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FINAL REPORT:
STUDY OF THE IMPACT ON SERVICE DELIVERY OF FAMILY SUBSTANCE ABUSE
(CONTRACT NO. 105-91-1811)

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The Administration for Children and Families
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Final Report: Study of the Impact on Service Delivery of Families with Substance Abuse Problems

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FINAL REPORT:
STUDY OF THE IMPACT ON SERVICE DELIVERY OF FAMILIES WITH SUBSTANCE ABUSE PROBLEMS

1. INTRODUCTION

From 1985 to 1990 substantial increases were reported in the incidence of infants exposed and addicted to alcohol and other drugs [Feig, 1990; General Accounting Office (GAO), 1990; Office of the Inspector General (OIG), 1990], babies born HIV positive *(Pediatric AIDS Fact Sheer,* ACCH, 1990), substance abuse problems among runaway and homeless youth (Southeastern Network, 1989), substance abuse-related child maltreatment cases (Feig, 1990), and demand for substance abuse treatment [National Association of State Alcohol and Drug Abuse Directors (NASADAD), 1989].

ACYF initiated the Study *of the Impact on Service Delivery of Families with Substance Abuse Problems (Contract #105-91-1811) in* response to a growing concern among experts in the human services field that service delivery systems were being severely taxed by increases in the number of families with AOD abuse problems among their client populations and by the difficulties encountered in serving these families. These increases in AOD abuse-related problems were of particular concern to ACYF since the programs it funds are among those responsible for serving abandoned or maltreated infants, children, youth, and their families, and AOD-abusing runaway and homeless youth and their families. Anecdotal information from ACYF-funded program administrators and staff indicated that children and families with AOD abuse problems were increasing both the demand for services in general and the need for specialized services. Programs operating within limited budgets and service capacities reported being hard pressed to meet the service needs of this population. Further, children and families with AOD abuse problems presented with treatment or detoxification services needs which had to be met before other types of services could be provided. Since these needs often could not be met within ACYF-funded programs, it was becoming increasingly necessary for programs to develop coordinated or cooperative relationships with other service delivery systems, particularly AOD treatment facilities and programs.

As illustrated above, the problem of family substance abuse affects the management, administration, and operations of each and every program funded by the Administration on Children, Youth, and Families (ACYF). The child from a substance abusing family, and the family as a whole, present very complex human service, child welfare, and

educational challenges. For example, children with substance-abusing parents are more likely to be neglected or abused and impact the child protection, foster care, and adoption service programs funded by ACYF. They are also more likely to pose special challenges to early childhood educational programs such as those of Head Start and the Comprehensive Child Development Centers. Further, the same children and families are frequently served by more than one ACYF program either sequentially or concurrently. Once reported, the abused or neglected child and his or her family, for example, become a child protective services (CPS) case. If removed from the home the child (and his/her family) become part of the foster care system which provides services to both the child and their family. The child may then enter adoption services. Children enrolled in other ACYF programs such as Head Start, CCDP, or the Parent Child Centers program come from at-risk families and are often encountered later in the child welfare system.

Substance abusing families are a persistent and growing segment of the low-income families ACYF programs serve. AOD (alcohol or drug) abuse is one of several types of family dysfunction that cut across all populations served by ACYF programs. While there is a plethora of anecdotal information on this topic, systematically collected national data regarding the percentages of families with AOD problems and how these families impact ACYF-funded service delivery programs was not available. There is little available information that the ACYF units can use to plan ways to address the needs of substance abusing families and their children. There is even less information available regarding how the changing nature of AOD abuse within the families served by ACYF programs has impacted on the capacity of these programs to achieve their mandated goals and purposes.

Hence, the primary purpose of the *Impact* study was to provide information to the Administration on Children, Youth and Families (ACYF) that would guide future policy and programmatic decisions and improve the overall quality and effectiveness of its service delivery programs. The study would assess both the size and nature of the impact of family substance abuse on the various service delivery systems implemented, funded, and/or administered by ACYF. These include Head Start, Head Start Parent Child Centers, the Comprehensive Child Development Program (CCDP), the Child Abuse and Neglect State Grant Program, the Federal Foster Care Program, the Adoption Assistance Program, and the Runaway and Homeless Youth Program.

Although these programs differ from one another with respect to services and service objectives, they were all implemented by Congress with the intent that they would improve the quality of the lives of the children and families served and enhance the potential of these children and families for personal growth, productivity, and self-sufficiency. A fundamental task of the *Impact* study was to determine whether substance abuse affects the ability of these service delivery programs to attain these intended goals, and if so, the ways in which these programs are affected.

The various programs funded by ACYF often serve the same clientele, either concurrently (e.g., CPS and Head Start) or in a consecutive interrelated process model (e.g., CPS-foster care-adoptions). A fundamental goal of this study for ACYF was an enhanced capacity to assess the core similarities and differences across program areas in addressing the problem of family substance abuse, ultimately leading to enhanced consistency and integration of approaches across ACYF-funded program areas.

It was hoped that the *Impact* project would also provide ACYF with critical information needed for identifying possible economies of scale in developing and providing informational materials, training, and technical assistance services to ACYF programs on family substance abuse. By identifying commonalities of need across ACYF program areas, integrated responses could be effectively developed.

1.X STUDY GOALS, OBJECTIVES, AND RESEARCH QUESTIONS

The information presented above suggests that parental and adolescent substance abuse may impact on ACYF-funded service delivery systems in a variety of ways. If these service systems are to respond appropriately, more concrete and comprehensive information is needed. While there was anecdotal information on this topic, systematically collected national data regarding the percentages of families with AOD problems and how these families impact ACYF-funded service delivery programs were not available. The *Impact* project was designed to address this knowledge gap. The study focused on five specific objectives:

Objective I: To assess the impact of substance abuse on current service delivery provided across the six programs that ACYF administers: Head Start, the Head Start Parent Child Centers, the Comprehensive Child Development Programs, the National Center on Child Abuse and Neglect, the Runaway and Homeless Youth Program, the Foster Care Program, and the Adoption Assistance Program.

Objective 2: To assess the number of children from families where substance abuse is present who are being served by the various programs and changes in the population served over the past 5 and 10 years.

Objective 3: To assess the impact of changes in substance abuse on the recruitment and retention of foster care and adoptive parents.

Objective 4: To assess the capability of service providers to change the behaviors of substance-abusing parents.

Objective 5: To assess the current responses of service delivery systems to the needs of children and families involved with substance abuse.

Taken together, these five objectives served as the framework for the original approach undertaken in the *Impact* study. Specific research questions were developed for each study objective, identifying variables to be operationally defined and addressed in the data collecting process. These questions, organized under study objective, are presented in Table 1 below.

The study questions, and the variables identified in each, can be classified into four broad categories or domains: Administrative, Program, Client, and Community. The Administrative domain incorporates all general Federal, State, and local statutes, regulations, policies, and perceptions affecting the impact of substance-abusing families on service systems funded by ACYF. The Program domain refers to those aspects of the ACYF-funded service systems that may be affected by family substance abuse as well as those that affect the nature and extent of the impact of substance-abusing families on service delivery. The Client domain pertains to the types and characteristics of clients and families served by ACYF-funded programs. Finally, the Community domain incorporates community perceptions, availability of services, and integration of services as they pertain to the impact of substance abuse on ACYF-funded programs, and as they affect the ability of ACYF-funded service systems to meet the needs of substance-abusing families. Included under community variables are the factors of the program's geographic location and its demographic and cultural characteristics.

1.2 BASIC STUDY APPROACH AND DESIGN

As originally planned, the *Impact* study was to consist of two key temporally sequenced phases, with each phase involving a different methodology for collecting data: Phase I, a mail survey; and, Phase 2, onsight interviews with key informants. Information collected in Phases I and II would be merged, when appropriate, to frame responses to the specific research questions identified above. For the most part, the interview data would serve to explicate and enhance the interpretation of data collected in the Phase I mail survey. Each of these study phases is briefly summarized below.

TABLE 1
STUDY OBJECTIVES AND RESEARCH QUESTIONS

Objective 1: To assess the impact of substance abuse on current service delivery provided across the six programs that ACYF administers.
Q. 1-a: How do various service delivery systems define or conceptualize substance abuse? What kind of substance use is considered a "problem" as opposed to use that is not a "problem?"
Q. 1-b: What are the State and local statutes or policies regarding assessing and reporting children and families with substance abuse problems?
Q. 1-c: What has been the impact of children and families with substance abuse problems on overall service costs and on service costs per family?
Q. 1-d: What changes have children and families with substance abuse problems occasioned over the past 10 years in the nature, scope, and intensity of the services provided by these programs? Has the demand for services increased?
Objective 2: Assess the number of children from families in which substance abuse is present who are being served by the various programs and changes in the population served over the past 10 years and over the past 5 years.
Q. 2-a: What is the current number of children and families with substance abuse problems served by ACYF-funded programs? How have the numbers changed over the past 10 years and over the past 5 years? Do the percentages of children and families with substance abuse problems vary as a function of geographic and demographic differences in the locations of ACYF-administered programs?
Q. 2-b: What are the characteristics of the children and families served who have substance abuse problems ? What are their raciallethnic backgrounds, ages, socioeconomic status, and family structures? In these families, which family members are likely to be the substance abusers?
Objective 3: Assess the impact of changes in substance abuse on the recruitment and retention of foster care and adoptive parents.
Q. 3-a: What is the current ratio between the demand for foster care and the availability of foster care placements? How has this ratio changed over the past 5 and 10 years? Does this ratio vary as a function of geographic and demographic differences?
Q. 3-b: What are the characteristics of children needing placements and how have these changed over the past 5 and 10 years? Do these characteristics vary as a function of demographic or geographic differences?
Q. 3-c: How many children who entered the foster care system in Fiscal Year 1990 have families with substance abuse problems or have substance abuse problems themselves? How has this changed over the past 5 and 10 years?
Q. 3-d: How do the characteristics of children in foster care placements who have family substance abuse problems differ from those of other children in foster care placements? What types of difficulties have been encountered in placing these children and in retaining placements for these children?

Q. 3-e: How many children are currently available for adoption? What percentage of these children are from families with substance abuse problems and how has this percentage changed over the past 5 and 10 years? Has the problem of children from substance-abusing families resulted in changes in State statutes regarding termination of parental rights?
Q. 3-f: How many of the children available for adoption have special medical and/or educational needs resulting from prenatal or later parental substance abuse? What are the difficulties experienced in placing children from families with substance abuse problems in adoptive homes? How are these difficulties being addressed?
Objective 4: Assess the capability of service providers to change the behaviors of the substance-abusing parents.
Q. 4-a: What do various service delivery systems perceive as their primary role in serving children and families with substance abuse problems?
Q. 4-b: What are the goals of various service systems with respect to changing parental behaviors? What types of parental behaviors do various service systems feel it is their responsibility to address?
Q. 4-c: What has been the impact of substance abuse on staffing of these programs? Have there been changes in "staffing mix" associated with the substance abuse problem? Has there been an impact on staff recruitment, retention, or need for training? Does the impact of substance abuse on staffing vary as a function of demographic and geographic differences?
Q. 4-d: What are the perceptions of community service providers outside of the ACYF-funded programs (e.g., courts, police, hospitals, community mental health centers) concerning the capacity of the programs to meet the needs of the populations served by these programs? How have relationships between ACYF-funded programs and other service providers been affected by children and families with substance abuse-related problems?
Q. 4-e: What is the relationship between the service systems and community substance abuse treatment programs? How have these relationships affected the capability of service providers to meet the needs of children and families with substance abuse problems?
Objective 5: Assess the current responses of service delivery systems to the needs of children and families involved with substance abuse.
Q. 5-a: What are the needs of children and families involved with substance abuse?
Q. 5-b: Are programs able to meet the needs of children and families with substance abuse problems? What are the perceptions of program staff? What practices do program staff members believe they need to change?
Q. 5-c: Are the services offered and provided suitable to the needs of substance-abusing families?
Q. 5-d: What barriers have been encountered in providing services to children and families with substance abuse problems? Which of these barriers have been overcome? What is needed to effectively address these barriers?
Q. 5-e: What are helpful and appropriate roles that each ACYF-administered program can perform in combatting substance abuse?

Phase I: Mail Survey ***Study***

Phase I of the project was designed to obtain information about the impact of substance abuse on each of ACYF-funded human services programs from a nationally representative sample of these programs and of the salient community service agencies that work with them. Initially, a total of 1780 respondents from different agencies and organizations were to be surveyed Given the cost and time restraints of the proposed project, a mailed survey form was chosen as the most appropriate data acquisition method for this phase.

Phase ***II: Onsite Interview Study***

The purpose of Phase II of the research project was to collect intensive and in depth information regarding the impact of substance abuse on the service delivery systems of ACYF-funded programs. An onsite interview study was to be conducted in six counties or cities selected on the basis of the magnitude of the impact of substance abuse each has experienced. Specifically, the Phase II effort would focus on gathering information on the nature of problems related to family substance abuse encountered by service providers and the ways that they cope with these problems. Another goal of Phase II effort was to obtain a comprehensive portrait of how ACYF service delivery systems coordinate their services with one another and with other community service agencies that may come into contact with their substance-abusing clients.

In practice, this study underwent significant modification over its course, reflecting factors beyond the control of either the contractor or ACYF. Phase I of the effort was completed only after extensive modification and reformulation following OMB failure to approve the study, and as a result Phase II was completed before Phase I. In the following chapter we provide a brief overview of the study implementation process and project accomplishments.

2. PROJECT IMPLEMENTATION AND ACCOMPLISHMENTS

Funded in September of 1991, the Impact project evolved substantially over its three-year history. Changes in the overall approach to the study reflected a number of factors including:

- Recommendations of the project's Advisory Panel;
- Recommendations and requests of ACYF program staff;and,
- Strategic responses to impediments encountered in procuring OMB approval of the survey portion of the study.

In this section of the report we attempt to summarize the evolution of the project over time, key developments in the implementation process, and project accomplishments. For the sake of clarity, this section is organized around project milestones and critical events in approximate temporal order of occurrence. It should be stressed however that although the project originally was planned as sequential and complementary phases resulting in an integrated study report, in practice difficulties encountered in the project implementation resulted in conducting these two "phases" as essentially separate efforts addressing common goals and objectives.

2.1 CONSTITUTING AND CONVENING THE ADVISORY PANEL

In consultation with ACYF program staff, a national Advisory Panel was formed and formally convened in the Fall of 1991 to provide guidance in the implementation of this study. A listing of Panel members is presented in Table 2. During the initial meeting of the panelists in November of 1991, advisors were asked to

- Provide insights into the current awareness of the impact of substance abuse on ACYF-funded programs;
- Review various sections of the study design for the proposed research project; and,
- Review the survey instruments before they are finalized for Office of Management and Budget (OMB) submission.

It was originally planned that the Advisory Panel would be reconvened at two additional points over the life of the project to review progress-to-date and to review final products. In practice, delays encountered in the OMB review process precluded reconvening of the panel after their first meeting.

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2.2 DEVELOPMENT OF FINAL RESEARCH DESIGN

The original study design proposed in Cygnus' response to the Request for Proposals (RFP) involved two data collection methods: (1) a national survey of State and local agency directors and staff conducted by mail (Phase I of the study), and (2) onsite in depth interviews with agency directors and staff in six selected urban areas (Phase II of the study). The design of Phase I underwent substantial modification and refinement from the original proposal prior to development of the OMB approval request. First, reflecting tasks in the RFP, Cygnus staff, in consultation with the FPO, prepared a fmal study design including specification of variables, data collection instruments and activities, sampling plans, and data processing and analysis specifications.

The most significant change from the originally proposed design was the decision to expand the sample frame for Phase I from 100 to 200 counties, but slightly drop the number of different respondent categories to be sampled in each county, resulting in an increase in the total number of projected respondents from 1780 to 2350. In addition, the design specified and operationalized study variables, data elements, and data sources, and clarified the proportional probability sampling techniques to be employed. Based on recommendations of the Advisory Panel, this design was further subsequently modified by adding new respondent categories to the design, resulting in a final design for Phase I involving a proportional probability sample of 266 counties (to provide for attrition) stratified by geographic region and a size index based on density of single-parent households. The final revised study plan is briefly summarized below for each of the two Phases of the study: A more detailed discussion of the design may be found in the *Request for OMB Review Supporting Statement: Study of the Impact on Service Delivery of Family Substance Abuse,* ACYF, 1993.

2.2.1 PHASE I REVISED STUDY DESIGN

The fmal Phase I study design provided for the collection of information through a mailed survey form from the following ACYF-funded or administered human service delivery programs:

- Local and State child welfare programs including foster care, CPS (child maltreatment), and adoption;
- RHY Basic Center (BC) programs;
- Head Start programs;
- Head Start Parent-Child Centers; and
- Comprehensive Child Development Programs.

In addition, the design provided for collection of supplemental information from staff of hospital pediatric wards and from juvenile or family court judges, to assist in the interpretation of study findings pertaining to the size of the AOD abuse problem and the ability of ACYF-funded programs to respond to the AOD problem.

The number of planned respondents by role for each programmatic area are provided in Table 3. The decision to sample respondents at different service levels was deemed necessary to obtain a comprehensive portrait of the impact of family AOD abuse on a given program.

Given the diversity of programs to be included in the study, the need for results which could be generalized to the entire populations of interest, and the relatively small sample sizes (reflecting budgetary constraints), development of an adequate sampling schema for the study became a creative challenge. The final study design called for surveying the entire universe of State Child Welfare Program directors (50), and staff from the entire universe of Head Start Parent Child Centers (36) and Comprehensive Child Development Programs (24) which had been funded prior to 1992. For the remaining respondent categories and groups, a complex stratified proportional random sampling schema was developed to ensure sample representativeness of the populations of interest while still allowing for analysis and interpretation of results based on group differences. Because of the variability in the number of programs to be sampled, particularly the relatively small size of the RHY Program, we adopted two general sample selection procedures. One procedure pertained to Head Start, the child welfare agency service components (foster care, child protective services, and adoption), judges, and hospitals. The other procedure concerned RHY programs.

23.1.1 *Sample Selection & Stratification: RHY Programs*

The stratification of RHY programs involved two general procedures. First, all programs would be stratified by census region to ensure geographic representation. The decision to use census regions rather than the 10 service regions of DHHS was based on the need to maintain a fairly high number of units in each cell. Since the total target sample size was only 112 programs (to hopefully yield useable information from at least 100 programs), using the census regions rather than DHHS regions served to maintain sufficient representation in each stratum.

