



**NATIONAL RESOURCE CENTER
FOR FOSTER CARE
& PERMANENCY PLANNING**

at the Hunter College
School of Social Work

**BRIDGING THE GAP:
PERMANENCY PLANNING WITH DRUG AFFECTED
FAMILIES**

A PROJECT OF
THE NATIONAL RESOURCE CENTER *for* FOSTER CARE & PERMANENCY PLANNING

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Hunter College School of Social Work

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ACKNOWLEDGEMENTS

This has been a special project for the National Resource Center for Foster Care and Permanency Planning. It represents the work that can be accomplished when the resources and diverse perspectives of several disciplines come together to address a common, pressing concern – how to provide permanent family connections and family continuity for children from drug-affected families.

We wish to thank Sybil Hite of the Hite Foundation and Barbara Greenberg from the Philanthropic Group for their interest in our developing work and their confidence in our ability to bring together representatives of the child welfare and substance abuse treatment systems to begin an urgent discussion. Their insights into the need for better collaboration – with all its challenges and opportunities – has been well appreciated.

We are grateful to our Planning Committee (see Appendix) for their support, encouragement, ideas and multiple contributions at the Workday itself. It was their suggestion that we re-frame the focus of our work to include substance abuse treatment as one strategy to achieve more timely permanency planning. This is an orientation we believe holds great promise for helping families become more involved in the planning and decision-making about where their children will grow up.

We offer special appreciation to our staff – Karyn Lee who skillfully and patiently coordinated the logistics for what became two events when hurricane Floyd forced us to reschedule our original workday in September, 1999. And of course, a special word of appreciation to Project Coordinator Judy Blunt, who grew as much as she helped us to grow through our stimulating discussions and considerations of a range of best practices.

We also offer many thanks to those who joined us for the Workday on November 19, 1999 for they truly “ worked ” to provide us with the core of this monograph - the key recommendations for better multi-systems collaboration to achieve safety, permanency and developmental well-being for children and families affected by drug use or abuse.

We hope you will let us know what you think and how you might help to “Bridge the Gap” between the child welfare and substance abuse treatment worlds.

Sarah B. Greenblatt, ACSW
Director – National Resource Center for Foster Care & Permanency Planning

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EXECUTIVE SUMMARY/RECOMMENDATIONS

**PREPARED BY JUDY BLUNT, MSW, JD
SPECIAL PROJECTS COORDINATOR**

On November 19, 1999 over seventy people representing the parent, substance abuse treatment, child welfare, policy, and legal communities spent the day wrestling with the issues facing the child welfare and substance abuse treatment systems and worked together to present these recommendations for policies and practices which together have the chance to increase the likelihood that families will receive a needed array of services to achieve early and meaningful permanence for children.

In summarizing the work done in the various workgroups and their recommendations, the themes of collaboration, commitment, understanding, and sharing that emerged during the welcome and panel presentation in the morning were evident again. To foster more effective collaborations between the child welfare and substance abuse treatment communities that better serve families, the workgroup participants proposed the following recommendations:

- Families must be involved in planning, treatment and decision-making to the fullest extent possible.
- All parties involved should understand and be guided by the importance of permanency for children.
- Agencies should engage in concurrent permanency planning to identify appropriate family resources early on.
- Extended families should be involved as potential resources for support, placement and permanency planning.
- Parent Advocates and/or mentors should be used early on to help parents navigate the child welfare system and make effective use of the substance abuse treatment programs.
- All parties, including parents, should be knowledgeable about ASFA, how decision-making timeframes have changed, and the implications for practice and treatment.
- Cross system training must be done to bring the child welfare and substance abuse treatment communities together to consolidate assessment strategies and develop mutually useful family assessment tools.
- Joint formal protocols for how child welfare and substance abuse treatment workers can support each other to respect confidentiality, ensure parent/child visitation, and provide post-treatment supports for families and children at the community level.
- A relapse assessment tool that can be incorporated into a safety assessment and plan should be developed.
- All parties involved with the family should have a complete record of the family's history and current situation before any decisions are made.
- The timely delivery of intensive services for all family members, including children should be paramount with drug-affected families.
- Parents should be receive treatment within, or close to, their own communities with a support system of community and family resources enhanced for post-treatment phases of recovery.

- Drug Courts and case management can have a positive impact on motivation, participation and success rates.

After reviewing the workday proceedings, the planning committee submitted the following additional recommendations:

- Find out how different goals regarding parents' progress and children's health, safety, well-being and permanency are met in various agencies. It is possible to meet your goals by using a different person or team for that task from different agencies.
- Workers should understand the complexities of mental health issues on both drug treatment and permanency planning - for example, depression and bi-polar disorder and how to recognize and treat them.
- Information on the impact of the trauma of parental substance abuse addictions and the child abuse and neglect on early childhood development should be infused in training and research materials.

We plan to use this report to meet with child welfare and substance abuse policy makers and program developers. Should you have comments, additional recommendations or would like to be involved with our on-going efforts to improve the collaborations between child welfare and substance abuse treatment providers, please contact Judy Blunt, Coordinator of Special Projects at the Center. We will be happy to hear your perspectives and include you in our work.

INTRODUCTION

Prepared by Judy Blunt, MSW, JD
Special Projects Coordinator

BACKGROUND

Since 1994, the National Resource Center for Foster Care and Permanency Planning (NRCFCPP) at the Hunter College School of Social Work of the City University of New York has been funded by the Children's Bureau of the federal Department of Health and Human Services to revitalize the promise of permanency planning for children. Through our training, technical assistance, and information services, we address the issues and concerns that serve as barriers to the timely achievement of quality foster care services and permanency planning efforts.

Since 1980 with passage of the Adoption Assistance and Child Welfare Act (PL96: 272), permanency planning has been the guiding principle of the child welfare system intended to limit unnecessary entry into out-of-home placement, limit the time children spend in out of home care, and "help children to live in a home which offers the hope of establishing lifetime family relationships" (Terpstra, 1986).¹

In February 1999 we received a grant from the Hite Foundation to explore strategies that address a major barrier to timely decisions about permanence for children – drug use and abuse. We wanted to address the implications of new timeframes for planning and decision-making mandated in the Adoption and Safe Families Act of 1997 (ASFA) on working with drug-affected families. We believe that greater opportunities for understanding and collaboration between child welfare agencies and substance abuse treatment providers are needed, thus we wanted to use a workday format to explore best practices in these necessary collaborations.

