Substance abuse is a prevalent factor in child abuse and neglect and escalates challenges present in the child welfare system. Substance-abusing parents have been found to have compromised parenting practices and an increased risk of child maltreatment. Most child welfare practitioners agree that at least one-third of referrals to the child welfare system and two-thirds of removals from the home involve substance abuse.¹ Once in the system, children of substance-abusing families experience longer stays in foster care and lower rates of family reunification. Substance abuse treatment options are limited and, for those parents who do gain access to treatment, compliance rates are low. State child welfare systems face many challenges in meeting the complex needs of substance-abusing families. In particular, the Adoption of Safe Families Act of 1997, which aims to shorten children’s stays in foster care, requires courts to make decisions about children’s permanent placement within 12 months after the child enters foster care. Recovery from substance abuse addiction is often a complex, slow process, and time restrictions may not allow parents enough time to overcome their addiction. Comprehensive, effective child welfare and substance abuse programs promote treatment, sustained recovery and self-sufficiency and strive to accomplish two goals: to assist parents to gain access to treatment services to reduce alcohol and drug use, and to keep children safe.

In 1996, the U.S. Department of Health and Human Services, Administration for Children and Families (ACF), announced a new opportunity for states to design and test a wide range of approaches in the delivery and financing of child welfare services. ACF released a proposal for states to apply for waiver demonstration projects using funds from Title IV-E of the Social Security Act, the largest single source of federal funding for child welfare programs. Traditionally, Title IV-E funds pay for room and board for eligible children in foster care and for some administrative costs, but the funds cannot be used for services to prevent placement into foster care or to facilitate family reunification. The Child Welfare Demonstration Projects provide states with greater flexibility in using Title IV-E funds for services that can improve safety, permanency and well-being for children. Since 1996, 17 states have implemented Title IV-E waiver demonstration projects, and three states used waiver funds to develop programs to address the needs of caretakers who have substance abuse problems.²

Collectively, the demonstration programs aimed to reduce the number of children and the amount of time spent in foster care, more restrictive and costly placement settings, recurrences of abuse and neglect and re-entry into foster care. The projects were required to be cost-neutral and produce comprehensive evaluation plans with process, outcome and cost-effectiveness measures. This Policy Matters brief describes the experiences of Delaware, Illinois and New Hampshire in implementing Child Welfare Demonstration Projects.
Delaware

In response to a rise in foster care cases involving parental substance abuse—and, consequently, in foster care costs—in 1996 Delaware’s Division of Family Services (DFS) applied for and received the first Title IV-E waiver to specifically address child welfare and substance abuse issues. Delaware hoped that, by coordinating substance abuse experts and child welfare staff, the state could lower foster care costs, reduce the number of children removed from their homes, and reduce the length of time spent out-of-home for those children who required such care.

DFS contracted with community-based substance abuse treatment agencies to hire certified alcohol and other drug (AOD) counselors for the child welfare units involved in the demonstration. The DFS program is based upon multidisciplinary team treatment, which pairs a certified substance abuse counselor with DFS caseworkers to help link parents to effective substance abuse treatment. Although DFS caseworkers had received some substance abuse training, the AOD counselors specialize in connecting clients to substance abuse resources and providing support for clients during treatment.

The DFS case workers, AOD counselors and program managers meet monthly to involve all in case and treatment decisions. Besides assisting in case planning and making service recommendations, the AOD counselors provide support services throughout the treatment continuum and may serve as counselors until spaces open for the parents in other drug and alcohol treatment programs. According to Joann Bruch, treatment program manager, one unexpected benefit of including AOD counselors was their ability to navigate the complicated insurance systems that pay for substance abuse treatment. The AOD counselors’ greater knowledge about covered services and time required to complete treatment regimens has made it easier for families to gain access to these services and regimens. Delaware completed its demonstration project in December 2002.