The second stratification procedure involved classifying programs within regions according to size (large vs. small). The size measure we determined to be most useful was the size of the total budget of the program (i.e., funds received from the Federal Government as well as from State and local governments and other sources). This figure had been found to correlate highly with other potential size measures such as number of program staff, number of youth served, number of shelter nights provided, etc., while having significant advantages over most other measures. These advantages included universal availability of the information on all programs (for example, "total youth

TABLE 3
PROGRAM, ROLE, AND NUMBER OF RESPONDENTS
MAIL SURVEY STUDY

Respondents	Expected number
Combined Child Welfare	
State Child Welfare Agency Directors	50
County or City Child Welfare Agency Directors	200
Child Protection	
CPS Unit Supervisors -- Investigations	200
CPS Unit Supervisors -- Ongoing Services	
CPS Case Workers -- Investigations	400
Foster Care	
Foster Care Unit Supervisor	200
Foster Care Caseworkers	200
Adoption Services	
Adoption Supervisors	200
Adoption Caseworkers	200
Head Start	
Head Start Program Directors	200
Head Start Social Service/Parent Involvement Coordinator	200
Head Start Teachers	200
Comprehensive Child Development Program	
CCDP Program Directors	24
CCDP Parent Coordinator	24
CCDP Family Services Coordinator	24
Parent-Child Centers	
P-CC* Program Directors.	36
P-CC Education Coordinator	36
P-CC Social Services Coordinator	36
Runaway & Homeless Youth Shelters	
Runaway and Homeless Youth Project Directors	100
Runaway and Homeless Youth Service Supervisors	100
Runaway and Homeless Youth Program Counselors	100
Other Respondents	
Hospital Pediatric Social Workers	200
Juvenile Court Judges	200
Total	3,330

served" data were only available on slightly over 80% of the programs), a common measurement metric across programs (i.e., $s), and a size measure relatively unbiased by individual center programmatic decision-making or services prioritizing ("staff size" for example might reflect program decisions regarding the use of volunteers, or "shelter nights" might show two shelter programs as being essentially comparable while in fact one had significantly more ancillary services in place).

2.2.1.2 Sample Selection & Stratification: Other Programs

Development of the survey sample for Head Start, CPS, foster care, adoptions, hospital pediatric wards, and juvenile/family courts was much more complicated, and a complete discussion including estimates of precision and sampling error may be found in the Request *for OMB Review* cited previously. Our decision was to rely on a sampling methodology primarily based on selecting counties stratified according to region and a compound measure of population density and potential service population size.

While there are 3,140 counties in the United States, they are not all served by Head Start programs. If the counties were selected without consideration to relevant program elements, there would be considerable risk that counties would be included in the study that did not include at least two of the targeted programs.. As a result, a decision was made to include in our universe only those 2,704 counties served by Head Start programs. Our review of our county/city data base indicated that those counties not served by a Head Start program have extremely small populations.

From this universe 266 counties would be selected for inclusion in the sample. Because of the selection process each of these counties was known to have Head Start programs and child welfare agency programs. For those counties selected that did not have a hospital within county boundaries, we selected the nearest hospital with a maternity ward serving the county population. Similarly, for those counties served by a circuit court system rather than a county system, we would solicit responses from the circuit court serving the county.

The number of counties to be sampled, 266, was based on our sample size requirement of 200 counties and our estimates of the anticipated response rates for respondents. The sample size requirement of 200 counties was based on the need to have a sample that was sufficiently large to ensure a representative sampling using stratification procedures while remaining within the bounds of limited budget requirements.

As a result of this decision, there were three levels of selection procedures for respondents. First, counties would be selected. Then, in the event of multiple programs within counties (which is a fairly rare occurrence), programs would be selected. Finally, individual respondents within programs would be selected.

Stratification and sample selection for counties. The final research design provided for drawing the sample the 266 counties using a two-way stratification: first by census region and then within region by a compound measure of size. The first level of stratification ensured the geographic representativeness of the sample for the Nation.

Within census region, the sample was further stratified into four size classes. The size classes were intended to incorporate both a measure of the potential service population within the county and a measure of the urbanicity of the county. Several potential size measures were reviewed. The size measure selected for stratification was based on 1990 U.S. Census figures on the number of female-headed single-parent households in a given county/city divided by the number or square miles in the county/city.

The decision to use female-headed single-parent households as a variable in determining our size measure was based on the need to stratify the sample in some manner that would be relevant to the programs being assessed. In previous studies, when population size alone has been assumed to be equated with service population size, this assumption has not been substantiated. Therefore, an effort was made to identify a population variable that met two criteria: (1) it is relevant to the two programmatic entities being assessed and (2) there is available information about the variable at the county level.

Using the variables of female-headed single-parent households and square mileage, we computed a size measure that was the square root of the number of female-headed single-parent households divided by the square mileage of the county/city. When we computed this measure for all of the 2,762 county/city entities included in our universe, we discovered that the measure was generally effective in discriminating among counties. However, there were a number of county/city entities with a very small number of female-headed single-parent households that also had exceedingly small land areas. These small population areas emerged in the data base as having population densities equivalent to large urban counties/cities. This occurrence was most noticeable in the South census region, and particularly in Virginia where there are a number of small cities independent of county entities. Since the total number of all households for these entities was less than 40,000, we decided to define the smallest size class of our sample in terms of the number of total households (less than 40,000) rather than using the size measure we developed for the other size classes. This ensures that these areas are included in the sample (i.e., they have a probability of being selected), but are not classified as highly urban areas.

Counties having a total number of all households greater than 40,000 are broken down into three size classes representing low, high, and very high densities, based on the square root of the number of female-headed single-parent households per square mile. The counties with very high densities were assigned to a certainty stratum to ensure their inclusion in the sample The universe and sample counts by region and size class are shown in Table 4, below.

TABLE 4
UNIVERSE AND SAMPLE COUNTS BY REGION AND SIZE CLASS

Region	Sample	Size Class 1 ≤ 40,000 house holds	Size Class 2 > 40,000 households Low Density	Size Class 3 > 40,000 house holds High Density	Size Class 4 Certainty Stratum
West	n=30	N_1=253, n_1=12	N_2=46, n_2=7	N_3=18, n_3=7	N_4=n_4=4
Midwest	n=60	N_1=812, n_1=30	N_2=62, n_2=12	N_3=30, n_3=13	N_4=n_4=5
North	n=90	N_1=121, n_1=26	N_2=70, n_2=38	N_3=22, n_3=22	N_4=n_4=4
South	n=86	N_1=1123, n_1=44	N_2=92, n_2=20	N_3=39, n_3=20	N_4=n_4=2

This stratification system classified sampling units on the basis of the two variables of most interest-the potential size of the service population (female-headed single-parent households) and the potential size of the AOD abuse problem (urbanicity or population density). The allocation of the sample to strata required two procedures: allocation by region and allocation by size class. The sample of counties shown in Table 4 was allocated to the census regions in a manner proportional to the total size of the density measure of each region, based on the largest three size classes. Once the number of sample counties was allotted to each region, the number of counties allocated to the size class strata was determined. Again the allocation was performed in a manner proportional to the total size of each size class stratum. The initial allocation was adjusted to ensure a sufficient sample size in all strata for estimation.

Other Sampling Considerations. In addition to the factors already addressed, the final study design for Phase I needed to operationalize other sample selection criteria, specifically selection of individual programs within county (where multiple programs exist) and individual respondent selection.

Agency/Program Selection. *In* a few instances there are multiple service centers of a specific program type serving a single county. For example, many counties are served by a single Head Start grantee but the services are often provided by several delegate agencies within the county. Similarly, some counties have child welfare systems with

separate branch offices serving different segments of the county. Further, within the child welfare service components, services such as CPS and foster care may be provided in branch offices, while adoption services may be centralized.

It is important to note that these branch offices or service centers are usually administered by a central agency. Thus, the kinds of data to be collected from grantee project directors or agency administrators would still be county-wide and would not be affected by the existence of branch offices and multiple service centers. However, the anecdotal and impressionistic data to be collected from supervisors and direct service providers would be specific to a particular office or service center within the county system. In these situations, when supervisors and direct service personnel were to be solicited, we decided to select the service centers purposively, choosing those serving the largest number of clients.

Respondent Selection. As can be seen in Table 3, each county selected for the sample will potentially provide 14 respondents (excluding State directors, and RHY, CCDP, and P-CC program staff). Respondents would be first selected on the basis of their job titles (i.e., directors/administrators and supervisors/direct service providers). When multiple individuals hold the same job category (e.g., Head Start teachers) we would select those direct service providers and line supervisors who have been in their jobs for the longest time period.

For supervisors and direct service providers, the universe of respondents within each program area vary considerably across counties. For example, some small counties have no more than five or six caseworkers in each child welfare program area and one or two supervisors. Other counties have well over 100 in the CPS division alone. Therefore, any analysis conducted of the qualitative information provided by these respondents requires weighing according to the number of potential respondents in the universe.

2.2.2 PHASE II REVISED STUDY DESIGN

The Revised Phase II design was primarily an elaboration of that provided in the original proposal. Phase II was designed as a supplemental effort to provide qualitative information regarding the impact of family substance abuse on ACYF-funded programs. In depth, onsite discussions with agency personnel would be conducted in 6 separate geographic locations selected purposively to reflect counties experiencing the greatest impact from family substance abuse. The original Phase II plan called for relying on preliminary analysis of the mail survey data to identify cities\counties to be selected, but the revised design used a combination of indices including an indicator of the overall level of community substance abuse (DAWN surveillance data for emergency room drug abuse episodes), the density of female headed households, geographic region, and the presence of a P-CC or a CCDP program in the community. As can be seen in Table 5, six primary and six alternate sites were proposed as part of the revised Phase II plan.

TABLE 5
PROPOSED PHASE II CITIES & SELECTION CRITERIA

REGION	CITY	DRUG ABUSE EPISODES PER 1000 PEOPLE	DENSITY OF FEMALE HEADED HOUSEHOLDS	PRESENCE OF CCDP OR P-CC PROGRAMS
WEST	*San Francisco	7.55	715	P-CC Only
WEST	*Denver	2.10	214	CCDP Only
WEST	Phoenix	2.46	7	Both
MIDWEST	*Chicago	2.33	288	P-CC Only
MIDWEST	*St. Louis	1.55	526	P-CC Only
MIDWEST	Minneapolis	1.47	67	Neither
NORTH	*Brooklyn	3.15	2459	CCDP Only
NORTH	*Philadelphia	3.69	860	P-CC Only
NORTH	*Boston	2.75	761	Neither
SOUTH	*Baltimore	2.61	763	Both
SOUTH	New Orleans	4.71	209	P-CC Only
SOUTH	Miami	1.52	40	CCDP Only

(Shaded cities represent the primary recommended cities, with unshaded cities representing alternates: Cities marked with an asterix (*) are included in the "certainty" strata of the Phase I design)

To attain the goals of Phase II, onsite interviews were to be conducted in the selected sites with direct service providers and administrators from the CPS systems, foster care and adoption systems, Head Start programs, P-CC or CCDP projects, runaway and homeless youth programs, mental health service programs, substance abuse treatment programs, police, juvenile justice programs, courts, public schools, and hospitals. If model programs addressing the issue of interagency coordination existed in any of the sites, individuals involved with implementing or providing services in these programs would also be interviewed.

2.3 DEVELOPMENT OF STUDY INSTRUMENTS

The revised study designs for the *Impact* study discussed above required the development of two different sets of instruments to guide data collection and information gathering efforts. First, we needed to develop a set of survey instruments for Phase I of the study addressing data elements associated with the study questions presented in Table I and suitable for use with all respondent classes identified in Table 3. Second, we needed to develop a set of discussion guides suitable for the intensive on-site discussions to be held with key informants as Phase II of the study. Of these two tasks, the former was by far the most complex and difficult. The development of each of these sets of study instruments are discussed briefly below.

2.3.1 INSTRUMENTS FOR THE MAILED SURVEY (PHASE I)

Work on development of the instruments for the mailed survey portion of the *Impact* study (i.e., Phase I) began in November of 1991. Initial templates of selected instruments by agency category were developed for review by the Advisory Panel as part of their December 1991 meeting, . Based on feedback from the Federal project officer and the Advisory Panel members, these templates underwent significant modification, including the decision to focus most questions addressing change on a five-year (rather than ten-year) time frame, and to both allow, and discriminate between responses based on actual program data versus responses based on estimates. In addition, significantly more questions allowing "open-ended" responses were added, reflecting a desire to maximize the study's capacity to identify unanticipated effects or impacts of family substance abuse on program operations.

Although the survey instruments developed were designed to be appropriate to the individual program areas, an attempt was also made to structure the questions in a similar manner across program areas. This was done to facilitate comparisons across programs with respect to the impact of suspected or known family AOD problems on service delivery. A decision also was made to construct a separate instrument for each type of respondent rather than combining questions for various respondents using skip patterns. The variations in the questions to be asked of respondents both within and across programs would result in a highly complex instrument if skip patterns had been used.

The complete package of survey instruments, consisting of 16 separate survey forms addressing respondents in 11 different service systems underwent numerous individual (i.e., revision of a specific instrument only) and collective revisions (i.e., revisions of all instruments or an entire class or set of instruments) between November of 1991 and the final accepted version completed in May of 1992. The final versions are presented here as Appendix A. Each instrument is accompanied

by a chart which cross-references specific survey questions or items to the broader study questions.

The survey instruments were designed to elicit statistical information and quantitative data using interval scale (e.g., Likert or semantic differential), dichotomous, or rank order response formats. The instruments also include both scaler and open-ended questions to elicit conceptions, opinions, beliefs, and perspectives from the various respondents. These types of information provide a contextual framework that serves to enhance the interpretation of the quantitative analysis. In general, program administrators and directors are queried regarding statistical and factual information about the client population; staffing arrangements; governing regulations and standards; and Federal, State, or local policies affecting program activities. These respondents also are asked to provide their opinions and perspectives on a few selected issues. In contrast, line supervisors and direct service providers are asked a few factual questions but primarily are requested to provide their opinions and perceptions. The survey instruments range from four pages (Juvenile Judges) to twenty-two pages (County/City Child Welfare Directors), depending upon the particular respondent category; most of the instruments however are 12 to 14 pages in length.

Development of the instruments was much more time consuming and labor intensive than originally had been anticipated. These difficulties in part reflected the impact of a number of conceptual and technical measurement issues that had to be resolved. One of the most important -- and yet most difficult to resolve -- conceptual issues to be addressed was the fact that different agencies and individuals mean different things by the terms "substance abuse" alcohol and/or drug (AOD) abuse" or "AOD use". Operationally defining our terms in a way that was both relevant and acceptable to all of the diverse groups to be surveyed proved to be a bigger challenge than we had imagined. It appeared that while "everyone knows what the term substance abuse means" in practice agencies and individuals had widely diverging perspectives. Some of the philosophical and pragmatic definitional issues raised included:

- Whether, or under what circumstances, <u>any</u> use of a proscribed substance automatically constitutes "abuse";

- Whether, or under what circumstances, use of licit substances (e.g., alcohol, prescription drugs, cigarettes, etc.) should be considered abuse;

and,

- The somewhat tautological nature of substance "abuse" definitions which depend on causal inferences and attributions (e.g., "When the consumption of alcohol interferes with an individuals ability to ...").

This definitional issue was never entirely satisfactorily resolved. The pragmatic study decision was to provide respondents with both a definition of the term "AOD" and "AOD abuse problem" upon which to base their responses while at the same time asking them to supply their own agency's definition if it differed significantly from the one provided. For study purposes therefore, the term "AOD" referred to,"... alcohol and other drugs with the exception of nicotine, caffeine, and prescription drugs under a doctor's supervision." and the term an AOD abuse problem referred to, "... a level of AOD use resulting in the user being unable to meet personal responsibilities, being unable to appropriately fulfill role requirements, and/or engaging in behaviors that are self-destructive or harmful to others ."

A second major issue that needed to be addressed was how to draw meaningful comparisons between AOD-abusing and non-AOD-abusing clients. We decided early in the design process that for the most part raw data on AOD-abusing clients would not be particularly useful unless direct comparisons could be made with non-abusing clients. Originally, we considered an approach (and developed questions reflecting this approach) where respondents would be asked to provide information on both AOD-abusing and non-abusing clients (e.g., "What is the average length of stay in foster care of children coming from AOD-abusing families? What is the average length of stay in foster care of children coming from families which don't abuse alcohol or drugs?"). While this approach had the advantage of allowing direct statistical comparisons between the client groups, in practice this approach proved to be impractical. First, this approach significantly increased the overall length of the survey instrument thereby increasing respondent burden. Second, the approach would seriously complicate data analyses and interpretation in terms of dealing with missing data or with estimated and actual values. Third, for many of the variables of interest we doubted that reliable information or even sound bases for estimation actually existed (e.g., average length of time cases are open, total staff time devoted to cases, etc.). For these reasons, we eventually settled on a strategy that asked respondents to make comparative judgements regarding AOD-abusing clients in relationship to non-abusing clients for example:

H2 Do ongoing services cases involving families with suspected or known AOD abuse problems require more caseworker time than other cases?

- ☐ Almost always require more caseworker time
- ☐ Frequently require more caseworker time
- ☐ Sometimes require more caseworker time
- ☐ Rarely require more caseworker time
- ☐ Don't know

Two additional problems arose around those questions asking for counts, frequencies, or percentages: what if any time frame should be specified and whether estimates should be allowed. The time frame issue was complicated by the fact that agencies lack a common metric for data gathering and reporting and by the fact that some of the statistical information requested (e.g., number of substance-abusing clients) if collected at all, may only be collected aperiodically or as part of a special study or program evaluation effort. We finally decided to rely on program fiscal year as the requested reporting period for actual counts and frequencies, but to leave the time frame for reporting percentages unspecified.

We also decided to allow program estimates for counts, frequencies, and percentages. This decision was predicated on a number of different factors. First, it would allow programs which collected data on the question of interest but not on a fiscal year basis to still respond. Second, particularly for supervisors and caseworkers we wanted to allow them to estimate percentages based on their experience, even when "hard data" didn't exist (e.g., "What percentage of your caseload involves families with a substance abuse problem?'). We also however felt it was important to know to what degree findings reflected actual data and to what degree they reflected estimates, so for each question requesting counts, frequencies, or percentages respondents were also asked to indicate whether their response was based on , "Reporting from data" or "Estimating response". This approach was also applied to those questions addressing change over time.

Although each of the sixteen survey instruments are customized for the individual respondents, in general each agency's (e.g., Head Start) set of instruments addresses nine basic topical domains:

1. Definitions. Agency or program definitions of substance abuse;

2. Respondent Information. Descriptive information on the respondent's background, role, and responsibilities;

3. Program Information. Agency policies, practices, and procedures, particularly as they relate to AOD abuse issues;

4. Data Availablity. Information on data routinely collected and maintained by the agency;

5. Service Population. Basic descriptive information on agency clients, and on AOD-abusing clients, including changes in AOD abuse over time;

6. Services and Staffing. Information on the types and characteristics of services provided by the agency and agency staffing levels and patterns;

7. Extent of the AOD Abuse Problem. Information on the scope and pattern of AOD abuse in the agency's client population;

8. Impact of AOD Abuse. Information on the effects of client AOD abuse on agency operations, including caseloads, staffing issues and staff training, agency policies, procedures, and programs.

9. Effectiveness of Services. Information on specific agency approaches to dealing with client AOD abuse and perceived effectiveness of these approaches.

