Academy, The Center for Human Services, UC Davis Extension

What would the field of child welfare look like if there were no such thing as alcohol or drugs? Can you even imagine it? No clients would show up for meetings under the influence. There would be no family violence because of reduced impulse control brought on by substance use. Children would not be born with positive toxicology tests and the subsequent effects of in utero drug or alcohol exposure. Children would not be victims of chronic neglect that often accompanies addiction. Children would not be exposed to the dangers of living in "crack houses" or homes with meth labs. Substance abuse would not be another area in which rural counties struggle to find and allocate scarce resources. If there was a world without substance abuse, how many families would even require the help of Child Protective Services?

It is almost impossible to visualize this world. Substance abuse is the biggest issue impacting child welfare. Some counties estimate that 85 to 90 percent of the families involved with child welfare are also struggling with the problems of substance abuse. This statement,

however, shows one of the many challenges of working with the issue of substance abuse in child welfare. Even though it is so prevalent, it is not an area in which the state systematically collects data. Apart from people's experiences in the field, we don't actually know how many families in child welfare are living with the impact of substance abuse. This means that county child welfare programs can only react to crises with substance abuse rather than anticipating them. We can't see coming trends. The methamphetamine epidemic is one good example.

The good news is that we know a lot about how to help families who are caught up in the vortex of substance abuse. From years of research and treatment, we know that the most successful strategy is to treat the whole family: the user, the spouse, the children and the community. We know what the stages of recovery from substance abuse are and how to help with each.

In this issue of Reaching Out, you will read about some successful programs in Northern California. You will also hear from a number of national and state experts on substance abuse. And, you will hear from clients and staff about how treatment works on the ground. Inside, you will also find a "Drugs 101 chart" to use as a reference tool

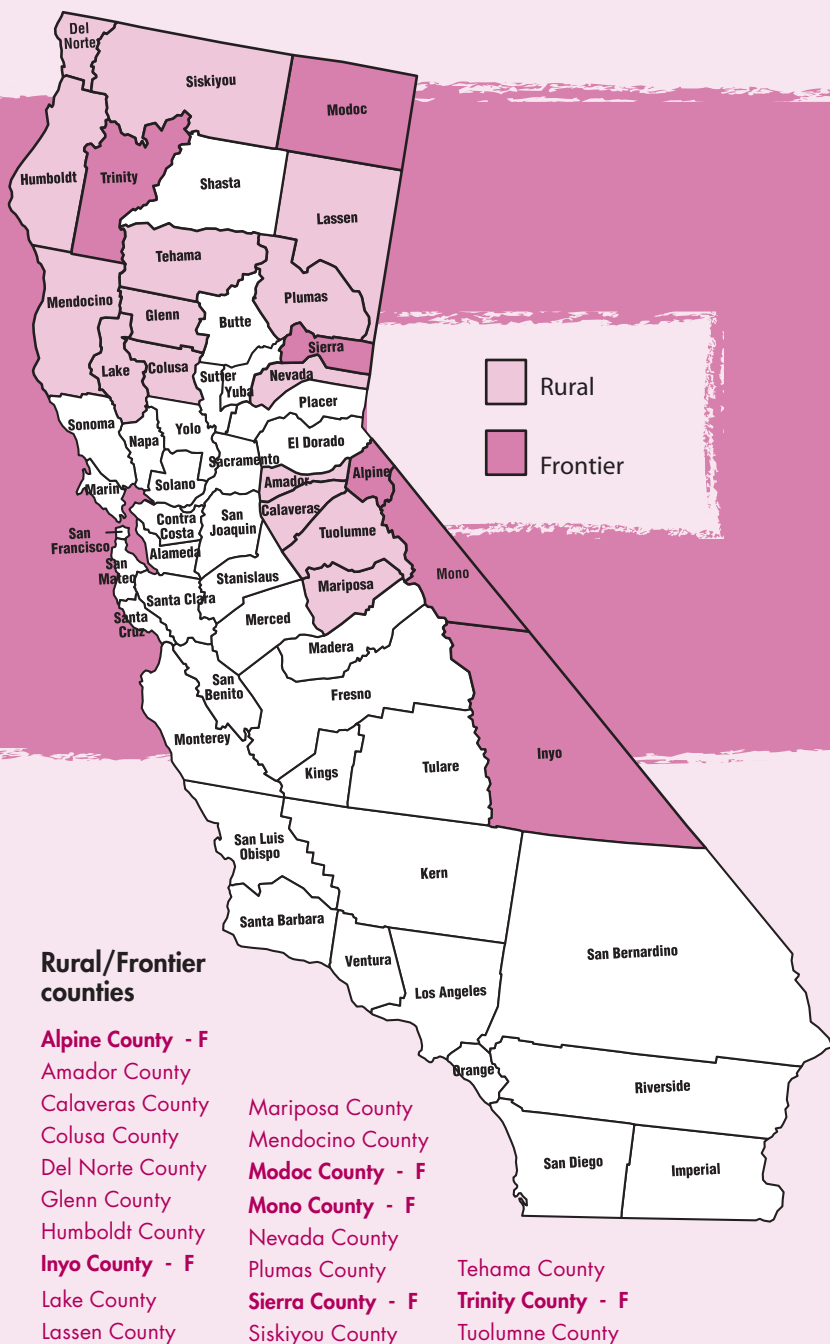
We hope you enjoy this issue of Reaching Out.