Despite a twenty-year emphasis on permanency, there has been a dramatic increase in the number of children entering and remaining in out-of-home care. In March 1999 it was estimated that there were close to 547,000 residing in foster care nationwide, more than twice the number of children in care a decade before.²

According to the Administration for Children, Youth and Families, infants and young children under the age of four have become the fastest growing population in need of foster care.³ Additionally when placed, these children remain in care longer and experience frequent moves resulting in traumatic relationship disruptions. If a child happens to be African American and male, his chances of remaining in care more than 3-4 years and experiencing multiple moves are even greater.⁴

¹ Terpstra, J. (1986). *The Partnership of Child Care Institutions and Child Placing Agencies*. Portland, ME: National Child Welfare Resource Center for Management and Administration.

² Hargrove, John (1999). *Presentation on AFCARS at the National Association of State Foster Care Managers Annual Meeting*. October 7, 1999; Washington, D.C.

³ US House of Representatives, Select Committee on Children, Youth and Families. (1996). *No place to call home: Discarded children in America*. Washington, DC: US Government Printing Office.

⁴ George, R.M., Wulczyn, F.H., and Harden, A.W. (1994). *A report from the multi-state foster care data archive: Foster care dynamics 1983-1993*. Chapin Hall Center for Children at the University of Chicago, 1155 East 60th Street, Chicago, IL 60637.

Research further shows that from 40-80% of the children in foster care today come from families where drugs are used or abused (Young et al, 1998).⁵ Parental substance abuse and prenatal drug exposure is prevalent among foster care cases and has emerged as an indicator of child abuse and neglect. (Green Book, 1998).⁶ Thus, without meaningful collaboration from child welfare and substance abuse practitioners, many children from drug-affected families are likely to remain in foster care for long periods of time.

At the Center, we believe that policies and programs must be created to encourage early permanency. This project helped us to gain insight and direction from those who have been collaborating, and to share lessons learned with those who are trying to collaborate.

THE ADOPTION AND SAFE FAMILIES ACT OF 1997

Responding to these troubling trends, in November 1997 Congress passed and President Clinton signed into law the Adoption and Safe Families Act (ASFA). This law radically changes the child welfare environment, requiring states to act within tighter timeframes to establish and achieve permanent placements for children in care. It is an attempt to refocus our attention on child safety, reduced time in out-of-home care, and the facilitation of adoption when appropriate. The major provisions of ASFA are as follows:

- Safety is paramount throughout the life of a case.
- Foster care as a temporary service requiring timely decisions about permanency for children.
- Services are needed to support birth, foster and adoptive families.
- Accountability - moving from a focus on process to outcomes.
- Innovation to achieve more timely and positive outcomes.
- The successful permanency outcomes within ASFA include:
 - Children remain safely with the families.
 - Children are reunified safely with their parents or extended families.
 - Children are placed safely for adoption with relatives or other families
 - Children are placed safely with legal guardians - relatives or other families.
 - Children are placed safely in alternative planned living arrangements with relatives, community families or in group care settings as necessary.

The Adoption and Safe Families Act also requires that there be a judicial permanency hearing 12 months after a child enters foster care and every 12 months thereafter. These reviews provide definite “points in time” for all individuals interested in the well-being of the child to come together under the judicial umbrella to determine the long-term permanent plan for the child.

⁵ Young and Gardner (need to check original proposal)

⁶ United States. Cong. House. Committee on Ways and Means. Title IV-E Foster Care Eligibility reviews and Child and Family Services State Plan. 105th Cong. Washington: GPO, 1998.

The law also mandates that if a child has been in care 15 of the past 22 months the child welfare agency must initiate a Termination of Parental Rights (TPR) unless certain exceptions exist. ASFA outlines the following three exceptions to filing or joining a TPR petition:

- 1) A fit and willing relative is caring safely for the child.
- 2) A state agency has documented in the case plan a compelling reason why freeing the child for adoption would not be in his/her best interest.
- 3) The State agency has not provided the services identified in the case plan as necessary to make the home safe for the child's return within timeframes established by law.

In essence, ASFA establishes rigorous new requirements governing state legal proceedings to terminate parental rights for children who have been in foster care for 15 of the past 22 months. This imposes on foster care agencies the arduous task of attempting to reunify these families within shorter time frames than have been allowed previously, or to more quickly find adoptive homes for children when reunification is not possible.

The law also allows child welfare agencies and courts to determine if reasonable efforts to prevent placements, or to reunify children are required given a parent's past involvement in the criminal justice system, their severe and chronic abuse of the child or sibling, or if the parent has had his/her rights terminated involuntarily in the past. Thus, the new law has major implications for whether child welfare agencies will even continue to work with parents if they have long histories of child welfare or criminal involvement. This challenge must be addressed directly and quickly within the two provider communities.

The drug treatment process for parents does not necessarily take into consideration new or even previous permanency planning timeframes and the need for parent-child contact to support children's attachment needs. And, child welfare professionals often do not understand the rehabilitation process and are not able to set meaningful goals for recovery and permanency with drug-affected parents. Thus, it is imperative within these new decision-making timeframes that these professionals collaborate early on so that parents can get the help they need to safely resume care of their children, or to responsibly make alternative permanency plans for where their children will grow up.

BRIDGING THE GAP PROJECT GOALS

We used the workday as an opportunity to begin new relationships and initiatives to actually move us past acknowledging the gap and toward bridging the gap.

This workday was designed to:

- (1) Bridge the knowledge and service gaps between child welfare and substance abuse providers to foster more meaningful collaborations.
- (2) Share information about 'best practices' involving child welfare and drug treatment and to identify common challenges to forming meaningful collaborations.
- (3) Achieve more timely involvement of drug-affected parents in drug treatment and permanency planning for their children.
- (4) Develop protocols for assessment, planning and timeframes for permanency planning for children with parents who use or abuse drugs.

We hope you find the ideas expressed in this monograph useful. We encourage you to join the effort to foster and promote collaboration between the child welfare and substance abuse treatment communities.

OVERVIEW & SUMMARY OF THE WORKDAY

OVERVIEW

The National Resource Center for Foster Care and Permanency Planning (NRCFCPP) hosted this workday to bridge the gap in knowledge and relationships between child welfare and substance abuse treatment practitioners in New York City. We wanted to provide an opportunity for practitioners and policy leaders from each sector to better understand their respective issues, concerns, and legal mandates. We also wanted to facilitate the sharing of best practices aimed at initiating collaborative systems change for children and families.

The format of the workday was unique. We were very deliberate in our decision to have the participants start to “work” early in the morning in their respective groups, delving into the identified issues and fleshing out recommendations. After lunch, the participants reconvened to continue their work. This allowed all of the issues to be addressed from different perspectives and provided room for exchange of knowledge and ideas.