Given the expanded scope and breadth of topics to be addressed, and the logistical demands of maintaining comparability of wording and measurement metrics for similar items across two or more instruments, length of the instruments and respondent burden became issues of some concern. Within agencies therefore we attempted to ensure that questions asked were most appropriate to each individual respondent's particular level of experience and presumed expertise. The final instruments, presented in Appendix A, represent the culmination of these efforts. Instruments for program or agency directors take approximately one to one and one-half hours to complete, including data retrieval, while those for staff supervisors and line staff require approximately 30 minutes to complete.

2.3.2 ONSITE DISCUSSION GUIDES

Although the plan called for relatively unstructured free-flowing discussions with staff of ACYF funded programs, topical discussion guides were prepared to serve as reminders to site visitors of key issues and topics to be addressed. In general, the discussion guides address most of the same general topics as those covered in the mail survey instruments, but are designed primarily to generate discussion on the topic, allowing those interviewed in large measure to set the tone, content, and depth of the discussion. We also however wanted these discussions to provide more in depth perceptions concerning service barriers, problems, and needs and the levels and effectiveness of interagency coordination and services integration. In addition, a key element of the Phase II effort included selective discussions with staff in ancillary programs or agencies who could provide an external perspective on the impact of family AOD abuse on ACYP-funded program areas.

These ancillary agencies included hospitals, schools, juvenile justice facilities, mental health services, and the juvenile or family court.

A total of 24 discussion guides -- one for each class of site visit participant-- and corresponding discussion protocols were developed. These were:

- County or City Child Welfare Agency
  - -- Child welfare agency director
  - -- CPS unit supervisors
  - -- CPS caseworkers
  - -- Foster care supervisor
  - -- Foster care caseworker
  - -- Adoption supervisor
  - -- Adoption caseworker
  - -- Foster care families focus group

- Head Start Program
  - -- Head Start program director
  - -- Head Start education coordinator
  - -- Head Start social services coordinator
  - -- Head Start families focus group

- CCDP/P-CC Programs
  - -- CCDP/P-CC director
  - -- CCDP/P-CC child development coordinator
  - -- CCDP/P-CC family services coordinator
  - -- CCDP/P-CC families focus group

- Runaway and Homeless Youth Program
  - -- Runaway and homeless youth program director
  - -- Runaway and homeless youth program service provider
  - -- Runaway and homeless youth focus group

- Juvenile/family Court judge

- Juvenile Justice Agency
  - -- Juvenile justice agency director
  - -- Juvenile justice agency service provider

- Substance Abuse Treatment Agency
  - -- Substance abuse treatment agency director
  - -- Substance abuse treatment agency service provider

- **Mental Health Services** Agency

-- Mental health services agency director
-- Mental health services provider

School
-- Supervisor of school counselors
-- School counselor

- Hospital
  -- Hospital social worker
  -- Hospital staff pediatrician

Included were discussion guides for four planned "consumer" focus groups: Foster care families; Head Start parents; CCDP and/or PC-C parents; and, runaway or homeless youth. These discussion guides in their final forms may be found in Appendix C.

2.4 SUBMISSION TO OMB FOR APPROVAL

Early in the project it was determined that Phase II was not subject to OMB review and approval under the Paperwork Reduction Act and 5 CFR 1320 because of the small number of interviewees in each class (i.e., six) and because of the unstructured nature of the information gathering process. OMB review and approval however was needed for Phase I, the mail survey. The OMB review process is intended to ensure that the data to be collected are needed, do not pose unnecessary respondent burden, and will yield meaningful information addressed to specific research questions.

Cygnus prepared, and submitted to ACYF, Standard Form 83: Request for OMB Review and a complete Supporting Statement for the Request for OMB Review. The original draft was submitted in June of 1993, and after several extensive sequential reviews and revisions, the final version was submitted to ACYF in December of 1993.

2.5 INITIAL PHASE II IMPLEMENTATION

In part reflecting delays in obtaining OMB clearance, in the Fall of 1993 it was decided to proceed with Phase II of the study and conduct the onsite interviews with key informants. As part of overall data collection revisions and modifications, it was decided to slightly modify the proposed onsite interview schedules. Specifically, it was decided to expand the number of interviewees in CPS to allow interviews with both "intake" and "continuing services" supervisors and caseworkers. It was also decided to identify and talk to additional key informants in city/county-wide AOD abuse services and community response

planning roles to obtain better city-wide statistics on AOD abuse patterns and characteristics and how these patterns had changed over time. Finally, it was decided not to conduct any of the originally-planned consumer focus groups, based on Advisory Panel perceptions that while consumer groups may know a great deal about AOD abuse in the community, they are unlikely to have a clear sense of the impact of AOD abuse on the particular programs themselves (e.g., foster care, Head Start, etc.).

As noted in Section 2.2.2 above, the revised plan recommended six cities for inclusion in the Phase II effort: Baltimore, Brooklyn, Denver, Chicago, New Orleans, and San Francisco. In practice, three of these cities were replaced with alternate selections for a number of reasons. First, at the ACYF FPO's request, Denver was replaced with Minneapolis, given the historic pattern of innovative service delivery models developed in Hennepin County (Minneapolis). Second, at the actual time of implementation, Chicago was undergoing a major restructuring of child welfare services, with all major leadership roles being redefined, current position holders being discharged, and layoffs of over two thousand staff in progress which in turn were being challenged in court. Overall, we decided that the climate in Chicago would not be conducive to implementation of the study at that time, and Chicago was replaced with St. Louis. Finally, we ran into extensive difficulties in obtaining local agency cooperation with the study in New Orleans, resulting in the decision to replace New Orleans with Miami/Dade County.

All Phase II site visits were conducted between August, 1992 and January, 1993. Two site visit teams, each consisting of two professional staff, were constituted to conduct the visits. With the exception of Baltimore, Maryland, which served as the initial pilot of the approach and methodology, each city was visited by one of these teams for four-to-five days (depending on interview scheduling). Joint interviews were routinely conducted with the Director of Child Welfare and with the person identified as being in charge of city-wide AOD abuse data collection or response strategies. Most other interviews were conducted by only one of the team members to allow for double-scheduling of interviews. In Baltimore, both teams participated in conducting interviews and all interviews were conducted jointly by two or more interviewers, with one of the two assuming a leading role. Subsequently, debriefing discussions were held regarding the content and productivity of the overall interview.

As discussed previously, these site visits were not intended to be case studies of the cities involved: The overall intent was to collect qualitative information which would further elucidate and enrich Phase I study findings. For this reason, no attempt was made to integrate information collected on either a city-wide (e.g., all San Francisco agencies) or agency-wide (e.g., all Head Start programs) basis. Rather, summary notes were prepared on each individual interview with the

primary focus on identifying particularly insightful or succinct observations on the part of the interviewees. When it became clear that implementation of the survey portion (Phase I) of the study was going to be significantly delayed due to the OMB review and approval process, the possibility of re-configuring these site visits into city-wide case studies was briefly considered, but ultimately was rejected jointly by both the project team and the ACYF FPO, primarily reflecting concerns that collection of objective operational data on agencies had not been a priority under the Phase II effort.

2.6 Pretest of Survey Instruments

While awaiting OMB approval, the mail survey instrument was selectively pretested with child welfare and Head Start personnel from May through August August of 1992. Pretests of were conducted in the greater Washington-Baltimore area for all respondents with the exception of Head Start programs, which relied on a voluntary sample from seven programs around the country. At the end of April, 1992 at the National Head Start Conference held in San Diego, volunteers from Head Start staff were recruited to complete the survey instruments and a feedback form on the instruments. These included 7 Head Start program directors, 9 education coordinators, and 9 social services/family services coordinators. Initial plans were also established for piloting other local agency survey instruments in July and August. Following up on a preliminary commitment by the Director of Child Welfare services in Fairfax County, Virginia, the child welfare survey instruments were mailed to her for pilot testing with her staff in the middle of August.

The pretest was designed to answer specific questions about the instrument itself inchlding:

- how much time it took to complete;
- whether staff could complete it on their own or whether they sought assistance from others in the agency;
- whether the items themselves were easy to understand and relevant to the program;

and,

- whether the instrument was comprehensive from the respondent's perspective and if not, why not.

A separate structured review sheet was prepared for pilot test respondents to record their observations and perceptions of the instrument itself.

In August it was decided to defer any further pretesting of the instrument pending final ACYF approval and OMB review. This decision reflected the concern that multiple and recurring reviews of the instrument within ACYF had resulted in extensive instrument modifications between April and August and were still ongoing at that time and that therefore the versions being pilot-tested were no longer the actual instruments which would be used in the study.

2.7 OMB DECISION AND REQUEST FOR RECONSIDERATION

At the end of June, 1993 we received notification that OMB had rejected the study, primarily based on OMB's perspective that the study would have little practical utility.

Numerous discussions were held between project and ACYF staff regarding how to proceed in light of the failure of OMB to approve the Phase I study. It was decided to request that OMB reconsider their decision, and a detailed written response to OMB's stated concerns was developed for review and approval by ACYF. Ultimately however it was decided not to proceed with an appeal to OMB.

2.8 REFORMULATED PHASE I IMPLEMENTATION

In June of 1994 ACYF requested that Cygnus propose an alternate plan for completion of the *Impact* study by the Fall of 1994. Based on this request, Cygnus prepared a preliminary plan for conducting intensive case studies of four cities and an up&ted review and synthesis of the research literature in lieu of the survey study. Here we briefly discus1s implementation of the plan's two key parts and the resulting products.

2.8.1 REVIEW OF THE RESEARCH LITERATURE

Given the delays encountered in the project, it was felt that one worthwhile new product would be an updated review of the research literature on the impact of family AOD abuse on ACYF-funded programs. Specifically, we proposed to provide an updated literature review of salient research studies for the period from 1986 to the present. This synthesis report on the state of the art research literature would provide a basis for ACYF consideration of what future research efforts might best address gaps in the current research base. Specifically, this literature review addresses:

- Available statistics pertaining to substance abuse among relevant populations, identifying the particular substance(s) the statistics pertain to and the various levels of use;

- Available research efforts that focus on the effects of substance abuse among the relevant populations; and

- Available research efforts and anecdotal information concerning the impact of substance abuse on ACYF-funded programs and the effectiveness of program responses to the problem..

The resulting product of this effort, *The Impact of Family Substance Abuse on ACYF-Administered Programs: A Review of the Research Literature,* is presented here as Appendix B. The review itself is organized into agency-specific (e.g., Head Start, RHY, etc.) sections addressing relevant research literature on both the impact of family AOD abuse and on agency responses to the problem. It also includes separate listing of reference by topic and an annotated bibliography of selected salient articles.

2.8.2 CASE STUDIES OF SELECTED CITIES

The reformulated Phase I plan proposed intensive case studies of the impact of AOD abuse on ACYF-funded programs in four cities: Baltimore, Miami, Minneapolis, and San Francisco. These cities were chosen to allow for some comparison over time with the information gathered in the Phase II site visits; only four cities were proposed (rather than the original six cities) because it was felt that this constituted the maximum number that could hopefully be accomplished within the time frame requested by ACYF.

Successful implementation of this part of the study in all four cities was predicated on a number of different assumptions. First, based on the Phase II effort conducted two years earlier, we believed that less time would be needed for logistical planning and overall implementation logistics in this phase. Second, given the short time frame for completion of the effort, selection of four sites was predicated on the assumption that consultants and subcontractors would be able to substantially assist in the effort With this in mind, we quickly arranged to hire a part-time research analyst in Miami to aid our efforts there, initiated a subcontract with Houston Associates, Inc. to provide assistance with both the literature review portion discussed above and with completion of the Baltimore site visit, and reached preliminary agreement with the National Council on Child Abuse and Family Violence to provide direct assistance in completion of the Minneapolis and San Francisco case studies (the Council has professional-level staff in-place in both sites).

With these preliminary arrangements in place, an orientation and training meeting for all staff, consultants, and subcontractors was held on Saturday, July 23, 1994. Following this meeting, we re-evaluated the feasability of completing all four cities, which in turn led to further revision of the reconfigured Phase I plan. It was proposed to ACYF that we further narrow the scope to only two cities: Baltimore and Miami. This proposal was accepted by ACYF and data collection efforts commenced. Site visits to agencies in each of these two cities were conducted in August and early September. Methodology and findings of these two case studies are covered extensively in Appendix C, *The Impact of Family Substance Abuse on ACYF-Funded Programs: The Baltimore and Miami Experiences.*

3. CONCLUSIONS AND OBSERVATIONS

As is clear in the foregoing discussion, the *Impact* study experienced a number of set-backs and difficulties from its very inception. Perhaps most fundamentally, it may have represented an attempt to advance the state of the art of research in this area faster and further than was advisable. Clearly, the measurement and sampling difficulties encountered -- which contributed to significant delay early in the project-- reflected problems inherent in the scope of the original study concept. Stated simply, in the absence of prior significant comparable work it was perhaps overly-ambitious to attempt a unified cross-agency study of this type at this time.

It is also clear that both Cygnus and ACYF significantly underestimated the time frames required for in-house review of core study documents and instruments and the number of iterations necessary to bring these measurement instruments and the OMB package to satisfactory completion. Again these difficulties in part reflect the "ground-breaking" and overly-ambitious nature of the original study concept,

Despite these many setbacks, the *Impact* study has achieved some significant and worthwhile outcomes. These include the development of a family of measurement instruments suitable for assessing the ongoing impact of family AOD abuse on each of the ACYF-funded program areas. These instruments may prove of significant value to agency-specific study efforts as well as local program evaluation efforts.

Second, and perhaps more importantly, the two city case studies presented in Appendix G provide a compelling and intensive picture of the day-to-day issues and problems encountered by ACYP-funded programs in attempting to meet their mandated responsibilities while dealing with AOD abusing families. Based on these case studies and the Phase II interviews, the following conclusions appear inescapable:

> *I) While all ACYF-funded programs are negatively impacted by family substance abuse, both the nature and degree of impact vary substantially across programs.* It is obvious that of all these systems, CPS is most seriously negatively impacted by family AOD abuse, followed by Foster Care, Head Start and the other early childhood education programs, then RHY programs, and finally, adoption services. For CPS the issues are complex and multifaceted, including devising more effective ways of managing cases where parents are incapacitated to a significant degree due to their AOD abuse, developing effective policies and procedures for addressing AOD-exposed and HIV-positive infants, and addressing

increasing concerns regarding worker safety in the field. For foster care, unresolved problems include the increasing number of "special needs" placements needed for AOD-exposed or HIV-positive children, the need for more effective intervention strategies geared toward family reunification, and the inherent conflict between a focus on family reunification on the one hand, and the need for accelerated termination of parental rights to facilitate permancy for the child on the other hand.

For Head Start and early childhood education programs, the most fundamental impact of family AOD abuse has been on the number and types of special needs children entering the programs, followed closely by difficulties encountered in engaging substance-abusing mothers in ancillary service programs. For the most part, RHY programs appear relatively unaffected by the family substance abuse problem, although programs acknowledge that parental substance abuse is a factor in a significant percentage of their cases and frequently poses a problem in terms of family reunification efforts; addressing the needs of substance-abusing runaway or homeless youth also is an increasing area of concern for these programs. Finally, the major impacts of family substance abuse on adoptions appears to be first in the increased need for subsidized adoptions for children with special needs, and second in terms of more effective policies, procedures, or programs for dealing with "sleeper" effects of AOD-exposure which may not appear until after the adoption has been finalized.

2) *Front-line staff in most ACYF-funded programs are ill-equipped and poorly trained for dealing with substance abusing families.* Particularly in CPS, Head Start, and foster care staff express a lack of preparation and confidence in dealing with AOD abusing families. Critical issues for staff include how to successfully engage and motivate substance abusing clients in both AOD treatment and in other service programs, risk assessment in these families, and how to effectively deal with ongoing patterns of child neglect in substance abusing families which, while not life threatening or posing imminent danger to children, has long term deleterious effects.

3) Effective intervention in cases of family substance abuse by ACYF-funded programs is significantly hampered by the lack of appropriate AOD treatment outlets. Although many staff interviewed felt that the overall availablity of AOD treatment resources in the community were inadequate, the more univeral and compelling plea was for inpatient detoxification and treatment programs which would accept pregnant women and for similar programs which provided for mothers with children. The lack of such programs **was almost universally** cited as a barrier to effective intervention,

frequently requiring a parent to choose between in-patient treatment and voluntary relinquishment of their children, or only outpatient treatment.

4) *Family substance abuse has resulted in fundamentally new challenges to all ACYF-funded programs in meeting their mandated functions. The* problems posed by family substance abuse have resulted in fundamental shifts in program approaches to providing services as each program grapples with the issues of which policies, procedures, and practices are most effective in addressing the problem. Examples include, among others: accelerated TPR policies and procedures; increased and enhanced post-adoption support services and pre-adoptive foster placement programs; expansion and modification of Head Start programs to address the needs of non-parental caretakers; and, special programs to address the needs of runaway and homeless youth who cannot safely return home due to parental or family substance abuse issues. The efficacy or of most of these approaches remains untested.

If ACYF service delivery systems are to meet the needs of children and families involved with substance abuse, they will require a better understanding of, and the development of more effective approaches to providing services that:

- help families with substance abuse problems overcome their problems and stay together while concurrently ensuring protection of children;
- help children compensate for the developmental and other problems caused by AOD exposure ; and,
- provide for the safety and nurture of adolescents from substance-abusing families.

Meeting these challenges will not be easy. Current efforts and program initiatives, although well- intentioned, lack a sound basis in research or program evaluation findings to justify the redirection of scarce program resources. Critical efforts are needed not only to devise new programs to meet the needs of substance abusing families but to carefully monitor, assess, and evaluate the outcomes of such programs. The *Impact* study, represented but a tenative beginning in this direction. Additional studies are needed to provide the Administration on Children, Youth and Families (ACYF) with information of critical importance to future policy and program decision-making regarding children and families with AOD (alcohol or drug) abuse problems. These studies must have practical utility for each of the ACYF Bureaus (e.g., NCCAN, Head Start, FYSB) as well as for ACYF as a whole. An enhanced understanding of the impacts of substance abuse

on these service programs and agency responses to this challenge will contribute to the development of more effective administrative and managerial responses to AOD problems and improved quality and effectiveness of ACYF service delivery programs.

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(2 of 4)

FINAL REPORT:
STUDY OF THE IMPACT ON SERVICE DELIVERY OF FAMILY SUBSTANCE ABUSE
(CONTRACT NO. 105-91-1811)

APPENDIX A: PHASE I SURVEY INSTRUMENTS

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CCDP Director

RESEARCH QUESTION	ITEM(S)
1a - Concept of AOD abuse	A1, A2
lb - State and local statutes	11 thru I7
1c - Service costs	F1, F2, F3, F4
1d - Change in services/demand for services	C2, C3, G4, G5, H6
2a - Number of clients with AOD abuse problems/change	E1 thru E3
2b - Characteristics	NA
3a - Foster Care	NA
3b - Adoption	NA
4a - Goals/effectiveness	G1, G2, G3
4b - Staffing	H1 thru H8
4c - Juvenile court and hospital social workers perspectives	NA
5a - Client needs	NA
5b - Staff effectiveness	NA
5c - Barriers	NA
5d - Roles	J1, J2, J3

Revised: July 30, 1992

Comprehensive Child Development Program (CCDP): Director

This questionnaire form is to be completed by the CCDP director or knowledgeable grantee administrator. Please feel free to seek assistance in completing this questionnaire from other program staff, particularly with respect to those questions that require statistical information.