## Rural Counties Defined

The definitions of rural are different depending on who is doing the defining and why. We are using the definition of “rural” used by the nationally-renowned *Annie E. Casey Foundation* in its 2004 publication *City and Rural KIDS COUNT Data Book*. That definition is as follows:

“Rural areas are the sparsely settled areas and the small towns outside metropolitan areas. Like the previous definition, it is county-based: an entire county is either inside or outside a metropolitan area. A metropolitan area has an urban core of at least 50,000 residents... Any county that is not inside a metropolitan area can be referred to as non-metropolitan. All non-metropolitan counties are included as rural.”



## AOD Terms and Acronyms

**AOD:** Alcohol and Other Drugs—the current term for the substance abuse field. This new term reflects the shift to the belief that alcohol is another drug and not a separate entity.

**Co-occurring disorders, dual diagnosis:** A diagnosis of mental illness and a substance abuse addiction. Some treatment facilities offer treatment for both mental health and substance abuse services in one setting.

**DEC:** Drug endangered children are “those children who suffer physical or psychological harm or neglect resulting from exposure to illegal drugs or persons under the influence of illegal drugs or exposure to dangerous environments where drugs are being manufactured or chemicals used to make drugs are accessible.”

**FASD (FAS, FAE):** Fetal Alcohol Syndrome Disorder. Fetal Alcohol Syndrome. Fetal Alcohol Effects. The most current umbrella term for the medical and psychological effects of being exposed to alcohol in utero.

**Medical Model:** One of two general models for substance abuse treatment. Along with counseling and peer support, these programs usually include a detox facility and medical staff who can prescribe drugs to help ease the detox process.

**Social Model:** The other general model for substance abuse treatment. This includes counseling and peer support. There is generally no medical staff in the program.

**Positive Tox Screen:** A positive result on a toxicology test. Using urine, blood or both, the toxicology test looks for the presence of alcohol, drugs and other toxic substances in a person’s system. A positive result means that there was a measurable amount of drugs or alcohol in the person’s system at the time of the test. This is often used on newborns to show if a mother has recently taken such substances, but for a more complete prenatal history of drug exposure, doctors have to analyze the infant’s hair or meconium (the infant’s first stool).

Information from the Population Reference Bureau, Washington D.C., is based on 2000 U.S. Census data

## Research Study Explores Values and Collaboration Between Child Welfare and Substance Abuse Treatment Fields

*By Laurie Drabble, Ph.D., M.S.W., M.P.H., Assistant Professor, San Jose State University School of Social Work*

Although recent research has highlighted the importance of “bridging the gap” between child welfare and substance abuse treatment delivery systems, few studies examine specific factors that may facilitate such collaboration. A recent study funded by the California Social Work Education Center examined similarities and differences in values and perceived capacity for collaboration between substance abuse and child welfare fields based on the experience and perceptions of over 350 respondents in 12 California counties. Respondents included managers, supervisors and line staff in child welfare and substance abuse treatment fields from the following counties: Contra Costa, Glenn, Humboldt, Merced, Napa, Sacramento, San Diego, San Joaquin, San Luis Obispo, Shasta, Stanislaus and Tehama.

Similarities and differences in values between substance abuse and child welfare fields were explored based on findings from the Collaborative Values Inventory (CVI). Differences between counties with a history of formalized collaborative programs and policies were compared to counties earlier in the collaborative process using a Collaborative Capacity Instrument (CCI). Both instruments were developed by Children and Family Futures. A few of the study highlights include the following:

- There was a near unanimous consensus between respondents from both child welfare and substance abuse fields in several areas related to planning, such as the importance of addressing both substance abuse and child welfare issues, which may be a pivotal starting point for growing collaborative efforts.
- Some differences in perceived strengths and weaknesses in service delivery systems underscore the importance of developing mechanisms for better communication and collaboration across fields in relation to shared case planning. For example, the study found that child welfare professionals were significantly more likely to agree that confidentiality of client records represented a substantial barrier to cooperation between systems.

- Other differences between fields point to the importance of values clarification and development of shared principles. For example, respondents from the alcohol and drug field were both more likely to define chemical dependency as a disease and to agree that parents who use, abuse or depend on drugs cannot be effective as parents. This finding suggests that development of policies and protocols for practice might require addressing fundamental exploration about how different stakeholders conceptualize the process of addiction as well as “effective” or “ineffective” parenting.
- Counties with established formal collaborative policies and practices compared to counties earlier in the collaborative process were more likely to report employing a number of collaborative practices. These practices, which ranged from use of multidisciplinary teams for case planning to use of multi-year budgeting to plan for integrated services, might be of interest to counties or regions interested in initiating or advancing their own collaborative practices.