The workday included a panel presentation by a mix of seven parent advocates and practitioners in the child welfare and substance abuse treatment arena. The seventy-plus participants who attended the Workday then attended smaller workgroups to more intensely examine key practice and policy issues as well as service delivery challenges and opportunities. They were asked to spend the afternoon developing and providing us with key recommendations for better systems collaborations. This monograph reflects the thoughts and ideas coming from the “work” done that day. We are grateful for the enthusiasm of the participants who eagerly shared their diverse perspectives, experiences, knowledge and hope for the fields of child welfare and substance abuse treatment.

SUMMARY

The workday began with welcoming comments from Sarah Greenblatt, Director of the National Resource Center for Foster Care and Permanency Planning; Bogart Leashore, Dean of the Hunter School of Social Work; and Junius Scott, Program Manager, Youth and Family Services Division of the Administration for Children and Families.

These welcoming comments reflected the workday’s themes of collaboration, commitment, understanding, and sharing in the following ways:

- *Collaboration* among child welfare and substance abuse practitioners in New York City to address the common goals of drug-free parents and permanency for children.
- *Commitment* to responsibly serving children and families engaged in the child welfare system.
- A deeper *understanding* of what it takes to achieve permanency planning with drug-affected families.
- The *sharing* of information about best practices involving child welfare and drug treatment.

Eric Brettschneider, Executive Director of Agenda for Children Tomorrow, facilitated a panel presentation to begin the Workday (a summary follows). The participants were then divided into five workgroups where they met before and after lunch to discuss one of the issues listed below and provide recommendations for strategies.

- Selected Barriers and Innovative Solutions.
- Challenges/Opportunities for Case Coordinators: Drug Treatment & Permanency Planning.

- Challenges/Opportunities of Engaging Parents in Planning, Treatment & Decision-Making.
- Relapse – Opportunities for Growth or Red Flags for Treatment?
- What Lessons Have We Learned from Successful Model programs?

At the end of the day the participants came together for a large group discussion again facilitated by Eric Brettschneider. The discussion focused on information shared and recommendations for strategies to foster collaboration between the child welfare and substance abuse community so that we can better serve families and children affected by substance abuse.

SUMMARY OF PANEL PRESENTATIONS

The morning panel was comprised of individuals involved in spearheading collaborative projects with vulnerable children, families, and communities. The individual presentations highlighted the issues faced in building and maintaining effective service delivery collaborations in their particular projects where child welfare and substance abuse treatment services overlap. The main points of each presentation follow.

RAYE BARBIERI, Project Director, Manhattan Family Treatment Court provided an overview of this relatively new program.

- Rapid and comprehensive family assessments are key.
- Speedy responses are essential.
- Accountability is necessary.
- Access to treatment as soon as possible is key to success, with continued reports to the court on progress.
- Collaborations/partnerships which are centered around a shared vision of “best interests of the children” guide the work.
- Court appearances present opportunities to do the comprehensive work necessary and possible on each case.
- Work is focused on parents’ treatment, parent and child visitation, appropriate placements, and permanency planning and decision-making.
- Informed decisions are made more quickly on behalf of the child by all involved.
- Average length of stay for children has been 11 months.

SHARON CADIZ, Senior Director of Agency-Wide Initiatives at Project Return, Inc. highlighted the uniqueness of helping women with a history of drug abuse, child neglect and domestic or family violence.

- Safe care arrangements for children are necessary.
- Substance abuse treatment for parents needs to be part of a plan for children, but can not focus only on adult treatment;
- Children’s needs are becoming the focus of planning and decision-making and the “lay of the land” has changed to include family treatment.
- Leaving the program may turn into failure to protect a child/family and could result in homelessness and foster care placement of children.
- Coordinated responses at points of contact to meet needs of families should include an advocacy and referral mechanism.

JAN FLORY, Director of Services at Children’s Aid Society in New York City outlined the key components of the Children’s Aid Society’s Twelve Months to Permanency Project.

- Immediate, intensive contact with parents works to engage them.
- Full disclosure is important from the beginning of the case.
- Small caseloads are essential.
- Early service linkages – front-loading services – allows for rapid service delivery while families may still be in crisis.
- Better involvement with all services, including more than drug treatment.
- Reduced length of stay is one important outcome – with reunification or adoption decisions arrived at much sooner.

Ms. Flory also described the program she previously managed, the Cleveland START Program

This program involved early intensive high level work with parents confronting them with what they need to do and the consequences of not following through.

- Social Worker and Family Advocates work together with families.
- Early contact with parents up front.
- Safety plans and drug treatment must begin immediately.
- 80-90% of parents remain sober when caseloads and services can support good practice.

NATALIE GREENE, Board Member of the Marshall Heights Community Development Organization in Washington, DC shared the process of the board’s development of a child welfare-related program initiative.

- East River Family Strengthening Collaborative is a community organization that developed a community-based system for child welfare service delivery, resulting from the large and steadily growing number of children in the neighborhood placed in foster care.
- Family preservation and support services are provided as an effective means to develop and strengthen the family, adequately and safely provide for children, stem the tide of foster care placements, and provide a service framework to support family reunification and adoption when necessary.
- Meetings are always started with the question “How are the children?”
- Social Workers and Family Advocates work together with the families.

ANNA LIVINGSTON, a Parent Advocate with the Child Welfare Organizing Project in New York City spoke about her personal experience and offered suggestions on how to serve parents better.

- Parents are often patronized and misunderstood.
- Family advocates can “bridge the gap” between the parent and the agency.
- Parents should be asked what they want to see happen.

DEBORAH RASCOE, a Parent Advocate with the Child Welfare Organizing Project in New York City offered a consumers perspective on the child welfare system.

- Communication, education, and collaboration are important.
- Finding out why people use drugs can help plan and offer services more effectively.
- Allot money for prevention and counseling to avert out-of-home placement and more serious drug-use.
- Parents are survivors and must be viewed as having the capacity to change.
- Treatment is important and should be easily accessible.

BARBARA LOWE, Independent Consultant, addressed the key components which made the Cumberland Treatment Center in Brooklyn, New York successful.

- The family was treated with respect in a supportive environment.
- Families had children with them because children are part of the treatment process.
- Comprehensive outreach to parents helped to engage clients (calls, letters, and visits).
- Listening to the client/parent or child and coordinating the needs of the family members with the system was a key component.
- Efforts to avoid setting clients up for failure was critical because failure is a good reason for the client to get high again.
- It was also important to emphasize “healing the healer”, by keeping staff moral high.