Guidelines for completion of the form

Please restrict your responses to impressions that are directly based on your experience as a CCDP director. Many of the questions require you to state opinions that are based on your own professional experience. In general you should answer these questions **only if:**

1) You have had direct contact with children and/or their families.

2) You have discussed cases or client situations with staff members.

3) You have access to records and/or databases containing pertinent information.

Otherwise, you should respond “don’t know”.

SECTION A: DEFINITIONS

As indicated in the cover letter, in this study we are interested in assessing the impact of family or youth alcohol and other drugs (AOD) abuse problems on your program. Although the term "AOD abuse problem" can be conceptualized in a variety of ways, we have defined this term in a way that we feel is meaningful for service delivery efforts. We would like you to keep the following definitions in mind while you are completing this questionnaire.

For the purposes of this study, AOD refers to alcohol and other drugs with the exception of nicotine, caffeine, and prescription drugs under a doctor's supervision.

AOD **abuse problem** refers to a level of AOD use resulting in the user being unable to meet personal responsibilities, being unable to appropriately fulfill role requirements, and/or engaging in behaviors that are self-destructive or harmful to others.

A1 Does your program define the term AOD abuse problem in a similar or different manner?

Similar ☐ Different c1 Do not have a program definition ☐

A2 If you answered **different,** please describe how your program defines a AOD abuse problem.

_____

_____

_____

_____

SECTION B: RESPONDENT/PROGRAM INFORMATION

B1 Name: _____

B2 Contact telephone # (-____)_____ _____

B3 Job title: _____

B4 What are your primary responsibilities?_____

_____

_____

B5 How long have you been employed in this position? _____

B6 What was your previous position and how long were you employed in that position?

Position: _____

Length of time: _____

B7 What type of grantee agency operates this program?

- ☐ Community Action Agency
- Cl City administration
- Cl Community family service center
- ☐ Community health center
- ☐ Other public agency
- ☐ Public nonprofit agency
- ☐ Private nonprofit agency
- ☐ Public school system
- ☐ Private school system
- ☐ Indian Tribe
- ☐ Other (specify) _____

B8 What percentages of families does your program serve in each of the following models?

Cent%r-based model
Hom%-based model

B9 How many centers does the grantee operate? _____

B10 What is the annual budget of the CCDP program (including non ACYF funding, for grantee as well as any delegate agencies)? $_____

SECTION C: SERVICE POPULATION

This section solicits information about the families served in your CCDP program. Please answer the questions for all centers operated by the grantee or delegates. Please answer all questions based on your personal experience.

If your program does not maintain these data, please provide your best estimates based on your own experiences. Also, please indicate by putting an X in the appropriate box if your answer is **from available data** or is au **estimate, If** you do not know an answer and you feel you cannot make an estimate, put an X in the box labelled "don't know."

Cl How many children were served?

Number of children _____
❑ Reporting from data ☐ Estimating response Cl Don't know

C2 How many families were identified as needing AOD abuse services?

Number of families _____
☐ Reporting from data ☐ Estimating response ☐ Don't know

Please provide percentages for the following client characteristics. (Please make sure that all percentages total 100 percent.)

c3 Ages of children

____% Under 1 years old
____% 2 years old
____% 3 years old
____% 4 years old
____% 5 years old
____% 6 years old

Reporting from data ☐
Estimating response ☐
Don't know ☐

c4 Racial/ethnic backgrounds

____% White (non-Hispanic)
____% Black (non-Hispanic)
____% Hispanic/Latino
____% Native American/Alaska Native
____% Asian or Pacific Islander
____% Other (specify) _____

Reporting from data ☐
Estimating response ☐
Don't know ☐

c5 Who children resided with at time of enrollment

____% Mother only
____% Mother and stepfather
____% Mother and father
____% Father only
____% Father and stepmother
____% Other relative
____% Unrelated adult
____% Foster parent/group home
- 9 0 Friend's house
____% Other (specify) _____

Reporting from data ☐
Estimating response ☐
Don't know ☐

C6 Household size

____% Large households (7 or more persons)
____% Moderate households (4-6 persons)
____% Small households (l-3 persons)

Reporting from data ☐
Estimating response ☐
Don't know ☐

SECTION D: SERVICES AND STAFFING

In this section, we are asking for information about the services provided to children and families served by your program. We want to know what services your program provides directly to the children and families as well as those that are provided by referrals to other agencies or service organizations. Note: This list is standardized for all programs surveyed for this study. We recognize that some services are not likely to be part of CCDP's service system.

D1 What services are provided by your CCDP program? Please put an X in the appropriate response for each service. More than one box may be used if appropriate. If services are not provided in any manner, put an X in the box under the column heading **Not provided.**

Type of service	Provided by program staff	Contractual, in-kind, direct purchase	Referred	Not provided	Don't know
Food	☐	cl	☐	cl	☐
Shelter for children/youth	☐	cl	☐	☐	☐
Shelter for families	☐	cl	☐	☐	☐
Physical examinations	☐	☐	☐	☐	☐
Medical tests	☐	☐	☐	☐	☐
Nutrition information	☐	☐	☐	☐	☐
Out-of-home placement for children/youth	☐	☐	☐	cl	☐
Independent living services	☐	☐	☐	cl	☐
Parenting classes	☐	cl	☐	cl	☐
Income maintenance services	☐	☐	☐	☐	☐
Legal services	☐	☐	☐	cl	☐
Child care services	☐	☐	☐	cl	☐
Child development services	☐	☐	☐	cl	☐
Support group for children/youth	☐	☐	☐	☐	☐
Support group for parents	☐	☐	☐	cl	☐
Home visits	☐	☐	☐	cl	☐
Individual counseling for children/youth	☐	☐	☐	☐	☐
Individual counseling for parents	☐	☐	☐	cl	☐
Group counseling for children/youth	☐	☐	☐	☐	☐
Group counseling for parents	☐	☐	☐	cl	☐
Family counseling	☐	☐	☐	☐	☐
Couples counseling	☐	☐	☐	☐	☐
AOD abuse assessment	☐	☐	☐	☐	☐

Type of service	Provided by program staff	Contractual, in-kind, direct purchase	Referred	Not provided	Don't know
AOD abuse treatment	☐	☐	☐	cl	☐
AOD abuse prevention services	☐	☐	☐	cl	☐
HIV prevention/counseling	☐	cl	☐	cl	☐
GED classes for youth	☐	☐	☐	☐	☐
GED classes for parents	☐	☐	cl	cl	☐
Education for children with special needs	☐	☐	☐	cl	☐
Employment preparedness/training classes for youth	☐	☐	cl	cl	☐
Employment preparedness/training classes for parents	☐	☐	cl	El	☐
Homemaker services	☐	cl	cl	☐	☐
Respite care	☐	☐	cl	☐	☐
Parent involvement activities	☐	☐	☐	☐	☐
Other (specify) _____	☐	cl	☐	cl	☐

D2 How many full-time staff with early childhood responsibilities does your program have?

D3 How many full-time staff with case management responsibilities does your program have? _____

D4 What is the average home visitor-to-child ratio? :_____

D5 What is the average classroom staff-to-child ratio? :_____

SECTION E: AOD ABUSE PROBLEMS: Extent

In this section we are interested in finding out about the extent of AOD abuse problems among the families served by your program during your last program year. Please answer all questions based on your personal experience. If your program maintains data on family AOD abuse problems, please use the data to provide your response. If not, estimate as before.

E1 What percent of the children in your program reside in families in which at least one member had a AOD abuse problem?_____ %
Reporting from data ☐ Estimating response ☐ Don't know ☐

E2 What percent of the children served by your program are known to have been prenatally addicted or exposed to AOD? _____ %
Reporting from data ☐ Estimating response ☐ Don't know El

E3 What percent of the children served by your program do you suspect may have been prenatally addicted or exposed to AOD? - - %
Reporting from data ☐ Estimating response ☐ Don't know ☐

SECTION F: AOD ABUSE PROBLEMS: Staff Activities

This section pertains to the impact of serving children and families with AOD abuse problems on staff activities. Please answer all questions based on your personal experience.

F1 Does serving children from families with AOD abuse problems require more of an education staff member's time than serving other children?

- ☐ Almost always requires more time
- ☐ Frequently requires more time
- ☐ Sometimes requires more time
- ☐ Rarely requires more time
- ☐ Don't know

F2 Do children from families with AOD abuse problems require more specialized services than other Children?

- ☐ Almost always require more specialized services
- ☐ Frequently require more specialized services
- ☐ Sometimes require more specialized services
- ☐ Rarely require more specialized services
- ☐ Don't know

F3 Does serving families with AOD abuse problems require more of a family service worker's time than serving other families?

- Cl Almost always requires more time
- ☐ Frequently requires more time
- Cl Sometimes requires more time
- ❑ Rarely requires more time
- Cl Don't know

F4 Do families with AOD abuse problems require more specialized social services than other families?

- Cl Almost always require more specialized social services
- ☐ Frequently require more specialized social services
- El Sometimes require more specialized social services
- ❑ Rarely require more specialized social services
- ☐ Don't know

SECTION G: SERVICE EFFECTIVENESS

This section of the questionnaire refers to the goals of the program with respect to serving children and families with AOD abuse problems, the effectiveness of the staff in attaining these goals, and the services or procedures that may have been, or need to be, implemented to assist staff in attaining program goals. Please answer all questions based on your personal experience.

G1 What are your program's goals with respect to serving **families** with AOD abuse problems and how important do you think these goals are?

	Very important	Moderately important	Somewhat important	Not important	Not a goal
To get family member to acknowledge AOD abuse problem	☐	☐	☐	☐	☐
To get family member to agree to seek treatment	☐	☐	☐	☐	☐
To enroll family member in a treatment program	☐	☐	☐	☐	☐
To enroll family member in counseling for problems related to AOD abuse	☐	☐	☐	☐	☐
To help family members cope with a AOD abuser	☐	☐	☐	☐	☐
To help child cope with a family member who has a AOD abuse problem	☐	☐	☐	☐	☐
To ensure that family AOD abuse does not result in child maltreatment	☐	☐	☐	☐	☐
To help child overcome problems resulting from living in families with AOD abuse problems	☐	☐	☐	☐	☐
Other goals (specify) _____	☐	☐	☐	☐	☐

G2 How successful do you feel program staff are with respect to achieving the goals listed in G1?

	Very successful	Moderately successful	Somewhat successful	Not successful	Not a goal
To get family member to acknowledge AOD abuse problem	☐	☐	☐	☐	☐
To get family member to agree to seek treatment	☐	☐	☐	☐	☐
To enroll family member in a treatment program	☐	☐	☐	☐	☐
To enroll family member in counseling for problems related to AOD abuse	☐	☐	☐	☐	☐
To help family members cope with a AOD abuser	☐	☐	☐	☐	☐
To help child cope with a family member who has a AOD abuse problem	☐	☐	☐	☐	☐
To ensure that family AOD abuse does not result in child maltreatment	☐	☐	☐	☐	☐
To help child overcome problems resulting from living in families with AOD abuse problems	☐	☐	☐	☐	☐
Other goals (specify) _____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

G3 For each goal that you answered that program staff are only **somewhat successful or not successful in attaining, please explain why you feel this way.**

To get family member to acknowledge AOD abuse problem

To get family member to agree to seek treatment

To enroll family member in a treatment program

To enroll family member in counseling for problems related to AOD abuse

To help family members cope with a AOD abuser

To help child cope **with** a family member who has a AOD abuse problem

To ensure that family AOD abuse does not result in child maltreatment

To help child overcome problems resulting from living in families with AOD abuse problems

Other goals (as specified above)

G4 Has your program implemented any new services in the past 5 years as a result of serving families with AOD abuse problems? Yes cl No ❑ Don't know ❑

G5 If yes, please describe the services that were implemented

_____

_____

_____

_____

SECTION H: AOD ABUSE: Impact on Staffing

In this section, we are soliciting information about the impact of serving children and families with AOD abuse problems on your program's staffing and staff training. Please answer all questions based on your personal experience.

H1 Does your program have difficulties recruiting staff as a result of serving families with AOD abuse problems?

Yes ❑ No ❑ Don't know Cl

If yes, please explain why. _____

_____

H2 Does your program have difficulties retaining staff as a result of serving families with AOD abuse problems?

Yes ❑ No ❑ Don't know ❑

If yes, please explain why. _____

_____

H3 In comparison to working with families without AOD abuse problems, are staff working **with** families with **AOD abuse problems** more likely, less likely, or equally likely to experience the following problems?

	More likely	**Less likely**	**No difference**	**Don't know**
Personal danger	❑	❑	❑	❑
Emotional "burnout"	❑	❑	❑	❑
Problems with personal unresolved AOD abuse issues	cl	cl	❑	❑
Other (specify)_____	❑	❑	❑	❑

H4 Do you think your program needs to implement special strategies or staffing changes in order to better serve families with AOD abuse problems?

Y e s ❑ No ❑ Don't know ❑

H5 **Please indicate how important you think the** following strategies or staffmg practices are in improving your program's ability to serve families with AOD abuse problems. (Note: Please provide your opinions regarding these practices even if they have not been implemented in your program.)

	Very important	Somewhat important	Not important	Don't know
Build a stronger referral network among community agencies	☐	☐	cl	☐
Work with local AOD abuse treatment services to give priority to CCDP families	cl	☐	☐	☐
Hire a consultant to help staff work with families with AOD abuse problems	cl	☐	❑	☐
Develop a team approach to case management in working with families with AOD abuse problems	cl	☐	☐	❑
Reduce staff workloads	☐	☐	☐	☐
Add new staff specialists to deal with AOD abuse problems	☐	❑	☐	☐
Create staffing teams/special unit to work with families with AOD abuse problems	☐	☐	☐	☐
Provide funds for staff to attend AOD abuse-related workshops	cl	cl	☐	☐
Other (specify) _____	cl	☐	☐	☐

H6 Please identify the strategies or staffing practices that have been implemented or that the program plans to implement_

	Has been implemented	Plan to implement	Do not plan to implement
Build a stronger referral network among community agencies	cl	☐	cl
Work with local AOD abuse treatment services to give priority to CCDP families	☐	☐	cl
Hire a consultant to help staff work with families with AOD abuse problems	cl	☐	cl
Develop a team approach to case management in working with families with AOD abuse problems	☐	☐	cl
Reduce staff workloads	☐	❑	☐
Add new staff specialists to deal with AOD abuse problems	☐	☐	cl
Create staffing teams/special unit to work with families with AOD abuse problems	☐	cl	☐
Provide funds for staff to attend AOD abuse-related workshops	☐	☐	☐
Other (specify) _____	☐	☐	☐

H7 Do you think your program needs to provide special training to staff to better serve families with AOD abuse problems?
Yes cl No ☐ Don't know ☐

H8 If yes, please identify the training needs and whether they are being addressed.

Type of training	Training needed and in place	Training needed and planned	Training needed but not planned	Training not needed
Diffusing potentially violent family situations	cl	☐	☐	☐
Basic drug and alcohol information (appearance, physiological effects, behaviors of those under the influence)	cl	☐	☐	☐
Basic health information	☐	☐	☐	☐
Street drug information/street culture (current street slang)	☐	☐	☐	☐
Family/couples counseling	☐	☐	☐	☐
Dealing with hostile family members	☐	☐	☐	☐
Conducting interventions with individuals with AOD abuse. problem	☐	☐	☐	☐
Codependency information (family dynamics, roles, behaviors)	☐	☐	☐	☐
Staff safety/self protection	☐	☐	☐	☐
AOD abuse prevention	☐	☐	☐	☐
Conducting AOD abuse needs assessments	☐	☐	☐	☐
Protecting children/reporting to CPS	☐	☐	☐	☐
Working with children from AOD abuse families	☐	☐	☐	☐
HIV treatment/prevention	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐

SECTION I: REPORTING REQUIREMENTS

I1 Does your program have specific child abuse and neglect reporting requirements for mandated reporters that pertain to AOD abuse? Yes Cl No ☐ Don't know ☐

I2 To whom are you required to report?
- ☐ Child Welfare
- ☐ Law enforcement
- ☐ Child abuse and neglect hotline
- ☐ Other (specify) _____

I3 Are you required to report the following situations?

	Yes	No	Don't know
A pregnant woman who is known to be using AOD	☐	☐	cl
A pregnant woman who is suspected of using AOD	cl	cl	cl
A parent or primary caretaker who is known to be a AOD abuser	cl	☐	cl
A parent or primary caretaker who is suspected of using AOD	☐	☐	☐
A parent who abuses AOD to the extent that a reporter suspects the children are being maltreated (although there has been no actual observation of maltreatment)	☐	☐	☐

14 Approximately how many children were reported for AOD abuse related maltreahnent during your last program year?
Number of children _____
Reporting from data ☐ Estimating response ☐ Don't know ☐

I5 Do you think that reporting requirements have been a barrier to serving children and families with AOD abuse problems? Yes ☐ No ☐ Don't know ☐

16 If you answered yes to the above question, please explain why you feel reporting requirements have been a barrier to serving children and families with AOD abuse problems.

_____

_____

17 In your experience with reporting families to child welfare or other authorities, how satisfied have you been with the way reports are handled?
Very satisfied ☐ Moderately satisfied ☐ Moderately dissatisfied ☐ Very dissatisfied ☐

18 Why were you dissatisfied?

☐ Confidentiality was not maintained
☐ Agency did not investigate the report
☐ Agency removed the child from the home rather than providing services to the family
☐ Agency did not place the child when placement was needed
☐ Other (specify) _____

SECTION J: GENERAL PERSPECTIVES

In this last section of the questionnaire, we are interested in determining how you view the problem of family AOD abuse in the context of other family problems that program staff must contend with in working with families.

J1 Do you feel that your program has a role in combatting AOD abuse?
Yes ☐ No ☐ Don't know ☐

J2 If you answered yes to the above question, please describe how you see your program's role.

_____

_____

_____

_____

J3 Overall, given the many problems that families served by your program are facing, how important do you feel it is for your program to confront the problem of family AOD abuse?