*For example, respondents from the alcohol and drug field were both more likely to define chemical dependency as a disease and to agree that parents who use, abuse or depend on drugs cannot be effective as parents.*

A training curriculum, based on some of the findings from the study, was recently posted on the CalSWEC Web site: [http://calswec.berkeley.edu/CalSWEC/Library\\_Pubs.html](http://calswec.berkeley.edu/CalSWEC/Library_Pubs.html). This curriculum provides research highlights, conceptual frameworks, tools and experiential opportunities to strengthen participant understanding of the relationship between substance abuse and child welfare and capacity to work collaboratively across fields. The primary audiences for this curriculum are IV-E students and entry-level child welfare professionals. However, many of the sections may be used or adopted for students or professionals in a variety of disciplines and levels of experience who may work in any way with issues of substance abuse and child maltreatment.



# Tips for Working with Clients Struggling with Chemical Dependency

While every child welfare client's combination of history, circumstances and outcomes is ultimately unique, those who suffer from drug or alcohol abuse share a common thread—a need for recovery and a guide to point them in the right direction. Below, experienced practitioners share what they believe to be the most important things to remember when working with clients struggling with addiction:

1. If a client is abusing alcohol or other drugs, this is the first issue that needs to be addressed. Until a client receives treatment for chemical dependency, he or she cannot deal with other issues in the family, including child abuse or neglect.
2. Substance abuse is a family issue. Successful treatment for substance abuse must involve the whole family.
3. The timelines for child welfare and recovery from chemical dependency are not compatible. A client in the child welfare system has a maximum of 18 months to accomplish a significant number of tasks including obtaining stable housing and, perhaps, a job. It can take a person in recovery from substance abuse about a year to get him or herself stabilized in a sober life.
4. The average wait time for someone to get into a recovery program in California is three months.
5. Most substance abuse recovery programs do not have accommodations for children.
6. Relapse is an expected part of recovery from substance abuse. It is not a treatment failure.
7. Recovery from substance abuse involves a series of distinct stages:
  - pre-contemplation: no admission of a problem, lots of denial, person is actively using.
  - contemplation: person realizes there is a problem and starts to think about how to deal with it.
  - preparation: person collects information, explores options.
  - action: person tries new behaviors, sees patterns of old behavior, works on making a change.
  - maintenance: (at least six months or a year after sobriety depending on the person and the substance) change is maintained more easily, but vigilance is still required to avoid slips.
  - relapse: a slip back into using. After a relapse, the person usually goes back to the action stage.
8. Recovery from chemical dependency is a lifelong process.

*Stages of recovery cited from work done by James O. Prochaska. Thanks also to Linda Carlson, Executive Director of Women's Recovery Association.*



## Humboldt County Mental Health Partners with Local PBS Station

*By T. Craig Hill, MFT, AOD Senior Program Manager*

Methamphetamine Community Awareness is the subject of a recent grant from Sound Partners for Community Health to KEET-TV and the County of Humboldt Department of Health and Human Services. KEET-TV became interested in this competitive national grant program of the Benton Foundation and collaborated with the Department of Health and Human Services in Humboldt County on a proposal to develop a community awareness film about methamphetamines (cited by Humboldt County Public Health Administrator, Ann Lindsay, M.D., as the biggest public health problem in the county).

Funded by the Robert Wood Johnson Foundation, the KEET-TV/ Humboldt County DHHS collaboration was among the 26 public radio stations and 10 public television stations and their local partners who collectively received a total of \$1.7 million in grant awards. KEET received \$60,000 with matching funds from the California Endowment to produce two documentaries. The first documentary, titled "Life after Meth: Facing the Northcoast Methamphetamine Crisis," focuses on the community impact of methamphetamine on individuals, families and communities in Northwestern California. The film includes the perspective of meth addicts who are struggling with recovery and those who have had years of successful clean and sober living. It also features local community members and leaders who speak about the devastating effect of this drug, and what some citizens are doing to take back their neighborhoods. This documentary provides an avenue for classroom and community discussions that help provide hope for changes necessary to overcome this dangerous societal problem.

A second documentary, "Speak Up," was created for teens by teens in cooperation with Zoe Barnum Continuation High School. With assistance from the Del Arte Theatre, the students created an anti-meth skit which was performed at numerous community screenings of the documentaries. Radio stations KHUM and KSLUG in Humboldt County also produced compelling on-air programming to address the methamphetamine problem plaguing the community. Both documentaries were initially shown May 2, 2006, with future national airings on PBS this fall.