WORKGROUPS – ISSUES & RECOMMENDATIONS

SELECTED BARRIERS AND INNOVATIVE SOLUTIONS

Facilitated by Monya Bunch, M.P.H. and Jan Flory, M.S.W

Barriers to progress are:

- Differing standards of confidentiality.
- Honest sharing of circumstances causing setbacks in client's treatment.
- Lack of mutual trust.

Practical cooperative solutions:

- Child welfare and substance abuse run pretreatment & motivational psycho-educational groups using successful clients as role models.
- Access to community-based prevention and family support resources.
- Substance abuse professionals should be included on service plan team in child welfare agencies.
- Joint formal protocols for how the child welfare worker and substance abuse worker can support each other in assessment, motivational techniques, case management, and visitation.
- Develop funding for client-centered tasks.
- Aftercare supports supplied by child welfare and substance abuse treatment agencies.
- Child welfare workers use leverage to retain birth parent in substance abuse treatment particularly during "window" (first 90 days) for relapse.
- Substance abuse worker reinforcing the reality of ASFA- recovery may be a process but your child can't wait.

CHALLENGES/ OPPORTUNITIES FOR CASE COORDINATORS: DRUG TREATMENT AND PERMANENCY PLANNING

Facilitated by Naomi Weinstein, M.P.H.

Challenges:

- Parents do not fully understand the ASFA time frames.
- Housing needs may be an obstacle to reunification even after the parent is ready and the court approves. This can easily take more than 12 months.
- Welfare to Work presents an obstacle to housing: you can't get your kids until you have housing but you are thrown off welfare if you do not have housing.
- Individuals not involved in case coordination can obstruct the Case Coordinator/Coordination.
- The fear that parents can have their rights terminated even if they are working well toward their goal.
- The caseworker needs to have an advocacy relationship with the client rather than an adversarial relationship.

Recommendations:

- Cross training for child welfare and substance abuse workers.
- Clear information about ASFA rights and responsibilities should be provided.
- Early intervention by Parent Advocates who have the time to spend with the client.
- Find a common definition for growth in treatment.
- Improve notice requirements and coordinate service plans.
- Service providers must exchange specific information on dates, timelines. Support services for relatives providing relative placement and kinship foster care.
- Increased court involvement and more regularly scheduled court reviews of progress.

CHALLENGES/ OPPORTUNITIES OF ENGAGING PARENTS IN PLANNING, TREATMENT, & DECISION-MAKING

Facilitated by Gershon Weiss, M.A., CASAC, and Barbara Lowe, R.N., M.P.H.

Goal of engagement and collaboration is to:

- Help client maintain sobriety and increased self-sufficiency while decreasing the time it takes for family reunification or an alternate permanency plan.

Child Welfare & Substance Abuse communities working together will require:

- Commitment to collaborating.
- Mutual respect of respective disciplines.
- Respect of regulatory issues- ASFA.

To bring the two fields together will require:

- Cross training and familiarization.
- Identifying agencies or groups that are well matched.
- Consolidation of assessment tools and format.

Recommendations:

1. Step down model for drug treatment to reduce reliance on residential treatment.
2. Extensive use of parent advocates who are role models for the client and can help them navigate the system.
3. Keep parental rights at forefront of treatment and bring attorneys into the process early on.
4. Serving children in drug treatment setting to:
 - Increase parent participation.
 - Consolidate, coordinate, integrate, and expedite services.
 - Increase the likelihood of keeping the family together.
 - Demonstrate the parallel process of a coherent provider system.

RELAPSE – OPPORTUNITY FOR GROWTH OR RED FLAG FOR TREATMENT?

Facilitated by Raye Barbieri, C.S.W. and Diane Bonovoto, C.S.W.

Relapse is an opportunity for growth and an indication that treatment could be in jeopardy. Attention should be paid to the circumstances surrounding the use of alcohol or drugs and the timing of the relapse-whether before or after permanence.

Major signs/precursors to a relapse are:

- Life changes.
- Stress.
- Return home of children- this is a high stress/high risk time.

Considerations in assessing relapse:

- Program participation.
- Admission/denial to relapse and if parent sought support.
- Level of functioning in other areas of their life.
- Level of involvement with children: visits, and planning efforts.
- Identification of triggers.

Relapse Planning should include:

- Aftercare Services.
- Communication between child welfare and drug treatment professionals to give parents clear consistent messages.
- Developing a support network to include self-help sponsors and peer counseling.
- Helping parents develop a personal recovery plan including coping skills for those situations which are problematic, e.g. holidays.

Recommendations:

- Recognize that relapse will occur and must be planned for.
- Acknowledge there is no standard number of relapses a parent should have before treatment goal is changed.
- Develop a relapse assessment tool to help child welfare and treatment professionals assess the circumstances surrounding a relapse. This tool should be incorporated into a safety assessment.
- Provide other essential services (food, transportation) to strengthen client.
- Adopt a strengths-based approach to assessment and relapse prevention.
- Address the “snowflakes” early on to avoid the “snowball.”
- Preventive services should be in place when children are returned home.
- Aftercare-step-down-services should be provided for parents to stay involved in treatment without starting over again.
- Ensure all players (including Judges) have a complete record before decisions are made.
- Communication should be consistent-not just when there is a problem.
- Educate lawyers, social workers, caseworkers, and other parties about recovery and relapse.

- Do concurrent planning – identify family resources to be used where appropriate.
- Children and youth should be informed and participate to the extent appropriate.

WHAT HAVE WE LEARNED FROM SUCCESSFUL MODEL PROGRAMS?

Facilitated by Cheryl Bobe, A.C.S.W. and Elizabeth Schnur, Ph.D.

Key elements of successful models are:

- Individual assessments, integration, and coordination of service delivery.
- Shared vision of family-centered practice.
- Protocols around rapid and meaningful case coordination.
- Case management with aftercare services.

Recommendations:

- Have a substance abuse liaison at child welfare field offices and Family Treatment Court.
- Facilitate case coordination.
- Use the Family Rehabilitation Model (blending child welfare and substance abuse treatment services).
- Provide substance abuse and child welfare services by the same worker.
- Use cross-systems training that includes:
 - foster and birth parents
 - high and mid-management to sanction training efforts.
 - the “culture bearers” – supervisors, who usually stay with the agency for a longer period of time.
- Systematize changes through forms, protocols, concise documentation, and evaluation.
- Provide comprehensive and intensive services ensuring that all family members, including children are served.