Number one priority of program ☐
Extremely important c l
Moderately important ☐
slightly important ☐
Not important ☐
Don't know c l

CCDP Case Manager Coordinator

RESEARCH QUESTION	ITEM(S)
1a - Concept of AOD abuse	A1, A2
1b - State and local statutes	NA
1c - Service costs	C2, C3, C4
1d - Change in services/demand for services	C2, C3, C4, E5
2a - Number of clients with AOD abuse problems/change	C5
2b - Characteristics	D1, D2, D3, D4, F5
3a - Foster Care	NA
3b - Adoption	NA
4a - Goals/effectiveness	E1, E2, E3
4b - Staffing	C6, E2, E3, E4, E5
4c - Juvenile court and hospital social workers perspectives	NA
5a - Client needs	F1, F2
5b - Staff effectiveness	C6, E1, E2, E3, E4, F2
5c - Barriers	F3, F4, F6, F7
5d - Roles	G1, G2, G3

Revised: July 30, 1992

Comprehensive Child Development Program (CCDP): Case Manager Coordinator

This questionnaire form is to be completed by the person employed by the CCDP program who is responsible for overseeing and/or providing services to families enrolled in the CCDP program.

Guidelines for completion of the form

Please restrict your responses to impressions that are directly based on your experience as a CCDP case manager coordinator. Many of the questions require you to state opinions that are based on your own professional experience. In general you should answer these questions **only if:**

1) You have had direct contact with children and/or their families.

2) You have discussed cases or client situations with staff members.

3) You have access to records and/or databases containing pertinent information.

Otherwise, you should respond “don’t know”.

SECTION A: DEFINITIONS

As indicated in the cover letter, in this study we are interested in assessing the impact of family or youth alcohol and other drug (AOD) abuse problems on your program. Although the term "AOD abuse problem" can be conceptualized in a variety of ways, we have defmed this term in a way that we feel is meaningful for service delivery efforts. We would like you to keep the following definitions in mind while you are completing this questionnaire.

For the purposes of this study, AOD refers to alcohol and other drugs with the exception of nicotine, caffeine, and prescription drugs under a doctor's supervision.

AOD abuse problem refers to a level of AOD use resulting in the user being unable to meet personal responsibilities, being unable to appropriately fulfill role requirements, and/or engaging in behaviors that are self-destructive or harmful to others.

A1 Does your program define the term **AOD abuse problem in** a similar or different manner?

Similar ☐ Different c l Do not have a program definition ☐

A2 **If you** answered **different,** please describe how your program defines a AOD abuse problem.

_____

_____

_____

_____

SECTION B: RESPONDENT INFORMATION

B1 Name: _____

B2 Contact telephone # (-____)_____ _____

B3 Job title: _____

B4 What are your primary responsibilities?

_____

_____

_____

B5 How long have you been employed in this position? _____

B6 What was your previous position and how long were you employed in that position?

Position: _____

Length of time: _____

SECTION C: AOD ABUSE PROBLEM: Impact on Staff Activities

In this section we are concerned with how children and families with AOD abuse problems impact on your activities. **All questions are to be answered based on your own personal experiences as a case manager coordinator.**

Cl What information do you use to determine whether there is a AOD abuse problem?

	Very rarely	Rarely	Sometimes	Frequently	Very frequently
Family needs assessment	☐	☐	☐	cl	☐
Child needs assessment	☐	cl	☐	☐	cl
Discussions with family members	☐	☐	☐	☐	cl
Discussions with child	☐	☐	☐	☐	cl
Discussions with other professionals who have had contact with the family/child	☐	☐	☐	☐	☐
Reports from social service agencies	☐	☐	☐	☐	☐
Medical reports on the child	☐	☐	☐	☐	☐
Medical reports on the family	☐	☐	☐	☐	☐
Observation of family members	☐	☐	☐	☐	☐
Observations of child	☐	☐	☐	☐	☐
Information from staff, neighbors, relatives, etc.	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐

C2 Does developing a Family Needs Assessment (FNA) for families with AOD abuse problems require more time than developing FNA for other families?

- ☐ Almost always requires more time
- ☐ Frequently requires more time
- ☐ Sometimes requires more time
- ☐ Rarely requires more time
- ☐ Don't know

C2a Does the type of drug being used make a difference?

Yes Cl No ☐ Don't know ☐

If yes, please explain.

_____

_____

_____

_____

c3 Do families with AOD abuse problems require more specialized social services than families without AOD abuse problems?

- ❑ Almost always require more specialized social services
- ❑ Frequently require more specialized social services
- ❑ Sometimes require more specialized social services
- ❑ Rarely require more specialized social services
- ❑ Don't know

C3a Does the type of drug being used make a difference?
Yes ❑ No ❑ Don't know ❑

If yes, please explain.

_____

_____

_____

_____

C4 Do FNAs require more staff time to implement when families have AOD abuse problems than when families do not have AOD abuse problems?

- ❑ Almost always require more staff tune
- ❑ Frequently require more staff time
- ❑ Sometimes require more staff time
- ❑ Rarely require more staff time
- ❑ Don't know

C4a Does the type of drug being used make a difference?
Yes ❑ No ❑ Don't know ❑

If yes, please explain.

_____

_____

_____

_____

C5 Approximately what percentage of the families you provide services to has at least one family member with a AOD abuse problem?

Percent of families _____
Reporting from data ❑ Estimating response ❑ Don't know ❑

C6 What types of training do you feel would help you better serve families with AOD abuse problems?

Type of training	Training needed but not available	Training needed and available	Training not needed
Diffusing potentially violent family situations	☐	☐	☐
Basic drug and alcohol information (appearance, physiological effects, behaviors of those under the influence)	☐	☐	☐
Basic health information	☐	☐	☐
Street drug information/street culture (current street slang)	☐	☐	☐
Family/couples counseling	☐	☐	☐
Codependency information (family dynamics, roles, behaviors)	☐	☐	☐
Dealing with hostile family members	☐	☐	☐
Conducting interventions with individuals with AOD abuse problems	☐	☐	☐
Staff safety/self protection	☐	☐	☐
HIV treatment/prevention	☐	☐	☐
AOD abuse prevention	☐	☐	☐
Conducting AOD abuse needs assessments	☐	☐	☐
Protecting children/reporting to CPS	☐	☐	☐
Working with children from AOD abusing families	☐	☐	☐
Other (specify) _____	☐	☐	☐

SECTION D: AOD ABUSE PROBLEM: Characteristics of families

In this section we are interested in your perceptions of the characteristics of families with AOD abuse problems and how these families differ from other clients. Please answer all questions based on your personal experience in working with these families.

D1 In comparison to families without AOD abuse problems, are families with AOD abuse problems more likely, less likely, or equally likely to exhibit the following characteristics?

Family characteristics	More likely	Less likely	No difference	Don't know
To have AFDC as primary support	☐	c l	☐	☐
To have incomes below the poverty level	☐	☐	☐	☐
To be headed by a single parent/mother	c l	☐	☐	☐
To be headed by a single parent/father	☐	☐	☐	☐
To have a stepparent	☐	☐	c l	☐
To be headed by an adolescent parent(s)	☐	☐	☐	☐

Family characteristics	More likely	Less likely	No difference	Don't know
To have non-family members living in the household	El	☐	☐	☐
To experience violence among family members	☐	☐	☐	☐
To experience chronic family conflict	•J	☐	☐	☐
To have a family member who has been arrested	☐	☐	☐	☐
To have a child who has been arrested	c l	☐	☐	☐
To move frequently	c l	☐	☐	☐
To be or have been homeless	☐	☐	☐	☐
To physically abuse a child	☐	☐	☐	☐
To sexually abuse a child	☐	☐	☐	☐
To emotionally abuse a child	☐	☐	☐	☐
To neglect a child	☐	☐	☐	☐
To abandon a child	☐	☐	☐	☐
To experience spouse abuse	☐	☐	☐	☐
To have a child who has a learning or developmental disability	☐	☐	☐	☐
To have a child who has emotional/psychological problems	☐	☐	☐	☐
To have family members who have attempted/committed suicide	☐	☐	☐	☐
To have a family member who has been the victim of a violent crime	☐	☐	☐	☐
To have a child who is shy and isolated from peers	☐	☐	☐	☐
To have a child who was placed for adoption	☐	☐	☐	☐
Other (specify) _____	c l	☐	☐	
_____	☐	☐	☐	
_____	☐	☐	☐	

D2 In comparison to families without AOD abuse problems, are families with AOD abuse problems more likely, less likely, or equally likely to exhibit the following behaviors?

	More likely	Less likely	No difference	Don't know
To be involved with the program	☐	☐	☐	☐
To have high "no-show" rates	☐	☐	☐	☐
To drop out of the program	☐	El	☐	☐
Toposeasafetythreattostaff	☐	☐	☐	☐
To have children who are chronically late for center activities	☐	☐	☐	☐
To have children who have higher absentee rates	☐	c l	☐	☐
To establish contact with the children's teacher	☐	☐	☐	☐
To have children who have physical health problems	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	
_____	☐	☐	☐	
_____	☐	c l	☐	

D3 Among the families you serve with AOD abuse problems, how many abuse the following drugs?

	Most	Some	Few	None	Don't know
Alcohol	☐	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐	☐
Crack	☐	☐	☐	☐	☐
Opiates (heroin, methadone)	☐	☐	☐	☐	☐
Amphetamines (speed, ice)	☐	☐	☐	☐	☐
Sedatives (valium, downers)	☐	☐	☐	☐	☐
Barbiturates	☐	☐	☐	☐	☐
Psychedelics (LSD, mushrooms, peyote)	☐	☐	☐	☐	☐
Inhalants (glue, gasoline)	☐	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐

D4 Which family member tends to exhibit the AOD abuse problem?

	Very rarely	Rarely	Sometimes	Frequently	Very frequently
Mother/stepmother	☐	☐	☐	☐	☐
Father/stepfather	☐	☐	☐	☐	☐
Sibling	☐	☐	El	☐	☐
Both parents	☐	☐	☐	☐	☐
Non-related resident adult	☐	☐	☐	☐	•I
Related resident adult	☐	☐	☐	☐	☐
Other (specify)_____	☐	☐	☐	☐	☐

SECTION E: AOD ABUSE PROBLEM: Service Effectiveness

This section of the questionnaire refers to the goals of the program with respect to serving children and families with AOD abuse problems, the effectiveness of the staff in attaining these goals, and the services or procedures that may have been implemented to assist staff in attaining their goals. Again, please answer all questions based on your personal experiences as a family services coordinator.

E1 What are your program's goals with respect to serving families with AOD abuse problems and how important do you think these goals are?

	Very important	Moderately important	Somewhat important	Not important	Not a goal
To get family member to acknowledge AOD abuse problem	❑	❑	❑	❑	❑
To get family member to agree to seek treatment	❑	❑	❑	❑	❑
To enroll family member in a treatment program	❑	❑	❑	❑	❑
To enroll family member in counseling for problems related to AOD abuse	❑	❑	❑	❑	❑
To help child cope with a family member who has a AOD abuse problem	❑	❑	❑	❑	❑
To help child understand they are not responsible for family member's AOD abuse problem	❑	c l	c l	❑	❑
To help child overcome problems resulting from living in families with AOD abuse problems	❑	❑	❑	❑	❑
Other goals (specify) _____	❑	c l	c l	❑	❑

E2 How successful do you feel you are with respect to achieving the goals listed in El?

	Very successful	Moderately successful	Somewhat successful	Not successful	Not a goal
To get family member to acknowledge AOD abuse problem	c l	❑	❑	❑	❑
To get family member to agree to seek treatment	❑	❑	❑	❑	❑
To enroll family member in a treatment program	❑	❑	❑	❑	❑
To enroll family member in counseling for problems related to AOD abuse	❑	❑	❑	❑	❑
To help child cope with a family member who has a AOD abuse problem	❑	❑	❑	❑	❑
To help child understand they are not responsible for family member's AOD abuse problem	❑	❑	❑	❑	❑
To help child overcome problems resulting from living in families with AOD abuse problem	❑	c l	❑	❑	❑
Other goals (specify) _____	❑	❑	❑	❑	❑

E3 For each goal that you answered that you are only **somewhat successful or not successful in attaining,** please explain why you feel this way.

To get family member to acknowledge AOD abuse problem

To get family member to agree to seek treatment

To enroll family member in a treatment program

To enroll family member in counseling for problems related to AOD abuse

To help child cope with a family member who has a AOD abuse problem

To help child understand they are not responsible for family member's AOD abuse problem

To help child overcome problems resulting from living in families with AOD abuse problems

Other goals (as specified above)

E4 Please indicate how important you think the following strategies or staffing practices are in improving your ability to serve families with AOD abuse problems. (Note: Please provide your opinions regarding these practices even if they have not been hnplemented in your program.)

	Very important	Somewhat important	Not important	Don't know
Build a stronger referral network among community agencies	☐	☐	☐	☐
Work with local AOD abuse treatment services to give priority to CCDP families	☐	☐	☐	☐
Hire a consultant to help staff work with families with AOD abuse problems	☐	c l	☐	☐
Develop a team approach to case management in working with families with AOD abuse problems	c l	c l	☐	☐
Reduce staff workloads	☐	☐	El	☐
Add new staff specialists to deal with AOD abuse problems	☐	☐	El	☐
Create staffing teams/special unit to work with families with AOD abuse problems	☐	☐	☐	☐
Provide special AOD abuse-related training for staff	☐	☐	☐	☐
Provide funds for staff to attend AOD abuse-related workshops	c l	☐	☐	☐
Other (specify) _____	☐	c l	☐	☐

E5 Please identify the strategies or staffing changes that have been implemented over the past 5 years.

	Has been implemented	Has not been implemented	Was already in place
Build a stronger referral network among community agencies	☐	c l	☐
Work with local AOD abuse treatment services to give priority to CCDP families	☐	☐	☐
Hire a consultant to help staff work with families with AOD abuse problems	☐	☐	☐
Develop a team approach to case management in working with families with AOD abuse problems	☐	☐	☐
Reduce staff workloads	☐	☐	☐
Add new staff specialists to deal with AOD abuse problems	☐	☐	c l
Create staffing teams/special unit to work with families with AOD abuse problems	☐	☐	☐
Provide special AOD abuse-related training for staff	☐	☐	☐
Provide funds for staff to attend AOD abuse-related workshops	☐	☐	☐
Other (specify) _____	☐	☐	☐

SECTION F: SERVICE NEEDS

In this section we are interested in determining whether families with AOD abuse problems have service needs that are different or similar to the service needs of families without AOD abuse problems. Please answer all questions based on your personal experience.

F1 In comparison to families without AOD abuse problems, are families with AOD abuse problems more likely, less likely, or equally likely to require the following services?

Type of service	More likely	Less likely	No difference	Don't know
Food	❑	❑	❑	❑
Shelter for children/youth	❑	❑	❑	❑
Shelter for families	❑	❑	❑	❑
Physical examinations	❑	❑	❑	❑
Medical tests	❑	❑	❑	❑
Nutrition information	❑	❑	❑	❑
Out-of-home placement for children/youth	❑	❑	❑	❑
Independent living services	❑	❑	❑	❑
Parenting classes	❑	❑	❑	❑
Income maintenance services	❑	❑	❑	❑
Legal services	❑	❑	❑	❑
Child care services	❑	❑	❑	❑
Child development services	❑	❑	❑	❑
Support group for children/youth	❑	❑	❑	❑
Support group for parents	❑	❑	❑	❑
Home visits	❑	❑	❑	❑
Individual counseling for children/youth	❑	❑	❑	❑
Individual counseling for parents	❑	❑	❑	❑
Group counseling for children/youth	❑	❑	❑	❑
Group counseling for parents	❑	❑	❑	❑
Family counseling	❑	❑	❑	❑
Couples counseling	❑	❑	❑	❑
AOD abuse assessment	❑	❑	❑	❑
AOD abuse treatment	❑	❑	❑	❑
AOD abuse prevention services	❑	❑	❑	❑
HIV prevention/counseling	❑	❑	❑	❑

Type of service	More likely	Less likely	No difference	Don't know
GED classes for youth	☐	•J	☐	•I
GED classes for parents	☐	☐	☐	cl
Education for children with special needs	☐	☐	☐	☐
Employment preparedness/training classes for youth	☐	☐	☐	cl
Employment preparedness/training classes for parents	☐	☐	☐	cl
Homemaker services	☐	☐	☐	☐
Respite care	☐	☐	☐	☐
Parent involvement activities	☐	☐	☐	☐
Other (specify) _____	☐	cl	☐	

F2 Do you feel you are able to meet the service needs of children with AOD abuse problems?

- ☐ Almost always
- ☐ Most of the time
- ☐ Some of the time
- ☐ Rarely
- ☐ Very rarely
- ☐ Don't know

F3 What kinds of barriers do you experience in **your efforts to serve** children and families with AOD abuse problems?

	Severe problem	Moderate problem	Not a problem
Insufficient number of no-cost (accept medicaid) AOD abuse inpatient treatment programs for adults	El	☐	☐
Insufficient number of no-cost (accept medicaid) AOD abuse inpatient treatment programs for adolescents	☐	☐	☐
Insufficient number of no-cost AOD abuse outpatient treatment programs	☐	☐	☐
Insufficient number of inpatient treatment programs that accept pregnant women	☐	☐	☐
Insufficient number of detoxification services	☐	☐	☐
Insufficient family support services in the community	☐	☐	☐
Insufficient respite care facilities	☐	☐	☐
Insufficient transportation for clients to access services	☐	☐	☐
Insufficient low cost housing for families	☐	☐	☐
Lack of formalized interagency cooperation	☐	☐	☐
Lack of information about relevant resources in the community	☐	☐	☐
Parents fear of losing their children	☐	☐	☐
Negative attitudes of program staff toward individuals with AOD abuse problems	☐	☐	☐
Resistance of parents to accept services	☐	☐	☐
Other (specify) _____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

F4. For each barrier that is a problem, please indicate how you think it might be addressed.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

F5 Compared with 5 years ago, how do you feel the abuse of specific drugs among the families you serve has changed?

	Increased	Decreased	No change	Don't know
Alcohol	☐	☐	☐	☐
Cocaine	Cl	☐	☐	☐
Crack	☐	☐	☐	☐
Opiates (heroin, methadone)	Cl	☐	☐	☐
Amphetamines (speed, ice)	☐	c l	☐	☐
Sedatives (valium, downers)	☐	☐	☐	☐
Barbiturates	☐	☐	☐	☐
Psychedelics (LSD, mushrooms, peyote)	☐	☐	☐	☐
Inhalants (glue, gasoline)	Cl	☐	☐	☐
Marijuana	Cl	☐	☐	☐
Other (specify) _____	Cl	☐	☐	☐

F6 Does the type of drug being abused affect the difficulty you (or your staff) experience in working with families?
Yes El No ☐ Don't know Cl

F7 If yes, please identify which type of AOD abuse is most difficult to work with and why.

_____

_____

SECTION G: GENERAL PERSPECTIVES

In this last section of the questionnaire, we are interested in determining how you view the problem of family AOD abuse in the context of other family problems that CCDP staff must contend with.

G1 Do you feel that your program has a role in combatting AOD abuse?
Yes ☐ No ☐ Don't know ☐

G2 If you answered yes to the above question, please describe how you see your prog-ram's role. If you answered no, please explain why you feel your program does not have a role.