*Interested parties may contact Jim Pfingstel of Humboldt County DHHS at (707) 269-4160 to receive copies of the documentaries to use in training classrooms.*

# Breaking the Cycle: An Interview with a Former Foster Child and Drug Addict

By Kristin Mick, UC Davis Extension

Stephani Durden's recent graduation from college was truly something to celebrate. Not because she boasted a 3.89 grade point average and earned high praise from her instructors. That was merely icing on the cake.

At age 37, Stephani's life has followed a tumultuous path. She knows what it's like to be a child abused and abandoned by her parents, a foster care runaway, a drug addict, a homeless mother of five children (one was removed from her custody at birth), a recovering addict, a mentor, a working student and a doting grandmother.

At 12, when most adolescent girls are thinking about boys and lipstick, Stephani found herself thinking about where she would find her next meal and where she would sleep for the night. Running away from home seemed to be the only option to escape the abuse. Ultimately, she was picked up and placed in the foster care system—where she spent the next year and a half in five foster homes.

"Some of the foster parents had their own kids, and there was favoritism," she remembers. "In one home, there was a separate refrigerator for the foster parents and their own children. It had a lock on it. That's where all of the good food was kept. The other refrigerator was for the foster kids."

Unfortunately, her social worker was not there for her, either. When she and her foster siblings called CPS to report the neglect of the "locked refrigerator," the social worker informed the foster mother that she would be paid a visit. Of course, there were no locks to be found when the social worker arrived, and the foster children were accused of lying.

Turning to drugs seemed like the only way to numb the pain and isolation Stephani felt every day. Once she graduated from high school, she was out of the foster care system and on her own...scared, addicted and alone. She became involved in relationships wrought with domestic violence.

"I used to do a lot of meth, weed, alcohol and pills—they were my cycle to get through the day by self-medicating," she says.

After years of struggling to make ends meet, raise her children and get sober, Stephani finally entered a six-month out-patient drug rehabilitation program in Napa in 1998. The children stayed with her husband during the first 90 days of treatment. After that, Stephani completed her time in rehab at the Napa Emergency Women's Shelter—where she was able to get her children back and leave an abusive marriage.

"I did not want my kids to go into the foster care

system," she says. "I knew I had to be there for them unconditionally. After I got my kids back, CPS was a part of our lives for about two and a half years. It was rough having them there—interviewing my kids...doing drug testing on me. The good thing that came out of this experience, though, was that they always kept the kids' best interests in mind."

"I have spent the last several years trying to break the cycle. I have to teach my children what's right by example," she adds. "Today, I am in a loving relationship and enjoy the good things in life. I will always remember where I came from and continue to grow everyday."

Now that Stephani has graduated from college, she plans to continue her education by entering Sacramento State University's MSW program. She also works as support staff at Volunteers of America in Sacramento. The clients are homeless, and many have lost their children.

*"I have spent the last several years trying to break the cycle. I have to teach my children what's right by example."*



"I can give them empathy. But also, I am careful about what I tell them," Stephani explains. "Most of them are struggling now, but I tell them 'Just because you're homeless today doesn't mean you'll be homeless tomorrow.'" Stephani knows this all too well.

Stephani enjoys working at Volunteers of America because she says she feels like she's making a difference.

"I'd like to one day open my own center for transitional living—a place where people can be with their children."

Having been through the child welfare system as both a foster child and a CPS client, Stephani has some advice to offer social workers: "As a social worker, you are the most important link in a child's life. Don't be judgmental—really listen to what they have to say. Also, make sure the kids are prepared for the real world. Be loving and supportive—a little bit goes a long way."

Stephani also urges social workers to realize how important they are in children's lives. "The social worker is the light at the end of the tunnel for these kids. They can make or break a child's future."

Last year, more than 36,000 children were placed in foster care in California. Stephani is just glad that her children are not among them.





## Working with Child Welfare Clients: Challenges Facing Staff in Substance Abuse Treatment Programs

By Sabina Mayo-Smith

There are four major challenges when working with people who are struggling with substance abuse issues and are also child welfare clients working to reunify their families, according to Linda Carlson, executive director of the Women's Recovery Association. Carlson, who has been working in the field of substance abuse treatment for the last 25 years, notes the following challenges: 1) conflicting timelines between recovering from substance abuse and working to reunify one's family, 2) the role of relapse in the reunification process, 3) the challenge of creating and continuing programs that work well with women who are also working with child welfare, and 4) funding.

The timelines for recovering from substance abuse and for reunifying one's family are fundamentally incompatible. It may have even worsened with the tightening and reduced flexibility of reunification guidelines for child protective services. Carlson says she understands the need to make sure that children are in safe, nurturing environments, but she also understands the needs of women in recovery and feels that the women who are trying both to get sober and get their children back might be "set up" to fail by the current system. Carlson says the timeline for recovery is approximately one year to stabilize one's life and function effectively as a sober person. Child welfare clients receive only 12 to 18 months to turn their lives around in order to reunite with their families. And for clients with children under age three, they have only six months to meet the child welfare requirements. Their tasks with child welfare may include substance abuse treatment, getting a job, finding stable housing and taking a parenting class. With this 12- to 18-month clock, people who are working to get and stay clean and sober may also have to simultaneously take on other large life tasks.