Illinois

The Illinois Department of Children and Family Services (DCFS) applied for a Title IV-E waiver in 1999. The Chicago and suburban Cook County program began in May 2000. Although the other two states designed their programs to co-locate substance abuse and child protective services and focused on the collaboration between those services, the Illinois program works with clients who already have had their children removed from home after the courts established cases of abuse and neglect. DCFS contracts with the Treatment Alternatives for Safe Communities—a private, nonprofit Chicago group—to hire recovery coaches to help identified families whose children have already been removed to obtain and stay engaged in alcohol and other drug abuse (AODA) treatment.

Recovery coaches provide case management for families to spur recovery and to reunify parents with their children. The demonstration redirects Title IV-E money from traditional programs to fund recovery coach teams of substance abuse specialists. Teams are comprised of a supervisor, four recovery coaches and one outreach worker—a “tracker” who specializes in locating difficult-to-reach clients. Recovery coaches, who may have various alcohol and other drug certifications

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Alcohol and Other Drug Counselors:

- Conduct initial substance abuse assessments.
- Link clients to appropriate substance abuse treatment.
- Work with child welfare treatment units to conduct home visits, develop joint case plans, monitor progress, and plan for services following discharge.
- Provide support services while parents are waiting for admission to a treatment program.
- Enter case notes and recommendations into the DFS database.
- Provide on-the-job training for DFS caseworkers on substance abuse issues and indicators.
and at a minimum are certified addiction referral specialists, provide specialized, intensive and therapeutic case management services for involved parents. DCFS presumed that repeated contact with coaches would increase treatment duration and improve treatment completion rates, and parents meet regularly with the recovery coaches.

At or soon after their temporary custody hearing, eligible families may be referred to the project. According to Sam Gillespie, AODA services manager, “Continuous outreach efforts get people into treatment quicker and result in them staying longer. Our early involvement makes a big difference in their success rate.” Recovery coaches have regular contact with the AODA treatment agency and child welfare workers and facilitate communication between child welfare, AODA providers and court systems. They provide all involved parties with timely information about parents’ treatment progress and other issues relevant to case, reunification and other permanency decisions. The demonstration program will run until June 2005.

New Hampshire

New Hampshire’s Division for Children, Youth and Families (DCYF) implemented its Title IV-E Child Welfare Demonstration program, Project First Step, in Nashua and Manchester. This waiver program differs from others because New Hampshire’s approach initiates services earlier. While Illinois and Delaware provide coaches or practitioners for parents who already are involved in the courts (and in some cases, after children have been removed from home), New Hampshire provides services to alcohol-or drug-involved families as a preventive effort to deter ongoing child welfare involvement.

When child abuse or neglect is first reported, DCYF has a 60-day investigation period to determine whether to take the case to court. Until a case is confirmed in court, DCYF has limited authority to provide or mandate services for families. In the interim, families may be referred to community-based family resource centers to receive services voluntarily, at which time the department assigns licensed alcohol and drug abuse counselors (LADACs) to child protection investigations for families that need them—before court and official DCYF intervention—in an attempt to prevent or discontinue abuse before the 60-day period ends.

The LADACs, who are certified family therapists, act as consultants for the child protection service workers to provide information and treatment recommendations. They work as therapists for the families, providing intervention, treatment and case tracking, and monitoring parents’ compliance with treatment recommendations. Bernie Bluhm, DCYF project manager, explained, “Once a child is in foster care, we are reasonably assured that the child is safe. However, what about the children who are still at home—what can be done to ensure their safety? The essence of Project First Step is to provide access in the early stages when the children are at the greatest risk and in need of services.” Project First Step received a short-term extension to run through November 2005.
Results

The states assessed improvements in safety, permanency and well-being for children in families that were threatened by substance abuse and experienced encouraging results. All states found that the time children spent in foster care decreased when families were offered substance abuse services; however, due to differences in the number of clients in each program, evaluation criteria and program design, results are difficult to compare.