_____

_____

_____

G3 Overall, given the many problems that clients served by your program are facing, how important do you feel it is for your program to confront the problem of family AOD abuse?

Number one priority of program ☐
Extremely important ☐
Moderately important ☐
slightly important ☐
Not important ☐
Don't know ☐

CCDP Early Childhood Education Coordinator

RESEARCH QUESTION	ITEM(S)
1a - Concept of AOD abuse	A1, A2
lb - State and local statutes	NA
1c - Service costs	C2, C3
1d - Change in services/demand for services	C2, C3, C7, E5
2a - Number of clients with AOD abuse problems/change	C7
2b - Characteristics	C4, C5, C6, D1, D2, D3, D4, F5
3a - Foster Care	NA
3b - Adoption	NA
4a - Goals/effectiveness	E1, E2, E3
4b - Staffing	C8, E2, E3, E4, E5
4c - Juvenile court and hospital social workers perspectives	NA
5a - Client needs	F1, F2
5b - Staff effectiveness	C8, E1, E2, E3, E4
5c - Barriers	F3, F4, F6, F-7
5d - Roles	G1, G2, G3

Revised: July 31, 1992

Comprehensive Childhood Development Program (CCDP): Early Childhood Education Coordinator

This questionnaire form is to be completed by the person employed by CCDP who is responsible for overseeing and/or providing education services to children enrolled in the CCDP program.

Guidelines for completion of the form

Please restrict your responses to impressions that are directly based on your experience as a CCDP early childhood education coordinator. Many of the questions require you to state opinions that are based on your own professional experience. In general you should answer questions only if:

1) You have had direct contact with children and/or their families.

2) You have discussed cases or client situations with staff members.

3) You have access to records and/or databases containing pertinent information.

Otherwise, you should respond “don’t know”.

SECTION A: DEFINITIONS

As indicated in the cover letter, in this study we are interested in assessing the impact of family or youth alcohol and other drug **(AOD)** abuse problems on your program. Although the term **"AOD** abuse problem" can be conceptualized in a variety of ways, we have defmed this term in a way that we feel is meaningful for service delivery efforts. We would like you to keep the following definitions in mind while you are completing this questionnaire.

For the purposes of this study, AOD refers to alcohol and other drugs with the exception of nicotine, caffeine, and prescription drugs under a doctor's supervision.

AOD **abuse problem** refers to a level of **AOD** use resulting in the user being unable to meet personal responsibilities, being unable to appropriately fulfill role requirements, and/or engaging in behaviors that are self-destructive or harmful to others.

A1 Does your program define the term **AOD abuse problem in** a similar or different manner?

Similar ☐ Different ☐ Do not have a program definition ☐

A2 If you answered **different,** please describe how your program defines a AOD abuse problem.

_____

_____

_____

_____

SECTION B: RESPONDENT INFORMATION

B1 Name: _____

B2 Contact telephone # (-____)_____ _____

B3 Job title: _____

B4 What **are your** primary responsibilities?

_____

_____

_____

B5 How long have you been employed in this position? _____

B6 What was your previous position and how long were you employed in that position?

Position: _____

Length of time: _____

SECTION C: AOD ABUSE PROBLEM: **Impact on** Staff **Activities**

In this section we are concerned with how children and families with AOD abuse problems impact on you or your staff's activities. **All questions are to be answered based on your personal experiences as an early childhood education coordinator.**

Cl What information do you use to determine whether there is a AOD abuse problem?

	Very rarely	Rarely	Sometimes	Frequently	Very frequently
Family needs assessment	cl	☐	☐	☐	☐
Child needs assessment	☐	☐	☐	☐	cl
Discussions with family members	☐	☐	☐	☐	☐
Discussions with child	☐	☐	☐	☐	☐
Discussions with other professionals who have had contact with the family/child	☐	☐	☐	☐	☐
Reports from social service agencies	☐	☐	☐	☐	☐
Medical reports on the child	☐	☐	☐	☐	☐
Medical reports on the family	☐	☐	☐	☐	☐
Observation of family members	☐	☐	☐	☐	☐
Observations of child	☐	☐	☐	☐	☐
Information from staff, neighbors, relatives, etc.	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐

C2 Does working with children from families with AOD abuse problems require more time from education staff than working with other children?

- ☐ Almost always requires more time
- ☐ Sometimes requires more time
- ☐ Rarely requires more time
- ☐ Almost never requires more time
- ☐ Don't know

C2a Does the type of drug being used by the family make a difference?

Yes ☐ No ☐ Don't know ☐

If yes, please explain.

_____

_____

_____

_____

c3 Do children from families with AOD abuse problems require more attention from project staff than other children?

- ❑ Almost always require more attention
- ❑ Frequently require more attention
- ❑ Sometimes require more attention
- ❑ Rarely require more attention
- ❑ Don't know

C3a Does the type of drug being used by the family make a difference?
Yes ❑ No ❑ Don't know ❑

If yes, please explain.

---

c4 Do children from families with AOD abuse problems exhibit more developmental problems than other children?

- ❑ Almost always exhibit more developmental problems
- ❑ Frequently exhibit more developmental problems
- ❑ Sometimes exhibit more developmental problems
- ❑ Rarely exhibit more developmental problems
- ❑ Don't know

C4a Does the type of drug being used by the family make a difference?
Yes ❑ No ❑ Don't know ❑

If yes, please explain.

C5 Do children from families with AOD abuse problems exhibit more behavioral problems than other children?

- ❑ Almost always exhibit more behavioral problems
- ❑ Frequently exhibit more behavioral problems
- ❑ Sometimes exhibit more behavioral problems
- ❑ Rarely exhibit more behavioral problems
- Cl Don't know

C5a Does the type of drug being used by the family make a difference?
Yes ❑ No ❑ Don't know Cl

If yes, please explain.

C6 Do children from families with AOD abuse problems exhibit more physical/medical problems than other children?

❑ Almost always exhibit more physical/medical problems
❑ Frequently exhibit more physical/medical problems
❑ Sometimes exhibit more physical/medical problems
❑ Rarely exhibit more physical/medical problems
❑ Don't know

C6a Does the type of chug being used by the family make a difference?
Yes ❑ No ❑ Don't know ❑

If yes, please explain.

c7 Approximately what percentage of the CCDP families have at least one family member with a AOD abuse problem?

Percent of families _____
Reporting from data ❑ Estimating response ❑ Don't know ❑

C8 What types of training do you feel would help you better serve children from families with AOD use problems?

Type of training	Training needed but not available	Training needed and available	Training not needed
Diffusing potentially violent family situations	☐	☐	☐
Basic drug and alcohol information (appearance, physiological effects, behaviors of those under the influence)	☐	☐	☐
Basic health information	☐	☐	☐
Street drug information/street culture (current street slang)	☐	☐	☐
Family/couples counseling	☐	☐	☐
Codependency information (family dynamics, roles, behaviors)	☐	☐	☐
Dealing with hostile family members	☐	☐	☐
Conducting interventions with individuals with AOD abuse problems	☐	☐	☐
Staff safety/self protection	☐	☐	☐
AOD abuse prevention	☐	☐	☐
Conducting AOD abuse needs assessments	☐	☐	☐
Protecting children/reporting to CPS	☐	☐	☐
Working with children from AOD abusing families	☐	☐	☐
HIV treatment/prevention	☐	☐	☐
Supporting parents AOD treatment efforts	☐	☐	☐
Other (specify) _____	☐	☐	☐

SECTION D: AOD abuse PROBLEM: Characteristics of children

In this section we are interested in your perceptions of the characteristics of children from families with AOD abuse problems and whether these children differ from other clients. Please answer all questions based on your personal experience in working with these children.

D1 In comparison to children from families without AOD abuse problems, are children from families with AOD abuse problems more likely, less likely, or equally likely to exhibit the following characteristics?

Child characteristics	More likely	Less likely	No difference	Don't know
Come from families with AFDC as primary support	☐	☐	☐	☐
Come from families with incomes below the poverty level	☐	☐	☐	☐
Come from families headed by a single parent/mother	☐	☐	☐	☐
Come from families headed by a single parent/father	☐	☐	☐	☐
Come from families with a stepparent	☐	☐	☐	☐

Child characteristics	More likely	Less likely	No difference	Don't know
Come from families headed by an adolescent parent(s)	☐	☐	☐	☐
Come from families with non-family members living in the household	☐	☐	☐	☐
Experience threats or physical violence from family member	☐	☐	☐	☐
Experience chronic family conflict	☐	☐	☐	☐
Have a parent who has been arrested	☐	☐	☐	☐
Have moved frequently	☐	☐	☐	☐
Have lived on the streets at some time	☐	☐	☐	☐
Have experienced physical abuse from a family member	☐	☐	☐	☐
Have experienced sexual abuse from a family member	☐	☐	☐	☐
Have experienced emotional abuse from a family member	☐	☐	☐	☐
Have experienced neglect	☐	☐	☐	☐
Have been abandoned/pushed out	☐	☐	☐	☐
Come from families where there has been spouse abuse	☐	☐	☐	☐
Have received special services for a learning or developmental disability	☐	☐	☐	☐
Have emotional/psychological problems	☐	☐	☐	☐
Come from a family where a member has attempted/committed suicide	☐	☐	☐	☐
Be shy and isolated from peers	☐	☐	☐	☐
Come from a family where a member was a victim of a violent crime	☐	☐	☐	☐
Other (specify)_____	☐	☐	☐	
_____	☐	☐	☐	
_____	☐	☐	☐	

D2 In comparison to families without AOD abuse problems, are families with AOD abuse problems more likely, less likely, or equally likely to exhibit the following behaviors?

	More likely	Less likely	No difference	Don't know
To be involved with the program	☐	☐	☐	☐
To have high "no-show" rates	☐	☐	☐	☐
To drop out of the program	☐	☐	☐	☐
To pose a safety threat to staff	☐	☐	☐	☐
To have children who are chronically late for center activities	El	☐	☐	El
To have children who have higher absentee rates	c l	☐	☐	☐
To establish contact with the children's teacher	☐	☐	☐	☐
To have children who have physical health problems	☐	☐	☐	El
Other (specify) _____	☐	☐	☐	
_____	☐	☐	☐	
_____	a	☐	☐	

D2a Does the type of drug being used by the family make a difference?

Yes Cl No ☐ Don't know Cl

If yes, please explain.

_____

_____

_____

_____

_____

_____

D3 Among the families you serve with AOD abuse problems, how many abuse the following drugs?

	Most	Some	Few	None	Don't know
Alcohol	c l	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐	☐
Crack	☐	☐	☐	☐	☐
Opiates (heroin, methadone)	☐	☐	c l	☐	☐
Amphetamines (speed, ice)	☐	☐	El	☐	☐
Sedatives (valium, downers)	☐	c l	☐	☐	☐
Barbiturates	☐	☐	☐	☐	☐
Psychedelics (LSD, mushrooms, peyote)	☐	☐	☐	☐	☐
Inhalants (glue, gasoline)	☐	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐

D4 Which family member tends to exhibit the AOD abuse problem?

	Very rarely	Rarely	Sometimes	Frequently	Very frequently
Mother/stepmother	☐	☐	☐	☐	☐
Father/stepfather	☐	☐	☐	El	☐
Sibling	☐	☐	☐	☐	☐
Both parents	☐	☐	☐	☐	☐
Non-related resident adult	☐	☐	☐	☐	☐
Related resident adult	☐	☐	☐	☐	☐
Other (specify)_____	☐	☐	cl	☐	☐

SECTION E: AOD ABUSE PROBLEM: Service Effectiveness

This section of the questionnaire refers to the goals of the program with respect to serving children and families with AOD abuse problems, the effectiveness of the staff in attaining these goals, and the services or procedures that may have been implemented to assist staff in attaining their goals. Again, please answer all questions based on your personal experiences as an education coordinator.

E1 What are your program's goals with respect to serving **families** with AOD abuse problems and how important do you think **these goals** are?

	Very important	Moderately important	Somewhat important	Not important	Not a goal
To get family member to acknowledge AOD abuse problem	☐	☐	☐	☐	☐
To get family member to agree to seek treatment	☐	☐	cl	☐	cl
To enroll family member in a treatment program	El	☐	•J	cl	☐
To enroll family member in counseling for problems related to AOD abuse	☐	☐	•J	☐	El
To help child cope with a family member who has a AOD abuse problem	☐	☐	☐	☐	☐
To help child understand they are not responsible for **family** member's AOD abuse problem	cl	☐	☐	☐	☐
To help child overcome problems resulting from living in families with AOD abuse problems	☐	☐	☐	☐	☐
Other goals (specify) _____	cl	☐	☐	☐	☐
_____	☐	☐	☐	cl	El

E2 How successful do you feel you are with respect to achieving the goals listed in El?

	Very successful	Moderately successful	Somewhat successful	Not successful	Not a goal
To get family member to acknowledge AOD abuse problem	☐	☐	☐	c l	☐
To get family member to agree to seek treatment	☐	☐	☐	☐	☐
To enroll family member in a treatment program	☐	☐	☐	☐	☐
To enroll family member in counseling for problems related to AOD abuse	☐	☐	☐	☐	El
To help child cope with a family member who has a AOD abuse problem	☐	☐	☐	☐	☐
To help child understand they are not responsible for family member's AOD abuse problem	☐	☐	☐	☐	☐
To help child overcome problems resulting from living in families with AOD abuse problem	☐	☐	☐	☐	☐
Other goals (specify) _____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

E3 For each goal that you answered that staff are only somewhat successful or not **successful in** attaining for the youth, please explain why you feel this way.

To get family member to acknowledge AOD abuse problem

_____

_____

To get family member to agree to seek treatment

_____

_____

To enroll family member in a treatment program

_____

_____

To enroll family member in counseling for problems related to AOD abuse

_____

_____

To help child cope with a family member who has a AOD abuse problem

_____

_____

To help child understand they are not responsible for family member's AOD abuse problem

To help child overcome problems resulting from living in families with AOD abuse problems

Other goals (as specified above)

E4 Please indicate how important you think the following strategies or staffing practices are in improving your ability to serve children from families with AOD abuse problems. (Note: Please provide your opinions regarding these practices even if they have not been implemented in your program.)

	Very important	Somewhat important	Not important	Don't know
Build a stronger referral network among community agencies	c l	❑	❑	❑
Work with local AOD abuse treatment services to give priority to CCDP families	❑	❑	❑	❑
Hire a consultant to help staff work with families with AOD abuse problems	❑	❑	❑	❑
Develop a team approach to case management in working with families with AOD abuse problems	❑	c l	❑	❑
Reduce staff workloads	❑	❑	❑	❑
Add new staff specialists to deal with AOD abuse problems	❑	❑	❑	❑
Create staffiig teams/special unit to work with families with AOD abuse problems	❑	❑	❑	❑
Provide special AOD abuse-related training for staff	❑	❑	❑	❑
Provide funds for staff to attend AOD abuse-related workshops	❑	❑	❑	❑
Other (specify) _____	❑	❑	❑	❑

E5 Please identify the strategies or staffing changes that have been implemented over the past 5 years.

	Has been implemented	Has not been implemented	Was already in place
Build a stronger refer-ml network among community agencies	❑	❑	❑
Work with local AOD abuse treatment services to give priority give priority to CCDP families	❑	•J	❑
Hire a consultant to help staff work with families with AOD abuse problems	❑	❑	❑
Develop a team approach to case management in working with families with AOD abuse problems	❑	c l	❑
Reduce staff workloads	❑	❑	❑
Add new staff specialists to deal with AOD abuse problems	❑	❑	❑
Create staffing teams/special unit to work with families with AOD abuse problems	❑	❑	❑
Provide special AOD abuse-related training for staff	❑	❑	❑
Provide funds for staff to attend AOD abuse-related workshops	❑	❑	❑
Other (specify) _____	❑	❑	❑

SECTION F: SERVICE NEEDS

In this section we are interested in determining whether children from families with AOD abuse problems have service needs that are different or similar to other children in your program. Please answer all questions based on your personal experience.

F1 In comparison to children from families **without** AOD abuse problems, are children from families **with** AOD abuse problems more likely, less likely, or equally likely to require the following services?

Type of service	More likely	Less likely	No difference	Don't know
Food	❑	❑	❑	❑
Shelter for children/youth	❑	❑	❑	❑
Shelter for families	❑	❑	❑	❑
Physical examinations	❑	❑	❑	c l
Medical tests	❑	❑	❑	c l
Improved nutrition	❑	❑	❑	❑
Out-of-home placement for children/youth	❑	❑	❑	❑
Home visits	❑	❑	❑	❑
Individual counseling	❑	❑	❑	a
Individual counseling for parents	❑	❑	❑	a

Type of service	More likely	Less likely	No difference	Don't know
Group counseling for children/youth	❑	❑	❑	❑
Group counseling for parents	❑	❑	❑	❑
Family counseling	❑	❑	❑	❑
Couples counseling	❑	❑	❑	❑
AOD abuse assessment for families	❑	❑	❑	❑
AOD abuse treatment	❑	❑	❑	❑
AOD abuse prevention services	El	❑	❑	❑
HIV prevention/counseling	❑	❑	❑	❑
GED classes for parents	❑	❑	❑	❑
Education for children with special needs	❑	❑	❑	❑
Employment preparedness/training classes for parents	❑	❑	❑	❑
Homemaker services	❑	❑	❑	❑
Respite care	cl	❑	❑	❑
Parent involvement activities	❑	❑	❑	❑
Other (specify) _____	❑	❑	❑	

F2 Do you feel you are able to meet the service needs of children with AOD abuse problems?

- ❑ Almost always
- ❑ Most of the time
- Cl Some of the time
- ❑ Rarely
- Cl Very rarely
- ❑ Don't know

F3 Please identify the kinds of problems and their severity that you experience in your efforts to serve children from families with AOD abuse problems?

	Severe problem	Moderate problem	Not a problem
Parental denial of AOD abuse problem	❑	❑	❑
Communication barrier with non-English speaking parents	❑	❑	❑
Negative attitudes of program staff toward individuals with AOD abuse problems	❑	❑	❑
Other (specify) _____	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑

F4 For each barrier that is a problem, please indicate how you think it might be addressed.

F5 Compared with 5 years ago, how do you feel the abuse of specific drugs among the families you serve has changed?

	Increased	Decreased	No change	Don't know
Alcohol	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐
Crack	☐	☐	☐	☐
Opiates (heroin, methadone)	☐	☐	☐	☐
Amphetamines (speed, ice)	☐	☐	☐	☐
Sedatives (valium, downers)	☐	☐	☐	☐
Barbiturates	☐	☐	☐	☐
Psychedelics (LSD, mushrooms, peyote)	☐	☐	☐	☐
Inhalants (glue, gasoline)	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐

F6 Does the type of drug being used affect the difficulty you (or your staff) experience in working with families?
Yes ☐ No ☐ Don't know ☐

F7 If yes, please identify which type of AOD abuse is most difficult to work with and why.