The relapse stage of recovery from chemical dependency happens when someone who is clean and sober starts using and abusing alcohol or other drugs again. According to Carlson, far from meaning that the person has failed, relapse is a natural part of the recovery process. However, there is almost no room for a relapse in a child welfare reunification plan. The parent usually has one chance to get and stay clean, and this is often monitored with drug tests. A court wants to hear that the child welfare client has checked "Get Sober" off her to-do list. Often in the case of a relapse, the plan is over, and the parent loses her child.

The programs that best help women recover from substance abuse and work on their plans for reunification are residential treatment programs that can accommodate the reunification while the client receives substance abuse treatment. For this, the program needs to have a facility that houses and treats women and their children. These programs can offer families a predictable, safe environment, good role models and lots of opportunity to practice what they learn. They can also provide services in the context of recovery. For example, women can take a parenting class that addresses both the issues that typical parents confront and the special needs of parents in recovery. We note this as the third challenge because these programs are expensive and more complex to operate.

Finally, there is the chronic problem of funding for substance abuse treatment. Carlson notes that there have been some good pieces of legislation passed in California but that many times there has been no money set aside. One example is Proposition 63, the Mental Health Services Act, which passed in November, 2004. One of the tenets of this act is that people who have co-occurring diagnoses of mental illness and chemical dependency should receive integrated services that address both, but there is no funding allocated for the substance abuse side of this problem.

What's going well? Carlson says she has seen some improvement in the last few years, particularly in the identification of pregnant women who are abusing alcohol or other drugs. She says these women are getting into treatment much earlier in their pregnancies than before. Carlson also says that for the most part, CPS social workers do their best to work effectively with substance abuse treatment programs that are helping their clients stay clean and sober and the clients who are trying to reunify their families. She cites the presence of multi-disciplinary teams who case manage families as being an effective model. When money allows, these teams include members from Child Protective Services, Mental Health and substance abuse treatment working together with a family. And, finally, Carlson adds that seeking treatment for chemical dependency seems to be somewhat less stigmatized than it used to be.

## Child Welfare and Treatment Providers Collecting and Sharing Information While Maintaining Confidentiality

When child welfare agencies and substance abuse treatment providers collaborate for the benefit of children and their parents, the result is improved outcomes for families. Crucial aspects of collaboration are the collection and sharing of information while maintaining confidentiality.

### Data Collection

It is a tremendous benefit when agencies collect data accurately, consistently and in a manner that allows that information to be compared with information provided by other agencies. For this to happen, the agencies need to collaborate about their data gathering procedures and systems; they need to agree on terminology and establish compatible databases and carefully consider what information is needed to provide an accurate picture of the overall situation.

### Information Sharing

When a parent is in AOD treatment, child welfare and the courts need information about that parent's progress in order to make sound decisions about safety, well-being and permanency. Additionally, the treatment provider needs information about the child so that treatment can be tailored to include issues related to abuse or neglect.

### Confidentiality

In this process, confidentiality becomes a critical issue. Each agency operates within strict federal, state and jurisdictional guidelines that specify how information can be shared, and families have a legal right to expect that their information will be kept confidential; however, it is possible to develop policies that allow the agencies to share information without violating legal or ethical standards.

Collaborating agencies can establish a standard interagency protocol for sharing information. Perhaps the most useful strategy is a consent form signed by the parent that allows specific, limited information to be shared with appropriate entities. Jurisdictions can develop a common consent form to be used by all agencies, or they can use federally-approved consent forms (see Resources section) Any information that the parent allows to be disclosed must be used to help the agencies collaborate for the best outcome for the family; it cannot be used to create a fear of reprisal, which would hinder the sharing of information.

### Conclusion

The implementation of solutions to information challenges depends on a high degree of cooperation and communication among child welfare professionals and treatment providers. Some California counties (Sacramento and San Diego, for example) have met these challenges, and as a result, the children and families they serve have benefited.

*Adapted from an article by the Children and Family Futures staff.*

*For more information, go to the Children and Family Futures Web site at [www.cffutures.org](http://www.cffutures.org).*



## Social Workers Have Options for AOD Education

By Kristin Mick and Sabina Mayo-Smith

Learning to work with families who are struggling with addiction issues is an important competency for staff in child welfare. As a result, child welfare practitioners need to understand the basics of what drugs do, the dynamics of substance abuse and recovery, the impact of these issues on the family, and how addiction effects parenting and child development, just to name a few.