BACKGROUND RESEARCH

In preparation for this workday our research included the review of reports and research about the relationship between child welfare concerns and substance abuse in families. Listed below is a summary of issues, barriers, and recommendations highlighted in recent reports about families with substance abuse problems involved with the child welfare system.

BARRIERS TO LINKAGES BETWEEN CHILD WELFARE AND SUBSTANCE ABUSE SYSTEMS

(From: Responding to Alcohol and Other Drug Problems in Child Welfare: Weaving Together Practice and Policy. Washington, DC: Child Welfare League of America 1998)

Issues:

- Differences in definition of, and focus on, the primary client in each field.
- Conflicts in values and philosophies about roles and treatment in the two systems.
- Differences in decision-making timing between the two systems arise from mandates, treatment approaches, the recovery process, developmental needs of children, and treatment approaches.
- Differences in staff training, education, expectations for practice methods, and a lack of cross training.
- The control of other important forces such as the courts and managed care companies over resources and clinical matters.
- Funding barriers created by the complexity of categorical systems and the gaps in comprehensive funding in both systems.

Recommendations:

- State and Local
- Develop a public education plan explaining the innovations that bridge both systems.
- Review and upgrade data on alcohol and other drugs and their implications for both systems.
- Review current screening tools used by child welfare agencies for their attention and responsiveness to alcohol and other drug problems.
- Begin transition to a results-based accountability system for agencies in the two systems.
- Development of a community scorecard to be used to monitor the annual progress being made in both systems to respond to alcohol and drug problems of parents in child welfare.

- Review all training funded under Title IVE of the Social Security Act and develop a multi-year staff development plan to include child welfare, substance abuse, court, and law enforcement personnel.
- Develop a comprehensive statement of values and principles about treatment for families with alcohol and other drug problems to be shared by both systems.
- Determine which outcomes will help convince policy makers to expand and redirect resources for alcohol and other drug treatment and related services and activities.
- Federal
- Determine the possibility of blending federal funds to increase flexibility in funding for families with alcohol and other drug problems in child welfare.
- Ensure that lessons from federally funded demonstrations are disseminated and best practice models are continued.
- Ensure that federal data collection activities support work across agencies on behalf of families with alcohol and other drug problems in child welfare.

CRITICAL WEAKNESSES IN THE RESPONSES OF CHILD WELFARE AGENCIES AND THE COURTS

(From No Safe Haven: Children of Substance-Abusing Parents. New York: The National Center on Addiction and Substance Abuse at Columbia University. January 1999.)

Issues:

- Lack of training and expertise to help child welfare staff and judges understand the nature of substance abuse and how to detect it and assess its severity.
- Minimum understanding of, and preparation for, relapse prevention, resulting in a revolving door of child abuse and foster care.
- Inadequate criteria to guide the determination of when to return children to their families where substance abuse is involved; decisions now often made with insufficient information.
- Lack of timely access to treatment and related services appropriate for the parents.
- Minimum amount of strategies to motivate parents to enter and complete treatment.

Recommendations:

- Increase focus on prevention with parents and children.
- Incorporate efforts to prevent child abuse and neglect and treat substance-abusing parents in other social programs early on.
- Establish protocols to assure that parents who are investigated for maltreatment are screened for alcohol and other drug problems and also assess the severity of the problem.

- Arrange for timely and appropriate treatment and services for substance abusing parents.
- Increase strategies to motivate parents to engage in treatment.
- Prepare parents for the prevention of relapse.
- Prepare parents for relapse.
- Provide funding for comprehensive treatment.
- Provide substance abuse training for all child welfare, court, social, and health service professionals.
- Integrate services across agency lines.
- Change organizational culture and practice to support understanding of substance abuse issues and treatment aprons.

DIFFICULTIES CHILD WELFARE AGENCIES FACE IN MAKING TIMELY PERMANENCY DECISIONS

(From: Foster Care Agencies Face Challenges Securing Stable Homes for Children of Substance Abusers. U.S. General Accounting Office. Washington, DC: September 1998.)

Issues:

- Lack of understanding about the nature and treatment of alcohol and drug addiction.
- Limited familiarity with alcohol and drug treatment resources.
- Absence of a continuum of alcohol and drug treatment options.
- Lack of close monitoring of parents' progress in treatment, which prevents timely decisions about permanency.
- Extension of time spent in foster care when alcohol and/or drugs are the problem.
- Limited research on best form of treatment for other drug abusers, except for the heroin addict.
- Problems in predicting parents' readiness for recovery and any potential for relapse.

Recommendations:

- Develop strong linkages between child welfare agencies and alcohol and other drug treatment providers.
- Improve the monitoring of progress in treatment by parents in the child welfare system.
- Develop strategies to achieve early permanency outcomes for children when efforts to reunify children with their birth families fail.

BLENDING PERSPECTIVES AND BUILDING COMMON GROUND: A REPORT TO CONGRESS ON SUBSTANCE ABUSE AND CHILD PROTECTION.

(From: U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, 1999.)

Issues:

- Parental substance abuse is a contributing factor for between one-third and two-thirds of the children involved with the child welfare system.
- An estimated 8.3 million children live in households where at least one parent is in need of alcohol or drug treatment.
- African American women are more likely to come to the attention of Child Protective Services than are Caucasian or Hispanic women.
- Children prenatally exposed to drugs and alcohol represent a small proportion of the children affected and endangered by parental substance abuse.
- Both alcohol and illicit drugs are abused simultaneously in many families. This makes the two problems indistinguishable.
- Alcohol and drug related cases are more likely to result in foster care placements than other child welfare cases.

Recommendations:

- Build collaborative working relationships between the two systems.
- Assure timely access to comprehensive substance abuse treatment services.
- Improve strategies to engage and retain clients in care and support recovery.
- Enhance services provided to children.
- Fill gaps in knowledge-base of interrelated issues of substance abuse and child maltreatment.
- Build a stronger continuum of interventions from prevention through aftercare.

SELECTED MODEL PROGRAMS RESOURCE LIST

THE ALBERT AND MILDRED DREITZER WOMEN & CHILDREN'S CENTER
315-317 East 115th Street
New York, NY 10029
212-348-4480/Fax 212-423-9140
Contact: Sharon Dorr

This center is a program of Project Return Foundation. It is a unique facility providing programming for both mother and child. This program uses a comprehensive approach to treating women with a dual diagnosis of mental illness and substance abuse. An interdisciplinary team assesses and designs an individual treatment plan for each mother and child.