Delaware calculated the average number of days spent in foster care for those children who were removed from their home. As table 1 shows, on average the children in the demonstration group spent a shorter time in foster care.

<table>
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<tr>
<th>Table 1. Comparison of Days Spent in Foster Care in Delaware</th>
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<tr>
<td>Number of Children</td>
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<tr>
<td>Number of children in each group who entered out-of-home placement</td>
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<tr>
<td>Average number of foster care days for children who entered out-of-home placement</td>
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Delaware examined its program’s ability to engage and keep parents engaged in treatment. The state found that it had linked to substance abuse treatment about one third of families served, a nearly 100 percent increase compared to before they implemented multidisciplinary team treatment. Delaware also found that, on average, the control cases remained open for six months longer than the demonstration cases.

To determine how long children spent in foster care, Illinois measured the length of time from case opening to case closing for the 122 children in the demonstration group and the 33 children in the control group who returned home with their parents. The results do not include children who were adopted or who entered guardianship. The children in the demonstration group had an open case for an average of 294 days, while the children in the control group had an open case for an average of 436 days. In addition, Illinois evaluated whether treatment services supported family reunification. The state found a statistically significant difference: as of December 2003, 10 percent of demonstration group children were living with their parents, as compared to 6 percent of the control group.

Illinois achieved even greater success with engaging parents in treatment. As illustrated in figures 1 and 2, the demonstration group was more likely to access treatment than the control group. Only 46 percent of the control group was engaged in treatment as of December 2003, while 73 percent of the demonstration group had completed, was engaged in, or was awaiting the start of treatment programs.
The demonstration group also accessed treatment more quickly: 40 days after their court assessment, 50 percent of demonstration group caretakers had their first treatment episode and were in contact with recovery coaches, while 100 days passed before 50 percent of the control group completed one treatment episode.\(^8\)

New Hampshire also discovered that the demonstration group experienced shorter stays in foster care (513 days compared to 616 days). However, since New Hampshire provides treatment services earlier than other programs, fewer children had been removed from the home during the evaluation, and the number of children assessed was much smaller than the other programs. The state's results are based on only 17 children in the control group and 15 children in the demonstration group who had been removed from home.\(^9\) New Hampshire also hypothesized that DCYF would receive fewer subsequent referrals for child abuse and neglect investigations for families that accessed LADAC services and this was confirmed. A lower percentage of cases were reopened for investigation for the group that received LADAC services, and a lower percentage of those cases were confirmed in court to be abuse or neglect.\(^10\) In addition, New Hampshire discovered that children ages 4 to 17 in the LADAC group had greater declines the following problem behaviors: anxiety and depression, withdrawn/depressed behavior, somatic problems, attention problems and aggressive behavior.\(^11\) One DCYF attorney affirmed, “This program works so much better at all levels—the court, administrative offices, and child protective services—when the parent’s recovery is taken into consideration.”\(^12\)

All states experienced some degree of savings. A direct comparison of states' savings is difficult, because each program used different numbers of participants in the control and demonstration groups overall, and each state had dissimilar initial program costs. Delaware found that the demonstration cost almost 38 percent less than costs associated with the control group and saved $655,000.\(^13\) The state acknowledges in its final report that some of the differences in cost are attributed to large sibling groups (three or more children) in foster care and to group home costs. One-fifth (21 percent) of the demonstration foster care costs were spent on large sibling groups and group home costs, while more than half (52 percent) of the control group's foster care costs were expended on large sibling groups and group home costs. As of September 2003, Illinois had a 4.2 percent savings of almost $1 million. Illinois served 1,165 clients.
through the first half of fiscal year 2004, with more than twice as many clients in the demonstration group (831) than in the control (334) group. As of August 2004, New Hampshire had a 23 percent savings of almost $300,000. New Hampshire's savings are based on 201 participants, with 101 in the demonstration group.

Although these programs were successful, states confronted some barriers. Most obstacles were related to the time required to complete treatment and to the complexities inherent in chronic substance abuse disorders.