SECTION G: GENERAL PERSPECTIVES

In this last section, we are interested in determining how you view the problem of family AOD abuse in the context of other family problems that CCDP staff must contend with.

G1 Do you feel that your program has a role in combatting AOD abuse?
Yes ☐ No ☐ Don't know ☐

G2 If you answered yes to the above question, please describe how you see your program's role. If you answered no, please explain why you feel your program does not have a role.

_____

_____

_____

G3 Overall, given the many problems that clients served by your program are facing, how important do you feel it is for your program to confront the problem of family AOD abuse?

- Number one priority of program ☐
- Extremely important ☐
- Moderately important ☐
- slightly important ☐
- Not important ☐
- Don't know ☐

Head Start Director

RESEARCH QUESTION	ITEM(S)
1a - Concept of AOD abuse	A1, A2
1b - State and local statutes	I1 thru I7
1c - Service costs	F1, F2, F3, F4
1d - Change in services/demand for services	C4, C5, G4, G5, H6
2a - Number of clients with AOD abuse problems/change	E1 thru E7
2b - Characteristics	NA
3a - Foster Care	NA
3b - Adoption	NA
4a - Goals/effectiveness	G1, G2, G3
4b - Staffing	H1 thruH8
4c - Juvenile court and hospital social workers perspectives	NA
5a - Client needs	NA
5b - Staff effectiveness	NA
5c - Barriers	NA
5d - Roles	J1, J2, J3

Revised: July 31, 1992

Head Start Program: Director

This questionnaire form is to be completed by the Head Start program director or knowledgeable grantee administrator. Please feel free to seek assistance in completing this questionnaire from other program staff, particularly with respect to those questions that require statistical information.

Guidelines for completion of the form

Please restrict your responses to impressions that are directly based on your experience as a Head Start director. Many of the questions require you to state opinions that are based on your own professional experience. In general you should answer these questions **only if:**

1) You have had direct contact with children and/or their families.

2) You have discussed cases or client situations with staff members.

3) You have access to records and/or databases containing pertinent information.

Otherwise, you should respond "don't know".

SECTION A: DEFINITIONS

As indicated in the cover letter, in this study we are interested in assessing the impact of family or youth alcohol and other drug (AOD) abuse problems on your program. Although the term "AOD abuse problem" can be conceptualized in a variety of ways, we have defined this term in a way that we feel is meaningful for service delivery efforts. We would like you to keep the following definitions in mind while you are completing this questionnaire.

For the purposes of this study, AOD refers to alcohol and other drugs with the exception of nicotine, caffeine, and prescription drugs under a doctor's supervision.

AOD abuse problem refers to a level of AOD use resulting in the user being unable to meet personal responsibilities, being unable to appropriately fulfill role requirements, and/or engaging in behaviors that are self-destructive or harmful to others.

A1 Does your program define the term AOD abuse problem in a similar or different manner?

Similar ☐ Different ☐ Do not have a program definition ☐

A2 If you answered **different**, please describe how your program defines a AOD abuse problem.

_____

_____

_____

_____

SECTION B: RESPONDENT/PROGRAM INFORMATION

B1 Name: _____

B2 Contact telephone # (-____)_____ _____

B3 Job title: _____

B4 What are your primary responsibilities? _____

_____

_____

B5 How long have you been employed in this position? _____

B6 What was your previous position and how long were you employed in that position?

Position: _____

Length of time: _____

B7 What type of grantee agency operates this program?

- ☐ Community Action Agency
- ☐ City administration
- ☐ Community family service center
- ☐ Community health center
- ☐ Other public agency
- ☐ Public nonprofit agency
- ☐ Private nonprofit agency
- ☐ Public school system
- ☐ Private school system
- ☐ Indian Tribe
- ☐ Other (specify) _____

B8 What model does your program use to provide Head Start services?

- ☐ Center-based model
- ☐ Home-based model
- ☐ Both center-based and home-based models

B9 How many months of direct services does your program provide over a year?

- Cl 9 months or less
- ☐ More than 9 months

B10 How many centers does the grantee operate? _____

B11 What is the annual budget of the Head Start program (including non ACYF funding, for grantee as well as any delegate agencies)? $_____

SECTION C: SERVICE POPULATION

This section solicits information about the families served in your Head Start program during your last program year - the program year for which you have completed data. Please answer the questions for all centers operated by the grantee or delegates. Where your program maintains data pertaining to families served for the Program Information Report (PIR) or other purposes, please use these data to answer the questions below.

If your program does not maintain these data, please provide your best estimates based on your own experiences. Also, please indicate by putting an X in the appropriate box if your answer is **from available data** or is an **estimate. If you** do not know an answer and you feel you cannot make an estimate, put an X in the box labelled "don't know."

Please identify the program year. _____

Cl How many children were served during your last program year? (Use 9.C.8 on the PIR)

Number of children _____

☐ Reporting from data ☐ Estimating response ☐ Don't know

C2 How many Head Start families were there during your last program year? (Use 12.A. on the PIR)

Number of families _____

☐ Reporting from data ☐ Estimating response ☐ Don't know

c3 How many families were identified as needing social services? (Use 12.C. on the PIR)

Number of families _____

☐ Reporting from data ☐ Estimating response ☐ Don't know

c4 How has the number of families in C3 needing social services changed over the past 5 years?

☐ Increased substantially
☐ Increased somewhat
☐ No change
☐ Decreased somewhat
☐ Decreased substantially
☐ Don't know

Reporting from data ☐
Estimating response ☐
Don't know ☐

C5 If it has increased, to what would you amibute the increase?

☐ In small part to an increase in the AOD abuse problem in the community
☐ In some part to an increase in the AOD abuse problem in the community
☐ In large part to an increase in the AOD abuse problem in the community
☐ Largely to factors other than the AOD abuse problem in the community
Identify other factors_____

_____

☐ Don't know

For families served during your last program year, please provide percentages for the following client characteristics (Please make sure that all percentages total 100 percent.)

C6 Ages of children (Use items 9.C.1 through 9.C.7 on the PIR)

____% Under 1 years old
____% 2 years old
____% 3 years old
____% 4 years old
____% 5 years old
____% 6 years old

Reporting from data ☐
Estimating response ☐
Don't know El

c7 Racial/ethnic backgrounds (Use items 24.A.1 through 24.A.5 on the PIR)

____% White (non-Hispanic)
____% Black (non-Hispanic)
____% Hispanic/Latino
____% Native American/Alaska Native
____% Asian or Pacific Islander
____% Other (specify) _____

Reporting from data ☐
Estimating response ☐
Don't know ☐

C8 Who children resided with at time of enrollment

____% Mother only
____% Mother and stepfather
____% Mother and father
____% Father only
____% Father and stepmother
____% Other relative
____% Unrelated adult
____% Foster parent/group home
____% Friend's house
____% Other (specify) _____

Reporting from data ❑
Estimating response ☐
Don't know cl

C9 Household size

____% Large households (7 or more persons)
____% Moderate households (4-6 persons)
____% Small households (l-3 persons)

Reporting from data ☐
Estimating response ☐
Don't know cl

SECTION D: SERVICES AND STAFFING

In this section, we are asking for information about the services provided to children and families served by your program. We want to know what services your program provides directly to the children and families as well as those that are provided by referrals to other agencies or service organizations. **Note: This** list is standardized for all programs surveyed for this study. We recognize that some services are not likely to be part of Head Start's service system. Also, we realize that this list is not exhaustive of all services provided by Head Start.

D1 Which of these services are provided by your Head Start program? Please put an X in the appropriate response for each service. More than one box may he used if appropriate. If services are not provided in any manner, put an X in the box under the column heading **Not provided.**

Type of service	**Provided by program staff**	**Contractual, in-kind, direct purchase**	**Referred**	**Not provided**	**Don't know**
Food	☐	☐	☐	☐	☐
Shelter for children/youth	☐	☐	☐	☐	☐
Shelter for families	☐	❑	☐	☐	☐
Physical examinations	☐	☐	☐	☐	☐
Medical tests	☐	☐	☐	☐	☐
Nutrition information	☐	☐	☐	☐	☐
Out-of-home placement for children/youth	☐	☐	☐	☐	☐
Independent living services	☐	☐	☐	☐	☐
Parenting classes	☐	☐	☐	☐	☐
Income maintenance services	☐	☐	☐	☐	☐

Type of service	Provided by program staff	Contractual, in-kind, **direct** purchase	Referred	Not provided	**Don't know**
Legal services	☐	cl	☐	☐	☐
Child care services	☐	cl	☐	cl	☐
Child development services	☐	☐	☐	cl	☐
Support group for children/youth	☐	☐	☐	cl	☐
Support group for parents	☐	❑	☐	cl	☐
Home visits	☐	☐	☐	☐	☐
Individual counseling for children/youth	☐	cl	☐	☐	☐
Individual counseling for parents	☐	El	☐	cl	☐
Group counseling for children/youth	☐	☐	☐	☐	☐
Group counseling for parents	☐	☐	☐	cl	☐
Family counseling	☐	☐	☐	☐	☐
Couples counseling	☐	☐	☐	❑	☐
AOD abuse assessment	☐	☐	☐	cl	☐
AOD abuse treatment	☐	☐	☐	☐	☐
AOD abuse prevention services	☐	☐	☐	❑	☐
HIV prevention/counseling	☐	☐	☐	cl	☐
GED classes for youth	☐	☐	☐	☐	☐
GED classes for parents	☐	cl	☐	cl	☐
Education for children with special needs	☐	cl	☐	☐	☐
Employment preparedness/training classes for youth	☐	❑	☐	cl	☐
Employment preparedness/training classes for parents	☐	El	☐	☐	☐
Homemaker services	☐	☐	☐	cl	☐
Respite care	☐	❑	☐	cl	☐
Parent involvement activities	☐	cl	☐	☐	☐
Other (specify) _____	☐	cl	☐	cl	☐

D2 How many full-time teachers, teacher's aides and home visitors does your program have? (Use 6.A. on the PIR)

D3 How many full-time Social Service staff does your program have? _____

D4 What is the average home visitor-to-child ratio (for home-based models only)? :_____

D5 What is the average classroom staff-to-child ratio? :_____

SECTION E: AOD ABUSE PROBLEMS: Extent

In this section we are interested in finding out about the extent of AOD abuse problems among the families served by your program during your last program year. Please answer all questions based on your personal experience. If your program maintains data on family AOD abuse problems, please use the data to provide your response, If not, estimate as before.

During your last program year:

E1 What percent of the children in your program resided in families in which at least one member had a AOD abuse problem? _____ %
Reporting from data ☐ Estimating response ☐ Don't know ☐

E2 How does the percentage in El differ from approximately 5 years ago?
Increased ☐ Decreased ☐ No change ☐ Don't know ☐

E3 If you answered increased or decreased to the above question, please provide the percent of children residing in families in which at least one member had a AOD abuse problem approximately 5 years ago. _____%
Reporting from data ☐ Estimating response ☐ Don't know ☐

E4 What percent of the children served by your program were known to have been prenatally addicted or exposed to AOD? _____ %
Reporting from data ☐ Estimating response ☐ Don't know Cl

E5 How does the percentage in E4 differ from approximately 5 years ago?
Increased ☐ Decreased ☐ No change ☐ Don't know ☐

E6 If you answered increased or decreased to the above question, please provide the percent of children residing in families in which at least one member had a AOD abuse problem approximately 5 years ago. _____%
Reporting from data ☐ Estimating response ☐ Don't know ☐

E7 What percent of the children served by your program during the last program year do you suspect may have been prenatally addicted or exposed to AOD? _____ %
Reporting from data ☐ Estimating response ☐ Don't know ☐

SECTION F: AOD abuse PROBLEMS: Staff Activities

This section pertains to the impact of serving children and families with AOD abuse problems on staff activities. Please answer all questions based on your personal experience.

F1 Does serving children from families with AOD abuse problems require more of an education staff member's time than serving other children?

- ☐ Almost always requires more time
- ☐ Frequently requires more time
- ☐ Sometimes requires more tune
- ☐ Rarely requires more time
- ☐ Don't know

F2 Do children from families with AOD abuse problems require more specialized education services than other children?

Cl Almost always require more specialized services
☐ Frequently require more specialized services
☐ Sometimes require more specialized services
Cl Rarely require more specialized services
Cl Don't know

F3 Does serving families with AOD abuse problems require more of a social service staff member's time than serving other families?

Cl Almost always requires more time
☐ Frequently requires more time
☐ Sometimes requires more time
☐ Rarely requires more time
Cl Don't know

F4 Do families with AOD abuse problems require more specialized services than other families?

☐ Almost always require more specialized social services
☐ Frequently require more specialized social services
☐ Sometimes require more specialized social services
☐ Rarely require more specialized social services
☐ Don't know

SECTION G: SERVICE EFFECTIVENESS

This section of the questionnaire refers to the goals of the program with respect to serving children and families with AOD abuse problems, the effectiveness of the staff in attaining these goals, and the services or procedures that may have been, or need to be, implemented to assist staff in attaining program goals. Please answer all questions based on your personal experience.

G1 What are your program's goals with respect to serving families with AOD abuse problems and how important do you think these goals are?

	Very important	Moderately important	Somewhat important	Not important	Not a goal
To get family member to acknowledge AOD abuse problem	☐	☐	☐	cl	☐
To get family member to agree to seek treatment	☐	☐	☐	☐	☐
To enroll family member in a treatment program	☐	cl	cl	☐	☐
To enroll family member in counseling for problems related to AOD abuse	cl	☐	cl	cl	☐
To help family members cope with a AOD abuser	☐	☐	cl	☐	☐
To help child cope with a family member who has a AOD abuse problem	cl	cl	cl	☐	☐
To ensure that family AOD abuse does not result in child maltreatment	☐	☐	☐	☐	☐
To help child overcome problems resulting from living in families with AOD abuse problems	☐	☐	cl	☐	cl
Other goals (specify) _____	☐	☐	☐	cl	☐
_____	☐	☐	cl	☐	☐

G2 How successful do you feel program staff are with respect to achieving the goals listed in G1?

	Very successful	Moderately successful	Somewhat successful	Not successful	Not a goal
To get family member to acknowledge AOD abuse problem	☐	☐	☐	☐	☐
To get family member to agree to seek treatment	☐	☐	☐	☐	☐
To enroll family member in a treatment program	☐	☐	☐	☐	☐
To enroll family member in counseling for problems related to AOD abuse	☐	☐	☐	☐	☐
To help family members cope with a AOD abuser	☐	☐	☐	☐	☐
To help child cope with a family member who has a AOD abuse problem	☐	☐	☐	☐	☐
To ensure that family AOD abuse does not result in child maltreatment	☐	☐	☐	☐	☐
To help child overcome problems resulting from living in families with AOD abuse problems	☐	☐	☐	☐	☐
Other goals (specify) _____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

G3 For each goal that you answered that program staff are only **somewhat successful or not successful in** attaining, please explain why you feel this way.

To get family member to acknowledge AOD abuse problem

_____

_____

To get family member to agree to seek treatment

_____

_____

To enroll family member in a treatment program

_____

_____

To enroll family member in counseling for problems related to AOD abuse

_____

_____

To help family members cope with a AOD abuser

_____

_____

To help child cope with a family member who has a AOD abuse problem

To ensure that family AOD abuse does not result in child maltreatment

To help child overcome problems resulting from living in families with AOD abuse problems

Other goals (as specified above)

G4 Has your program implemented any new services in the past 5 years as a result of serving families with AOD abuse problems? Yes ☐ No ☐ Don't know ☐

G5 If yes, please describe the services that were implemented.

SECTION H: AOD ABUSE: Impact on Staffing

In this section, we are soliciting information about the impact of serving children and families with AOD abuse problems on your program's staffmg and staff training. Please answer all questions based on your personal experience.

H1 Does your program have difficulties recruiting staff as a result of serving families with AOD abuse problems?

Yes ☐ No ☐ Don't know ☐

If yes, please explain why.

H2 **Does your program have difficulties retaining staff as** a result of serving families with AOD abuse problems?

Yes ☐ No ☐ Don't know ☐

If yes, please explain why. _____

_____

H3 In comparison to working with families without AOD abuse problems, are staff working with **families with AOD abuse problems** more likely, less likely, or equally likely to experience the following problems?

	More likely	Less likely	No difference	Don't know
Personal danger	☐	cl	☐	☐
Emotional "burnout"	☐	cl	☐	☐
Problems with personal unresolved AOD abuse issues	El	☐	☐	cl
Other (specify)_____	☐	☐	☐	☐

H4 Do you think your program needs to implement special strategies or staffing changes in order to better Serve families with AOD abuse problems?

Yes Cl No ☐ Don't know ☐

H5 Please indicate how important you think the following strategies or staffing practices are in improving your program's ability to serve families with **AOD** abuse problems. (Note: Please provide your opinions regarding these practices even if they have not been implemented in your program.)

	Very important	Somewhat important	Not important	Don't know
Build a stronger referral network among community agencies	❑	❑	❑	❑
Work with local AOD abuse treatment services to give priority to Head Start families	❑	❑	❑	❑
Hire **a consultant to** help staff work with families with AOD abuse problems	❑	❑	❑	☐
Develop a team approach to case management in working with families with AOD abuse problems	❑	❑	❑	❑
Reduce staff workloads	❑	❑	❑	❑
Add new staff specialists to deal with AOD abuse problems	❑	❑	❑	☐
Create staffing teams/special unit to work with families with AOD abuse problems	❑	❑	❑	❑
Provide funds for staff to attend AOD abuse-related workshops	☐	❑	❑	❑
Other (specify) _____	❑	❑	❑	❑

H6 Please identify the strategies or staffing practices that have been implemented or that the program plans to implement.

	Has been implemented	Plan to implement	Do not plan to implement
Build a stronger referral network among community agencies	☐	☐	☐
Work with local AOD abuse treatment services to give priority to Head Start families	☐	☐	☐
Hire a consultant to help staff work with families with AOD abuse problems	☐	cl	☐
Develop a team approach to case management in working with families with AOD abuse problems	☐	cl	☐
Reduce staff workloads	☐	☐	☐
Add new staff specialists to deal with AOD abuse problems	cl	☐	☐
Create staffing teams/special unit to work with families with AOD abuse problems	cl	☐	☐
Provide funds for staff to attend AOD abuse-related workshops	☐	☐	☐
Other (specify) _____	☐	☐	☐

H7 Do you think your program needs to provide special training to staff to better serve families with AOD abuse problems? Yes ☐ No ☐ Don't know ☐

H8 If yes, please identify the training needs and whether they are being addressed,

Type of training	Training needed and in place	Training needed and planned	Training needed but not planned	Training not needed
Diffusing potentially violent family situations	☐	☐	☐	☐
Basic drug and alcohol information (appearance, physiological effects, behaviors of those under the influence)	cl	❑	☐	☐
Basic health information	☐	☐	☐	☐
Street drug information/street culture (current street slang)	☐	☐	☐	☐
Family/couples counseling	☐	❑	☐	☐
Dealing with hostile family members	☐	☐	☐	☐
Conducting interventions with individuals with AOD abuse problem	☐	☐	☐	☐
Codependency information (family dynamics, roles, behaviors)	☐	☐	☐	☐
Staff safety/self protection	☐	☐	☐	☐
AOD abuse prevention	☐	☐	☐	☐
Conducting AOD abuse needs assessments	☐	☐	☐	☐
Protecting children/reporting to Child Protective Services	☐	☐	☐	☐
Working with children from AOD abuse families	☐	☐	☐	☐
HIV treatment/prevention	☐	☐	☐	☐
Supporting clients AOD treatment efforts	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐

SECTION I: REPORTING REQUIREMENTS

11 Does your program have specific child abuse and neglect reporting requirements for mandated reporters that pertain to AOD abuse?