CENTER FOR COLLABORATION FOR CHILDREN
California State University
Fullerton School of Human Development and Community Service
714-278-2166/Fax 714-278-5235
Contact: Sid Gardner or Soraya Coley

Founded in 1991, the primary focus of the Center is to meet the needs of children and families by promoting collaborative, cross-agency efforts that use school-based and community-based models of serving the child in that family's community.

THE CHILDREN'S AID SOCIETY (CAS) 12 MONTHS TO SOBRIETY
105 East 22nd Street
New York, NY 10010
212-949-4800/Fax 212-682-8016
Contact: Jan Flory

Based on the concurrent planning model, permanence is achieved through timely decisions about reunification or adoption. The program was designed to meet the needs of very young children in foster care who were affected by the drug use or addiction of their parents.

CHILD WELFARE ORGANIZING PROJECT
3280 Broadway 8th Fl
New York, NY 10027
212-694-1866/Fax 212-694-1863
Contact: Mike Arsham

The goal of Child Welfare Organizing Project is to restore families divided by the child welfare system and to assist those who fear losing their children. Parents are assisted in navigating the child welfare system and given opportunities to develop a voice in public policy.

CUYAHOGA COUNTY DEPARTMENT OF CHILDREN AND FAMILY SERVICES (CCDCFS) SOBRIETY
TREATMENT AND RECOVERY TEAMS (START)
3955 Euclid Ave

Cleveland, OH 44115
216-432-3335/Fax 216-432-3512
Contact: Tammy Chapman-Wagner

This program is designed to develop safe, nurturing, and stable living environments for children by helping their parents overcome drug addictions.

FAMILY OUTREACH CENTER, INC.
Family and Community Compact
1939 S. Division
Grand Rapids, MI 49507
616-247-3815/Fax 616-245-0450
Contact: Veneese Chandler, Executive Director

Based on the New Zealand Family Group Conference model in which family and community make decisions about child placements rather than the courts.

FAMILY TREATMENT COURT
New York County Family Court
60 Lafayette Street
New York, NY 10013
212-374-1022/Fax: 374-0412
Contact: Raye Barbieri, Project Director

The comprehensive approach to treatment offered by Family Treatment Court is designed to break the cycle of addiction and neglect and to limit foster care stays through ongoing case monitoring, and informed expedited permanency planning.

GOOD SHEPHERD SERVICES
305 Seventh Avenue
New York, NY 10001
212-343-7070/Fax 212-929-3412
Contact: Sr. Paulette LoMonaco

Good Shepherd Services addresses the complex needs of the parents in their foster care program by working in coordination with many city-wide treatment programs.

MARSHALL HEIGHTS COMMUNITY DEVELOPMENT ORGANIZATION, INC.
Ward Seven, Washington, DC
3939 Benning Road NE
Washington, DC 20019
Contact: Shirley Profitt
202-396-1200/Fax 202-396-4106

The RCI committee developed a community-based system for child welfare delivery, with an emphasis on the large and steadily growing number of foster children in the neighborhood.

ST. CHRISTOPHER'S INC.
71 South Broadway
Dobbs Ferry, NY 10522
914-693-3030/Fax 914-693-8325
Contact: Jane Restivo

St. Christopher's Family Services Unit is built around Parent Advocates who help birth parents receive needed services in order to be reunified with their children. The Parent Advocates work with, and advocate for, the rights of birth parents.

UNITED BRONX PARENTS
773 Prospect Avenue
Bronx, NY 10455
718-617-6060/Fax 718-589-2986
Contact: Bobby Rosado

United Bronx Parents offers services that close the gap between child welfare workers and substance abuse counselors. The organization is committed to the client and provides outreach to find services not readily accessible, and aftercare treatment for parents who have completed their residential drug treatment program.

VERITAS-YOUNG MOTHERS, INFANTS, AND TODDLERS PROGRAM
912 Amsterdam Avenue
New York, NY 10025
212-222-5825/Fax 212- 222- 3254
Contact: Shirley Taylor

This program provides comprehensive treatment and services to families and children affected by substance abuse to help them recover, strengthen the family, and break the cycle of addiction.

The following selected programs are engaged primarily in collaborative efforts to preserve families affected by substance abuse.

ADVOCACY FOR SUBSTANCE ABUSING PARENTS
Brooklyn Legal Services Corp B
Family Law Unit
105 Court Street, Brooklyn NY 11201
718-237-5568/Fax: 718-855-0733
Collaborative Partner: The Legal Action Center
Contact: Barbara Lerner

FAMILY CONSULTATION SERVICE
Preventive Services Program
216-10 Jamaica Avenue
Queens Village, NY 11428
718-776-2333/Fax:718-479-0205
Collaborative Partner: The Diocese of Long Island
Contact: Willard Hill

PREGNANT ADDICTS AND ADDICTED MOTHERS
1900 Second Avenue 12th Fl
New York, NY 10029
Collaborative Partner: Metropolitan Hospital
Contact: Liliana Valor

APPLE MOTHER AND CHILD
153 East Main Street
P.O. Box 9021
Smithtown, NY 11781
515-979-7300/Fax: 516-979-6890
Collaborative Partner: The State University of New York at Stony Brook
Contact: Dan Ravid

SUBSTANCE ABUSE FAMILY EVALUATION (SAFE)
Department of Children and Families
505 Hudson Street
Hartford, CT 06106
860-550-6536/Fax: 860-566-8022
Collaborative Partners: Advanced Behavioral Health, Department of Social Services
Contact: Joe Sheehan

FAMILY DRUG TREATMENT COURT
Suffolk County Family Court
400 Carleton Ave
Central Islip, NY 11702
516-853-4482/Fax: 516-853-4359
Collaborative Partner: Suffolk County Department of Social Services
Contact: Christine Olsen

COALITION FOR HISPANIC FAMILY SERVICES
315 Wyckoff Avenue, 4th Floor

Brooklyn, NY 11237
718-497-6090
Contact: Denise Rosario

THE MIRACLE MAKERS, INC.
510 Gates Avenue
Brooklyn, NY 11216
718-483-3000
Contact: Willie Wren

SELECTED FAMILY REHABILITATION PROGRAMS

The Family Rehabilitation Program (FRP) is a unique combination of substance abuse treatment and intensive, comprehensive, community-based social services aimed at preserving or re-unifying families where a parent's chemical dependency places children at risk.