Education in the area of chemical dependency comes from a number of sources. In fact, a survey conducted by the National Association of Social Workers in 2000 found that practitioners got their information about working with families struggling with addiction from the following sources: academic coursework, continuing education courses, field placement, clinical supervision, volunteer work and other sources. (See table below)

### Substance Abuse Education and Training

Field Placement	16%
Clinical Supervision	24%
Formal Coursework	38%
Continuing Education	68%
Volunteer Work	5%
None	18%
Other	12%

California's L.C.S.W. licensure standards require training in alcohol and drug addiction. The Council on Social Work Education strongly supports this curriculum in both undergraduate and graduate programs. The purpose is to meet the need in our region for social work practitioners who are knowledgeable in the area of alcohol and drug abuse. In the north state, the three California State Universities with schools of social work all offer courses that educate students on issues of chemical dependency, but their approaches vary.

Second-year MSW students at CSU Chico must take Substance Abuse: Foundations for Social Work Practice. This course examines the incidence of chemical dependency and its impact on individuals, families and society. It addresses pharmacological properties and physiological, psychosocial and cultural aspects of substance use, assessment techniques, and models of interventions and treatment.

"Failure to identify alcohol and drug issues leads to incorrect problem analysis and inappropriate interventions with individuals, families and communities," explains Sue McVean, L.C.S.W., who teaches in the MSW program at Chico State.

Students studying social work at CSU Sacramento are not required to complete coursework on AOD issues, although electives are offered at both the undergraduate and graduate level. However, CSU Sacramento's specialized Title IV-E Training Program now requires students to complete eight hours of AOD training—along with scheduled trainings in mental health, domestic violence and conflict resolution—prior to starting that program.

"The Title IV-E training is designed to provide an introduction to the kinds of situations that students might face during the intern experience," says Jim Bowie, assistant professor and project coordinator of the Title IV-E Program at CUS Sacramento.

CSU Humboldt offers a graduate-level course for second-year and advanced-standing MSW students which helps them develop assessment skills, treatment planning skills, primary and secondary intervention skills, and policy analysis and development skills related to alcohol and drug abuse. Students also cover significant material on the policy and practice components of harm reduction, according to Ronnie Swartz, BSW program director at CSU Humboldt. In particular, students learn how to assist people in reducing the harm alcohol and other drugs pose to individuals and families, while working for policies that minimize harm to drug users. The school also offers an undergraduate version of this course which focuses more on the history and effects of various common drugs of abuse, the history of U.S. drug policy, and basic skills in prevention and treatment.

As demonstrated by the NASW survey, much of the education on this topic takes place in continuing education settings rather than through formal academic coursework. Many university extension programs have extensive course offerings on substance abuse treatment. For example, the Center for Human Services at UC Davis Extension offers more than a dozen courses on specialized AOD topics such as substance-abusing parents, drug-exposed infants, treatment for adolescent addicts, multicultural aspects of substance abuse and more.

The California Association of Alcoholism and Drug Abuse Counselors (CAADAC) offers individual courses as well as the following certification programs: Certified Prevention Specialist, Certified Alcohol and Drug Counselor I & II and Certified Clinical Supervisor. For more information, contact CAADAC at (916) 368-9412 or go to [www.caadac.org](http://www.caadac.org).



## Clearinghouse on Evidence-Based Practice for Child Welfare Established

Child welfare is increasingly handled by incorporating evidence-based practice into everyday use. Practitioners see EBP as a way to maximize resources and improve service to children and families using the best information available. Programs and services are now bolstered by research, whereas previous models were based more on tradition—with less focus on outcomes.

The California Evidence-Based Practice Clearinghouse was created to help keep state and county agencies, public and private organizations, and individuals informed of current best practices. The clearinghouse rates various programs using two different scales. The first is a scientific scale that rates programs on how strongly they are backed by research. The most recent ratings are as follows:

**1.** Well-supported, effective practice

*Example:* Motivational Interviewing (MI)

**2.** Supported, efficacious practice

**3.** Promising practice

*Examples:* Alcoholics Anonymous (A.A.), Community Reinforcement Approach (CRA), Community Reinforcement + Vouchers Approach (CRA + Vouchers)

**4.** Acceptable, emerging practice

*Examples:* Reno Family Drug Court, Substance Abuse Recovery Management System (SARMS), Specialized Treatment and Recovery Services (STARS), Nurturing Program for Families in Substance Abuse Treatment and Recovery

**5.** Evidence fails to demonstrate effect

**6.** Concerning practice

The second scale relates specifically to child welfare. The three-point child welfare scale explores whether the program or model in question was intended for families involved in the child welfare system. The child welfare ratings are based on peer-reviewed studies and take into account safety, permanence and child and family well-being.

On the child welfare rating scale, a low number indicates a high relevance to children and families who are a part of the child welfare system.