- Delaware's initial proposal estimated that AOD counselors would work with clients for three months; however, the average time required was closer to nine months. In addition, although collaboration was mostly positive, it took a significant amount of time to increase the DFS caseworkers’ knowledge of substance abuse and AOD counselors’ knowledge of child safety issues. Their experience underscored the need for ongoing education and training for both groups.
- Although family reunification rates increased in Illinois after recovery coaches were hired, the rates were low. One possible explanation is that working toward reunification takes more time; chronic alcohol and drug addiction is a deeply rooted, relapsing disease that requires time, patience and very concentrated resources to address.
- Only a small percentage of child abuse and neglect cases are actually referred to New Hampshire courts. Officials noted that some substance-abusing adults do not realize they need services unless there is court involvement. All interventions depend on parental cooperation. Interventions may be short-term and sporadic and, as a result, may be difficult to track.
- Some federal limitations exist for obtaining a waiver. Previous child welfare regulations required that new waiver proposals be unique; one state waiver application could not duplicate another state’s efforts. In the last round of child welfare waivers, however, the Department of Health and Human Services indicated that it would consider proposals that replicated interventions being tested elsewhere. Congressional provisions that would reauthorize the child welfare waivers and would put into statute such flexibility have not yet been acted upon.

Conclusion

The child welfare demonstration programs contribute to a growing pool of effective strategies for serving substance-abusing families in the child welfare system. A recent survey of all parents involved in Delaware’s child protective services discovered that 51 percent of respondents had a substance abuse problem at that point in time. Joann Bruch commented, “This is astronomical. There must be a way to address such a prevalent problem. For us, the answer is co-locating [child welfare and substance abuse services]. This gets clients into treatment faster and we can see that the program benefits both children and parents.”

The child welfare demonstration projects reveal better outcomes for children, lower rates of cases reopening, and reduced time in foster care. Incorporating substance abuse treatment into child welfare programs improves services offered to families and, as parents access and complete treatment, may have a lasting effect on the quality of families’ lives. Professionally trained substance abuse counselors provide greater insight into parents’ complicated substance abuse issues and the level of trauma that children and parents have been exposed to throughout their addiction history, enhancing the system’s ability to tailor services to meet families’ needs.
Substance abuse specialists’ perspective is valuable in the case review process as child welfare agencies and courts increasingly view substance abuse as an important factor in making decisions about foster care placement, treatment plans and case closures.

Moreover, savings were notable. Delaware demonstrated that, with specialized substance abuse services, resistance to treatment is reduced, treatment entry is facilitated, and reliance on foster care is reduced. New positions paid for themselves with saved foster care costs. The programs continue to receive funding; in 2003, the Delaware legislature provided funds to expand the program, and the Administration for Children and Families issued another announcement for states to apply for waivers for fiscal year 2004 demonstrations. The experiences of Delaware, Illinois and New Hampshire provide an incentive for other states to develop strategies to improve the delivery, effectiveness and efficiency of such services for vulnerable families.

For more information about state Child Welfare Demonstration Projects:
- Delaware Department of Services for Children, Youth and Families, Division of Family Services
  (302) 633-2500
  http://www.state.de.us/kids/fs.htm

- Illinois Department of Children and Family Services
  (217) 785-2509
  http://www.state.il.us/dcfs/index.shtml

- New Hampshire Department of Health and Human Services, Division for Children, Youth and Families
  (603) 271-4451
  http://www.dhhs.state.nh.us/DHHS/DCYF/default.htm

Notes

2. Maryland received a waiver as well, but the state terminated the program due to an insufficient number of referrals for alcohol and other drug treatment.
8. Ibid.
10. Ibid.


16. Refer to http://www.acf.hhs.gov/programs/cb/laws/im/im0306all.pdf to access the Department of Health and Human Services memorandum suggesting that increased flexibility would be considered in states’ child welfare waiver applications.