BRONX

CARDINAL MCCLOSKEY CHILDREN & FAMILY SERVICES

FAMILY OUTREACH PROGRAM

951-853 Southern Boulevard, 3rd Floor

Bronx, NY 10459

718-542-0255/Fax 718-542-0354

Contact: Marion Greaux, Administrative Director

DOMINICAN SISTERS FAMILY HEALTH SERVICES

FAMILY LIFE PROGRAM II (FRP)

279 Alexander Avenue, 2nd Floor

Bronx, NY 10454

718-292-0151, 81/Fax 718-983-1747

Contact: Jacqueline Hall-Martin, Program Director

KINGSBRIDGE HEIGHTS COMMUNITY SERVICES

PARENT AND CHILD PROGRAM

3101 Kingsbridge Terrace

Bronx, NY 10463 (Temporary Site)

718-884-0700/Fax 718-884-0858

Contact: Gary Kogan, Program Director

LEAKE AND WATTS SERVICES, INC.

NEW DIRECTIONS

1384 Metropolitan Avenue

Bronx, NY 10462

718-824-1370/Fax 718-863-8646

Contact: Daphne Stephenson, Program Director

NEIGHBORHOOD YOUTH & FAMILY SERVICES

FAMILY ENRICHMENT PROGRAM

1910 Arthur Avenue, 8th Floor

Bronx, NY 10457

718-294-0499/Fax 718-294-3189

Contact: Michael Hopkins, Program Director

NEW YORK FOUNDLING
MOTT HAVEN PREVENTION PROGRAM
364 East 151st Street, Basement
Bronx, NY 10455
718-993-2500/Fax 718-993-0590
Contact: Enid Clinton, Program Director

THE SALVATION ARMY SOCIAL SERVICES FOR CHILDREN
MORRIS HEIGHTS CENTER FOR FAMILIES
(Location to be Determined)
Bronx, NY 10453
212-352-5503/Fax 212-989-3335
Contact: Ann Lowe, Assistant Executive Director

SCAN-NEW YORK
FAMILY RENEWAL CENTER
1075 Grand Concourse, Street Level
Bronx, NY 10452
718-293-2230/Fax 718-293-2674
Contact: Evelyn Castro, Program Director

BROOKLYN

FAMILY CONSULTATION SERVICE DIOCESE OF LONG ISLAND
BROOKLYN FAMILY REHABILITATION PROGRAM
966 Bushwick Avenue
Brooklyn, NY 11221
718-919-0100/Fax 718-919-0286
Contact: Willard Hill, Program Director

FLATBUSH HAITIAN CENTER, FLATBUSH FAMILY SERVICES
INTENSIVE PREVENTIVE SERVICES
2211 Church Avenue
Brooklyn, NY 11226
718-693-5700/Fax 718-348-1309
Contact: Margarete Tropnas, Program Director

VICTIM SERVICES
FAMILY ALLIANCE
3021 Atlantic Avenue
Brooklyn, NY 11208
718-827-4700/Fax 718-348-1309
Contact: Ed Higgins, Program Director

MANHATTAN

ALIANZA DOMINICANA
CENTER FOR REHABILITATION EDUCATION & ORIENTATION (CREO)
2410 Amsterdam Avenue
New York, NY 10032
212-740-1961/Fax 212-740-1967
Contact: Lillian Martinez

CARDINAL McCLOSKEY CHILDREN AND FAMILY SERVICES
EAST HARLEM REHABILITATION CENTER
205 East 122nd Street
New York, NY 10035
212-897-1806/Fax 212-348-0504
Contact: Rose Marie Rosa, Assistant Program Director

NEW YORK FOUNDLING
PATHWAY CENTER
3280 Broadway
New York, NY 10027
212-281-2259/Fax 212-362-6044
Contact: Daniel Melore, Program Director

RHEEDLEN CENTERS FOR CHILDREN AND FAMILIES
PROJECT CLASS
2770 Broadway
New York, NY 10025
212-866-0700/Fax 212-932-2965
Contact: Regina Garrett, Program Director

ST. LUKE'S ROOSEVELT HOSPITAL
VERY INTENSIVE PREVENTIVE (VIP)
1111 Amsterdam Avenue, Scrymser 6
New York, NY 10025
212-523-2687/Fax 212-523-3206
Contact: Carmen Gaines, Program Director

TALBOT PERKINS CHILDREN'S SERVICES
PROJECT PREVENTION I
250 East Houston Street
New York, NY 10002
212-674-7733/Fax 212-505-6171
Contact: Deborah Rubien, Program Director

QUEENS

FAMILY CONSULTATION SERVICES
QUEENS FAMILY REHABILITATION PROGRAM
216-10 Jamaica Avenue
Queens Village, NY 11428
718-776-2333/Fax 718-479-0205
Contact: Willard Hill, Program Director

QUEENS CHILD GUIDANCE CENTER
JAMAICA FAMILY CENTER
'89-56 162nd Street
Jamaica, NY 11432
718-297-8000/Fax 718-262-8228
Contact: Loren Fisher, Clinic Administrator

STATEN ISLAND

SEAMEN'S SOCIETY FOR CHILDREN AND FAMILIES
HEALTHY FAMILIES PROGRAM
25 Hyatt Street
Staten Island, NY 10301
718-273-9562/Fax 718-273-4376
Contact: Joyce Russell-Anderson, Program Director

CONFERENCE MONOGRAPH SUBMISSION

National Resource Center for Foster Care and Permanency Planning *“Bridging the Gap: Permanency Planning With Drug Affected Families”*

Since at least the mid-1980's, the principle function of New York City's child welfare system has been to cope with the repercussions of parental substance abuse. It has taken the better part of a decade for the system to begin to come to grips with this reality, one which has long been evident to people living in the communities most impacted both by drugs, and by government intervention in family life.

Professional consciousness of the relationship between substance abuse and child welfare is on the rise, however. The compressed Adoption and Safe Families Act (ASFA) time-frames for termination of parental rights demand professionals' best efforts to reconcile the treatment needs of parents with the permanency needs of children. ASFA also mandated an important U.S. Department of Health and Human Services study: *“Blending Perspectives and Building Common Ground — A Report to Congress on Substance Abuse and Child Protection.”* Also published in early 1999 was a provocative and influential report from The National Center on Addiction and Substance Abuse at Columbia University: *“No Safe Haven — Children of Substance A busing Parents.”*

A host of conferences, forums, and symposiums have followed. Many of these events have failed to include the voices of those most directly effected by the issues at hand: parents struggling to overcome addiction and raise safe, healthy children. Not only do these parents have a human right to be heard, they can also bring a unique depth of insight to this vital policy debate.

The Child Welfare Organizing Project (CWOP) thanks the National Resource Center for Foster Care and Permanency Planning for featuring the parent voice alongside the voices of legal and human services professionals in their November 19, 1999 conference, *“Bridging the Gap: Permanency Planning With Drug Affected Families.”* The following are transcripts of Parent Organizers Anna Livingston's and Deborah Rascoe's opening remarks, followed by a brief analysis by Mike Arsham, CWOP's Director.