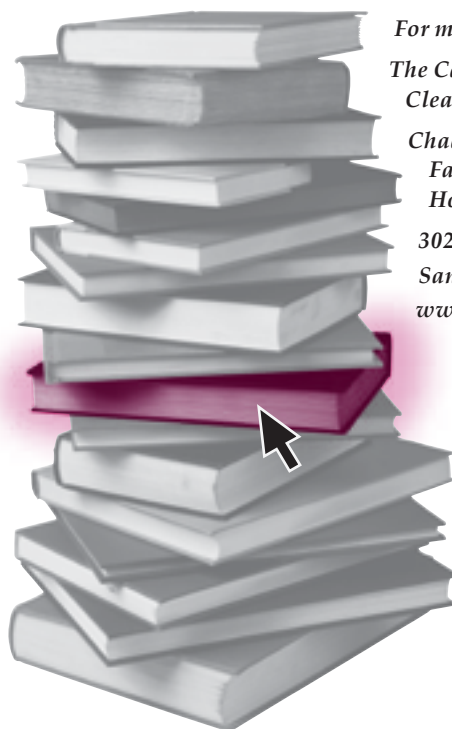
**1:** The program was designed, or is commonly used, to meet the needs of children and/or families receiving child welfare services.

**2:** The program was designed, or is commonly used, to serve children and/or families who are similar to child welfare populations (i.e., in history, demographics or presenting problems) and likely include current and former child welfare services recipients.

**3:** The program was designed, or is commonly used, to serve children and/or families with little or no apparent similarity to the child welfare services population.

All of the programs rated 1 and 3 received a child welfare rating of 2, meaning they were designed for populations similar to children and families involved in the child welfare system.

The Clearinghouse for Evidence-Based Practice is an exciting and helpful resource for child welfare practitioners and partners in serving children and families in child welfare services. Be sure to mark your “favorites” and refer to the clearinghouse for detailed information on evidence-based practice for parental substance abuse and other topics related to serving children and families in child welfare.



*For more information, contact:*

*The California Evidence-Based  
Clearinghouse for Child Welfare*

*Chadwick Center for Children and  
Families Rady Children's  
Hospital-San Diego*

*3020 Children's Way, MC 5017  
San Diego, CA 92123*

*[www.cachildwelfareclearinghouse.org](http://www.cachildwelfareclearinghouse.org)*

## Holding Us Back: Lack of Government Data Impedes Child Welfare/AOD Treatment Collaboration

According to the latest data available, over 235,000 Californians are in treatment for alcohol and other drugs. Almost 4,500 of those are pregnant women. And throughout the state in 2005, nearly half a million children were involved in the child welfare system through referrals (of which 108,582 were substantiated). Social workers on the front line know that parental substance abuse and chronic neglect are the two most cited reasons for a child's entry into the child welfare system, so the question is obvious: How many Californians are involved both in treatment and in the child welfare system, and what's being done about it?



The answers, unfortunately, are “No one knows,” and “Very little.”

The only data detailing the crossover between child welfare and substance abuse treatment is anecdotal. It's widely accepted that between 60 and 80 percent of families involved in the child welfare system also have some issue with alcohol or drugs. Some counties have performed their own studies—involving case reviews, hair testing or other research—leading many to believe that the number is even higher.

**“The simple fact is, substance abuse is one of the primary underlying issues of children and families in the child welfare system, yet know one knows how prevalent it actually is.”**

The problem is that no hard data exists. The California Department of Alcohol and Drug Programs collects data on treatment issues, but does not track the number of children or the home life of those in treatment. The California Department of Social Services maintains data on families in the child welfare system, but it does not note whether there are AOD issues with the family. The CWS/CMS system has the capacity to collect limited amounts of information on alcohol or drug use, but that data is not collected consistently throughout the state.

The simple fact is, substance abuse is one of the primary underlying issues of children and families in the child welfare system, yet know one knows how prevalent it actually is.

The lack of data is, ironically, one of the reasons that few programs exist to address substance abuse among the families served by child welfare. Without hard evidence that the problem exists—though everyone agrees that it does—it's difficult to make a case for funding. With no funding, there is no hope of seeing new programs develop to help substance-abusing parents. And without additional programs, the problems will only worsen.

Observers believe that it might take community involvement to bring about change. Child safety, permanence and well-being are issues that affect the entire community, not just one child or one family. And for changes to finally come about, the entire community needs to work with local, state and legislative bodies to demand support for new treatment programs to benefit parents—and, ultimately, their children.



## Resources

### California

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California Attorney General's Crime and Violence Prevention Center: [www.safestate.org](http://www.safestate.org) and [www.stopdrugs.org](http://www.stopdrugs.org)

California Department of Drug and Alcohol Programs, Resource Center: [www.adp.ca.gov/rc/rc\\_sub.shtml](http://www.adp.ca.gov/rc/rc_sub.shtml)

Through the Clearinghouse, more than 600 alcohol, tobacco, and other drug booklets, pamphlets, research papers, posters, technical manuals and other helpful materials are available to California residents at no cost. Publications can be obtained by ordering through the online shopping cart [http://www.adp.ca.gov/RC/rc\\_catal.shtml#PageTop](http://www.adp.ca.gov/RC/rc_catal.shtml#PageTop), by faxing 916/323-1270, emailing to [ResourceCenter@adp.ca.gov](mailto:ResourceCenter@adp.ca.gov), or by writing to the Department of Alcohol and Drug Programs, Resource Center, 1700 K Street, Sacramento.

California Department of Alcohol and Drug Programs: [www.adpa.ca.gov](http://www.adpa.ca.gov)

Partnership for a Drug Free California: [www.drugfreeca.com](http://www.drugfreeca.com)

Children and Family Futures: [www.cffutures.org](http://www.cffutures.org)

California Evidence-Based Clearinghouse for Child Welfare: [www.cachildwelfareclearinghouse.org](http://www.cachildwelfareclearinghouse.org)

### National

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American Council for Drug Education: [www.acde.org](http://www.acde.org)

Center for Substance Abuse Prevention: [www.prevention.samhsa.gov](http://www.prevention.samhsa.gov)

The Community Anti-Drug Coalitions of America (CADCA): [www.cadca.org](http://www.cadca.org)

Crystal Meth Anonymous: [www.crystalmeth.org](http://www.crystalmeth.org)

Join Together Online: [www.jointogether.org](http://www.jointogether.org)

Making the Grade: [www.drugstrategies.org](http://www.drugstrategies.org)

March of Dimes: National office: 1275 Mamaroneck Ave., White Plains, NY 10605, 914/997-4488: [www.marchofdimes.com](http://www.marchofdimes.com)

Meth Resources: [www.methresources.gov](http://www.methresources.gov)

Mothers Against Drunk Driving: [www.madd.org](http://www.madd.org)

National Center on Addiction and Substance Abuse at Columbia University: [www.casacolumbia.org](http://www.casacolumbia.org)

National Clearinghouse for Alcohol and Drug Information (NCADI): Box 2345, Rockville, MD 20847-2345, 800-729-6686: [www.ncadi.samhsa.gov/](http://www.ncadi.samhsa.gov/)

National Council on Alcoholism and Drug Dependence: [www.ncadd.org](http://www.ncadd.org)

National Inhalant Prevention Coalition: 322-A Thompson St., Chattanooga, TN 37405, 800-269-4237: [www.inhalants.org](http://www.inhalants.org)

National Institute of Alcohol Abuse and Alcoholism: 5635 Fishers Lane, MSC 9304, Bethesda, MD, 208-92-9304: [www.niaaa.nih.gov/](http://www.niaaa.nih.gov/)

National Institute on Alcohol Abuse and Alcoholism, youth alcohol prevention site: [www.thecoolspot.gov](http://www.thecoolspot.gov)

National Institute on Drug Abuse: [www.nida.nih.gov](http://www.nida.nih.gov)

Office of National Drug Control Policy: [www.whitehousedrugpolicy.gov](http://www.whitehousedrugpolicy.gov)

Partnership for a Drug-Free America: [www.drugfreeamerica.org](http://www.drugfreeamerica.org)

Substance Abuse and Mental Health Services Agency: [www.samhsa.gov](http://www.samhsa.gov)

Center for Substance Abuse Treatment: [www.csat.samhsa.gov](http://www.csat.samhsa.gov)

Center for Substance Abuse Prevention: [www.csap.samhsa.gov](http://www.csap.samhsa.gov)

## ANNOUNCEMENTS

### Children's Summit

November 2-3, 2007

The Northern California directors are sponsoring a Children's Summit on issues facing children and families, with a specific focus on substance abuse. This summit will bring together policy leaders to explore resources, program development and collaboration to support children and families impacted by alcohol and drug addiction in Northern California.

### Nurses Symposium

May 2007

### Research to Practice: Permanency for Children in Child Welfare

March 2007

***We can't publish this  
newsletter without you.***

We received lots of helpful and interesting feedback on our last issue. Please send your comments and any ideas for future issues to me at [sbrooks@unexmail.ucdavis.edu](mailto:sbrooks@unexmail.ucdavis.edu).

The theme for our next issue will be Permanency and Placement Stability for Children in Foster Care.



## NORTHERN CALIFORNIA Training Academy

*Supporting Children & Family Services*

### About the Northern California Training Academy

The Northern California Training Academy provides training, technical assistance and consultation for 33 northern California counties. The counties include rural and urban counties with various training challenges for child welfare staff. The focus on integrated training across disciplines is a high priority in the region. This publication is supported by funds from the California Department of Social Services.



### About The Center for Human Services

The Center began in 1979 with a small grant to train child welfare workers in northern California. It has grown to become an organization that offers staff development and professional services to public and private human service agencies throughout the state. The Center combines a depth of knowledge about human service agencies, a standard of excellence associated with the University of California, extensive experience in developing human resources and a deep dedication to public social services.

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