Good morning, my name is Anna Livingston. I am a mother of five children. I am a Parent Advocate for the Child Welfare Organizing Project, and for Neighborhood Youth and Family Services Young Mothers Program, which is a substance abuse treatment program...

My story begins in 1987, when my children were taken from me because of my drug addiction. I had three children, ages 3, 2, and a newborn, who was born with positive tox. When they were removed, no one told me that drug treatment might be available, or that my foster care agency was there to help me as well as my children. I continued to use. I then had a fourth child, and continued to repeat the same cycle of substance abuse. ACS took my fourth child. Still, no one asked me what was going on in my life, or suggested that I should enter treatment.

In 1994, I had another child that was not born positive tox. I had stopped using on my own, but knew I would need help to stay clean and keep my baby. I found a program on my own. This was at a time when treatment programs for women were becoming more

available. During my recovery process, my foster care agency still did not communicate with me. When I had a year and a half clean, I went to them.

I asked my worker what can I do to get my children out of the system? I was told they were no longer my children. The worker said to me “didn’t you just have a newborn baby? Be happy and do not call here anymore.” I felt so ashamed. I also felt this worker had no feeling for what it is to be a mother. When you talk about bridging the gap, let’s talk about changing the culture, the mindset, the way the system thinks about parents, and the way the system sees parents.

How do you think parents feel when asking for help from a system which is caring for their kids, and - just from my experience — I felt that the system was not on my side? I viewed the system as my enemy.

But I am not here to put down social workers, because there are some that are doing a very good job. Once I became educated to child welfare law, and my rights within the system, I was able to have a new worker assigned to my case. This one was willing to work with me as well as with my children. On August 15, 1996, I regained custody of my children.

Hello, I am Deborah Rascoe, a mother of four children, and also a Parent Advocate for the Child Welfare Organizing Project and Neighborhood Youth and Family Services Young Mothers Program...

Communication, education, dedication, and respect are the tools for bridging the gap. We must communicate with one another, not blame one another, when children are involved. Parents, social workers, counselors, the community, anyone involved with children must be educated on the devastating effects that drugs will have on you as well as your children.

To help someone, the parent receiving the help must be dedicated, and know that it is a great accomplishment in their life when they can overcome addiction, one day at a time. Respect the parent that is trying to get their life back. Children don’t understand why they are being removed out of their homes and away from their mother. Most of the time, the children feel it’s their fault. Find out ~ drugs have taken control of their life. A person who uses drugs doesn’t do it simply because they “want” to. It has to be something so wrong, so powerful, that without treatment, you will die emotionally, financially, and spiritually. Help these parents. Help their children, don’t punish them. Why not put more money into preventive services and counseling for these families before you take their children away?

Like I said, I am a parent, but also a survivor, a survivor of domestic violence. When you first get into treatment, myself, as well as many other women, are not motivated. Motivation and self-esteem are things you just do not feel. All you feel is shame and guilt. It is a process that must be taught, along with how to love; how to care for your children; how to have goals; how to stand up for yourself and be responsible. These are some of the things that were taught to me at the treatment program I attended - the Young Mothers program – an 18-24 month treatment program, before the budget cuts.

When my children were taken, I was told to attend a 3-day per week, 4-hours per day program. But I knew in my heart that after using drugs for many years, and being physically, emotionally, and sexually abused for twelve years, a more intense program was what I needed. I found the Young Mothers program, a 5-day per week, all day program, with preventive services such as a domestic violence group, individual and group counseling, acupuncture, independent living skills, a therapeutic nursery, and parenting skills.

Today I am a graduate of the Young Mothers program and a more powerful individual. I also went to college for medical billing, and finished, but my heart still lies in helping parents in any way that I can.

Now I have a poem I wrote about three years ago. I want you to think of children and parents while I read it.

The Lost Child

*I am the lost child
Feeling ashamed and filled with despair
I didn't like what I saw
Oh why oh why did it have to be so?
Self-esteem and love for me was lost inside of me
As she grew up, she found a life full with pain
She lost herself inside of drugs, to take her outside of herself
But now an adult, she had to learn about herself
Accepting herself
Loving herself
Cherishing herself
And finally, the lost child has found herself*

Anna and Deborah's remarks are full of honesty and insight. Several important themes emerge:

- Many addicted mothers would like to be able to turn to the public service system that cares for children for help with their own issues. Unfortunately, the system is most often experienced as blaming and rejecting parents. These mothers are suffering, and may acknowledge a need for help, but feel unwelcome and unable to turn to a system seen as, at best, indifferent, at worst, hostile. *'I viewed the system as my enemy.'*
- Chemically dependent mothers are often characterized as lacking motivation or the capacity to make good decisions. But from the addict's perspective, concepts such as "motivation" and "choice" may have little meaning or relevance. Many feel trapped by their circumstances, and in the grip of a compulsion over which they are powerless. Addiction, and the dysfunctional personal relationships by which it is often preceded and accompanied, are driven not so much by "bad choices" as by the sense that one has no choice. *"A person who uses drugs doesn't do it simply because they 'want' to."*
- Addiction does not occur in a vacuum. Its precedents often include a history of early victimization, predictive of faulty, frequently violent, adult relationships. Its repercussions may, typically, include estrangement from family, poor health and high risk of HIV infection, poverty and impaired educational and vocational achievement. While this context may be understood by child welfare professionals as factors placing children at risk, *"no one asked me what was going on in my 4/e"* is a too-common refrain among the parents. Battered women, in particular, are much more likely to self-disclose if asked the right questions. Posed respectfully and with genuine concern for the mother as an individual, such questions are much more likely to be perceived as a show of concern than as an intrusion.
- While child welfare authorities have argued for laws facilitating earlier protective removal and expedited termination of parental rights for children of substance abusing parents, what is often overlooked is that the mother deemed unsalvageable and an inappropriate candidate for family preservation efforts may keep having children. Both the long-term protective interests of children, living and yet to be born, and the fiscal viability of public child welfare systems may best be served by directing more of these systems' resources towards helping mothers achieve and sustain recovery. Anna and Deborah are living proof that effective treatment modalities exist. Deborah also makes the important point that children do not necessarily experience removal as "protection."
- Deborah's closing poem underscores the futility of public policy that frames parent service needs and child protective needs as competing interests. Today's substance abusing mother is yesterday's abused or neglected child. Both are equally worthy of compassion, respect, and society's best redemptive efforts.

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