Yes Cl No ☐ Don't know ❑

I2 To whom are you required to report?

☐ Child Welfare
Cl Law enforcement
☐ Child abuse and neglect hotline
☐ Other (specify) _____

13 Are you required to report the following situations?

	Yes	No	Don't know
A pregnant woman who is known to be using AOD	☐	☐	☐
A pregnant woman who is suspected of using AOD	☐	☐	cl
A parent or primary caretaker who is known to be a AOD abuser	cl	☐	☐
A parent or primary caretaker who is suspected of using AOD	❑	☐	cl
A parent who abuses substances to the extent that a reporter suspects the children are being maltreated (although there has been no actual observation of maltreatment)	cl	☐	☐

14 Approximately how many children were reported for AOD abuse related maltreatment during your last program year?

Number of children _____

Reporting from data ☐ Estimating response ☐ Don't know ☐

I5 Do you think that reporting requirements have been a barrier to serving children and families with AOD abuse problems?

Yes ☐ No ☐ Don't know ☐

16 If you answered yes to the above question, please explain why you feel reporting requirements have been a barrier to serving children and families with AOD abuse problems.

_____

_____

17 In your experience with reporting families to child welfare or other authorities, how satisfied have you been with the way reports are handled?

Very satisfied ☐ Moderately satisfied ☐ Moderately dissatisfied ❑ Very dissatisfied ☐

18 Why were you dissatisfied?

☐ Confidentiality was not maintained
☐ Agency did not investigate the report
☐ Agency removed the child from the home rather than providing services to the family
☐ Agency did not place the child when placement was needed
☐ Other (specify) _____

SECTION J: GENERAL PERSPECTIVES

In this last section of the questionnaire, we are interested in determining how you view the problem of family AOD abuse in the context of other family problems that program staff must contend with in working with families.

J1 Do you feel that your program has a role in combatting AOD abuse?
Yes ☐ No ☐ Don't know ☐

J2 If you answered yes to the above question, please describe how you see your program's role.

_____

_____

_____

_____

J3 Overall, given the many problems that families served by your program are facing, how important do you feel it is **for your program to** confront the problem of family AOD abuse?

- Number one priority of program ☐
- Extremely important ☐
- Moderately important ☐
- slightly important ☐
- Not important ☐
- Don't know ☐

Head Start Education Coordinator

RESEARCH QUESTION	ITEM(S)
1a - Concept of AOD abuse	A1, A2
1b - State and local statutes	NA
1c - Service costs	C2, C3
1d - Change in services/demand for services	C2, C3, C7, C8, E5
2a - Number of clients with AOD abuse problems/change	C7, C8
2b - Characteristics	C4, C5, C6, D1, D2, D3, D4, F5
3a - Foster Care	NA
3b - Adoption	NA
4a - Goals/effectiveness	E1, E2, E3
4b - Staffing	C9, E2, E3, E4, E5
4c - Juvenile court and hospital social workers perspectives	NA
5a - Client needs	F1, F2
5b - Staff effectiveness	C9, E1, E2, E3, E4
5c - Barriers	F3, F4, F6, F7
5d - Roles	G1, G2, G3

Revised: July 3 1, 1992

Head Start: Education Coordinator

This questionnaire form is to be completed by the person employed by the Head Start program who is responsible for overseeing and/or providing education services to children enrolled in the Head Start program.

Guidelines for completion of the form

Please restrict your responses to impressions that are directly based on your experience as a Head Start education coordinator. Many of the questions require you to state opinions that are based on your own professional experience. In general you should answer these questions only if:

1) You have had direct contact with children and/or their families.

2) You have discussed cases or client situations with staff members.

3) You have access to records and/or databases containing pertinent information.

Otherwise, you should respond “don’t know”.

SECTION A: DEFINITIONS

As indicated in the cover letter, in this study we are interested in assessing the impact of family or youth alcohol and other drug (AOD) abuse problems on your program. Although the term "AOD abuse problem" can be conceptualized in a variety of ways, we have defined this term in a way that we feel is meaningful for service delivery efforts. We would like you to keep the following definitions in mind while you are completing this questionnaire.

For the purposes of this study, **AOD** refers to alcohol and other drugs with the exception of nicotine, caffeine, and prescription drugs under a doctor's supervision.

AOD abuse problem refers to a level of drug use resulting in the user being unable to meet personal responsibilities, being unable to appropriately fulfill role requirements, and/or engaging in behaviors that are self-destructive or harmful to others.

A1 Does your program define the term AOD abuse problem in a similar or different manner?
Similar ☐ Different ☐ Do not have a program definition ☐

A2 If you answered different, please describe how your program defines a AOD abuse problem.

_____

_____

_____

_____

SECTION B: RESPONDENT INFORMATION

B1 Name: _____

B2 Contact telephone # (-____)_____ _____

B3 Job title: _____

B4 Do you serve in any other role(s) for Head Start or for other child care programs?
Yes ☐ No ☐

If yes, please list (e.g. social service coordinator, teacher, board member).

_____

_____

_____

B5 What are your primary responsibilities as education coordinator?

_____

_____

_____

B6 How long have you be-en employed in this position? _____

B7 What was your previous position and how long were you employed in that position?

Position: _____

Length of time: _____

SECTION C: AOD ABUSE PROBLEM: **Impact on Staff Activities**

In this section we are concerned with how children and families with AOD abuse problems impact on you or your staff's activities. All **questions are to be answered based on your personal experiences as an education coordinator.**

C1 What information do you use to determine whether there is a AOD abuse problem?

	Very rarely	Rarely	Sometimes	Frequently	Very frequently
Family needs assessment	☐	☐	☐	☐	☐
Child needs assessment	☐	☐	☐	☐	☐
Discussions with family members	☐	☐	☐	☐	☐
Discussions with child	c l	☐	☐	☐	☐
Discussions with other professionals who have had contact with the family/child	☐	☐	☐	☐	☐
Reports from social service agencies	☐	☐	☐	☐	☐
Medical reports on the child	☐	☐	☐	☐	☐
Medical reports on the family	☐	☐	☐	☐	☐
Observation of family members	☐	☐	☐	☐	☐
Observations of child	☐	☐	☐	☐	☐
Information from staff, neighbors, relatives, etc.	☐	☐	☐	☐	☐
Other (specify) _____	c l	☐	☐	☐	☐

C2 Does working with children from families with AOD abuse problems require more time from education staff than working with other children?

El Almost always requires more time
☐ Frequently requires more time
☐ Sometimes requires more time
☐ Rarely requires more time
☐ Don't know

C2a Does the type of drug being used by the family make a difference?
Yes ❑ No ❑ Don't know Cl

If yes, please explain.

c3 Do children from families with AOD abuse problems require more attention from education staff than other children?

- ❑ Almost always require more attention
- ❑ Frequently require more attention
- ❑ Sometimes require more attention
- ❑ Rarely require more attention
- ❑ Don't know

C3a Does the type of drug being used by the family make a difference?
Yes ❑ No ❑ Don't know ❑

If yes, please explain.

c4 Do children from families with AOD abuse problems exhibit more learning problems than other children?

- ❑ Almost always exhibit more learning problems
- ❑ Frequently exhibit more learning problems
- ❑ Sometimes exhibit more learning problems
- ❑ Rarely exhibit more learning problems
- ❑ Don't know

C4a Does the type of drug being used by the family make a difference?
Yes Cl No ❑ Don't how ❑

If yes, please explain.

C5 Do children from families with AOD abuse problems exhibit more behavioral problems than other children?

- ☐ Almost always exhibit more behavioral problems
- ☐ Frequently exhibit more behavioral problems
- ☐ Sometimes exhibit more behavioral problems
- ☐ Rarely exhibit more behavioml problems
- ☐ Don't know

C5a Does the type of drug being used by the family make a difference?
Yes ☐ No ☐ Don't know ☐

If yes, please explain.

_____

_____

_____

_____

C6 Do children from families with AOD abuse problems exhibit more physical/medical problems than other children?

- ☐ Almost always exhibit more physical/medical problems
- ☐ Frequently exhibit more physical/medical problems
- ☐ Sometimes exhibit more physical/medical problems
- ☐ Rarely exhibit more physical/medical problems
- ☐ Don't know

C6a Does the type of drug being used by the family make a difference?
Yes ☐ No ☐ Don't know ☐

If **yes,** please explain.

_____

_____

_____

_____

c7 During your last program year, approximately what percentage of the children enrolled in Head Start had at least one family member with a AOD abuse problem?

Percent of children _____
Reporting from data ☐ Estimating response ☐ Don't know El

C8 How has the percentage in C7 changed over the past 5 years?

- ❑ Increased substantially
- ❑ Increased moderately
- ❑ No change
- ❑ Decreased moderately
- ❑ Decreased substantially
- ❑ Don't know

Reporting from data ❑
Estimating response ❑

C9 What types of training do you feel would help you better serve children from families with AOD abuse problems?

Type of training	Training needed but not available	Training needed and available	Training not needed
Diffusing potentially violent family situations	❑	❑	❑
Basic drug and alcohol information (appearance, physiological effects, behaviors of those under the influence)	❑	❑	❑
Basic health information	❑	❑	❑
Street drug information/street culture (current street slang)	❑	❑	❑
Family/couples counseling	❑	❑	❑
Codependency information (family dynamics, roles, behaviors)	❑	❑	❑
Dealing with hostile family members	❑	❑	❑
Conducting interventions with individuals with AOD abuse problems	❑	❑	❑
Staff safety/self protection	❑	❑	❑
AOD abuse prevention	❑	❑	❑
Conducting AOD abuse needs assessments	❑	❑	❑
Protecting children/reporting to Child Protective Services	❑	❑	❑
Working with children from AOD abusing families	❑	❑	❑
HIV treatment/prevention	❑	❑	❑
Supporting parents AOD treatment efforts	❑	❑	❑
Other (specify) _____	❑	❑	❑

SECTION D: AOD ABUSE PROBLEM: Characteristics of children

In this section we are interested in your perceptions of the characteristics of children from families with AOD abuse problems and whether these children differ from other clients. Please answer all questions based on your personal experience in working with these children.

D1 In comparison to children from families without AOD abuse problems, are children from families with AOD abuse problems more likely, less likely, or equally likely to exhibit the following characteristics?

Child characteristics	More likely	Less likely	No difference	Don't know
Come from families with AFDC as primary support	❑	❑	•J	❑
Come from families with incomes below the poverty level	❑	❑	❑	❑
Come from families headed by a single parent/mother	❑	❑	❑	❑
Come from families headed by a single parent/father	❑	❑	❑	❑
Come from families with a stepparent	❑	❑	❑	❑
Come from families headed by an adolescent parent(s)	❑	❑	❑	❑
Come from families with non-family members living in the Cl household		❑	❑	❑
Be from an racial/ethnic minority group	❑	❑	❑	❑
Experience threats or physical violence from family member	❑	❑	❑	❑
Experience chronic family conflict	❑	❑	❑	❑
Have a parent who has been arrested	❑	❑	❑	❑
Have moved frequently	❑	❑	❑	❑
Have lived on the streets at some time	❑	❑	❑	❑
Have experienced physical abuse from a family member	❑	❑	❑	❑
Have experienced sexual abuse from a family member	❑	❑	❑	❑
Have experienced emotional abuse from a family member	❑	❑	❑	❑
Have experienced neglect	❑	❑	❑	❑
Have been abandoned/pushed out	❑	❑	❑	❑
Come from families where there has been spouse abuse	❑	❑	❑	❑
Have received special services for a learning or developmental disability	❑	❑	❑	❑
Have emotional/psychological problems	❑	❑	❑	❑
Come from a family where a member has attempted/ committed suicide	❑	❑	❑	❑
Be shy and isolated from peers	❑	❑	❑	❑
Come from a family where a member was a victim of a violent crime	❑	❑	❑	❑

Child characteristics	More likely	Less likely	No difference	Don't know
Come from a family where a child was placed for adoption	☐	c l	☐	☐
Other (specify)_____	☐	☐	☐	
_____	☐	☐	☐	
_____	☐	☐	☐	

D2 In comparison to families without AOD abuse problems, are families with AOD abuse problems more likely, less likely, or equally likely to exhibit the following behaviors?

	More likely	Less likely	No difference	Don't know
To be involved with the program	☐	•J	☐	☐
To have high "no-show" rates	☐	El	☐	☐
To drop out of the program	☐	☐	☐	☐
To pose a safety threat to staff	☐	☐	☐	☐
To have children who are chronically late for center activities	☐	c l	☐	☐
To have children who have higher absentee rates	☐	☐	☐	☐
To establish contact with the children's teacher	☐	c l	☐	☐
To have children who have physical health problems	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	
_____	☐	c l	☐	
_____	☐	c l	☐	

D2a Does the type of drug being used by the family make a difference?
Yes ☐ No ☐ Don't know Cl

If yes, please explain.

_____

_____

_____

_____

_____

_____

D3 Among the families **you serve with** AOD abuse problems, how many abuse the following drugs?

	Most	Some	Few	None	Don't know
Alcohol	☐	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐	☐
Crack	☐	☐	☐	☐	☐
Opii (heroin, methadone)	☐	☐	☐	☐	☐
Amphetamines (speed, ice)	☐	☐	☐	☐	☐
Sedatives (valium, downers)	☐	☐	☐	☐	☐
Barbiturates	☐	☐	☐	☐	☐
Psychedelics (LSD, mushrooms, **peyote)**	☐	☐	☐	☐	☐
Inhalants (glue, gasoline)	☐	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐

D4 Which **family** member tends to exhibit the AOD abuse problem?

	Very rarely	Rarely	Sometimes	Frequently	Very frequently
Mother/stepmother	☐	☐	☐	☐	c l
Father/stepfather	☐	☐	☐	☐	☐
Sibling	c l	☐	☐	☐	☐
Both parents	☐	☐	☐	☐	☐
Non-related resident adult	☐	☐	☐	☐	☐
Related resident adult	☐	☐	☐	☐	☐
Other (specify)_____	☐	☐	☐	☐	☐

SECTION E: AOD ABUSE PROBLEM: Service Effectiveness

This section of the questionnaire refers to the goals of the program with respect to serving children and families with AOD abuse problems, the effectiveness of the staff in attaining these goals, and the services or procedures that may have been implemented to assist staff in attaining their goals. Again, please answer all questions based on your personal experiences as an education coordinator.

E1 What are your program's goals with respect to serving families with AOD abuse problems and how important do **you think these goals are?**

	Very important	Moderately important	Somewhat important	Not important	Not a goal
To get family member to acknowledge AOD abuse problem	☐	☐	☐	☐	☐
To get family member to agree to seek treatment	☐	☐	☐	☐	☐
To enroll family member in a treatment program	☐	☐	☐	☐	☐
To enroll family member in counseling for problems related to AOD abuse	☐	☐	☐	☐	☐
To **help child cope with** a family member who has a AOD abuse problem	☐	☐	☐	☐	☐
To help child understand they are not responsible for family member's AOD abuse problem	☐	☐	☐	☐	☐
To help child overcome problems resulting from living in families with AOD abuse problems	☐	☐	☐	☐	☐
Other goals (specify) _____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

E2 How successful do you feel you are with respect to achieving the goals listed in El?

	Very successful	Moderately successful	Somewhat successful	Not successful	Not a goal
To get family **member to** acknowledge AOD abuse problem	☐	☐	☐	c l	c l
To get family member to agree to seek treatment	☐	☐	☐	☐	☐
To enroll family member in a treatment program	☐	c l	c l	☐	c l
To enroll family member in counseling for problems related to AOD abuse	☐	c l	☐	☐	☐
To help child cope with a family member who has a AOD abuse problem	☐	☐	☐	☐	☐
To help child understand they are not responsible for family member's AOD abuse problem	☐	☐	☐	☐	☐
To help child overcome problems resulting from living in families with AOD abuse problem	☐	☐	a	☐	☐
Other goals (specify) _____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

E3 For each goal that you answered that you are only somewhat **successful or not successful in** attaining for the youth, please explain why you feel this way.

To get family member to acknowledge AOD abuse problem

_____

_____

To get family member to agree to seek treatment

_____

_____

To enroll family member in a treatment program

_____

_____

To enroll family member in counseling for problems related to AOD abuse

_____

_____

To help child cope with a family member who has a AOD abuse problem

_____

_____

To help child understand they are not responsible for family member's AOD abuse problem

_____

_____

To help child overcome problems resulting from living in families with AOD abuse problems

_____

_____

Other goals (as specified above)

_____

_____

_____

E4 Please indicate how important you think the following strategies or staffing practices are in improving your ability to serve children from families with AOD abuse problems. (Note: Please provide your opinions regarding these practices even if they have not been implemented in your program.)

	Very important	Somewhat important	Not important	Don't know
Build a stronger referral network among community agencies	☐	☐	☐	☐
Work with local AOD abuse treatment services to give priority to Head Start families	☐	☐	☐	☐
Hire a consultant to help staff work with families with AOD abuse problems	☐	☐	☐	☐
Develop a team approach to case management in working with families with AOD abuse problems	☐	☐	☐	☐
Reduce staff workloads	☐	☐	☐	☐
Add new staff specialists to deal with AOD abuse problems	☐	☐	☐	☐
Create staffing teams/special unit to work with families with AOD abuse problems	☐	☐	☐	☐
Provide special AOD abuse-related training for staff	☐	☐	☐	☐
Provide funds for staff to attend AOD abuse-related workshops	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐

E5 Please identify the strategies or staffing changes that have been implemented over the past 5 years.

	Has been implemented	Has not been implemented	Was already in place
Build a stronger referral network among community agencies	☐	☐	☐
Work with local AOD abuse treatment services to give priority to Head Start families	☐	☐	☐
Hire a consultant to help staff work with families with AOD abuse problems	☐	☐	☐
Develop a team approach to case management in working with families with AOD abuse problems	☐	☐	☐
Reduce staff workloads	☐	☐	☐
Add new staff specialists to deal with AOD abuse problems	☐	☐	☐
Create staffing teams/special unit to work with families with AOD abuse problems	☐	☐	☐
Provide special AOD abuse-related training for staff	☐	☐	☐
Provide funds for staff to attend AOD abuse-related workshops	☐	☐	☐
Other (specify) _____	☐	☐	☐

SECTION F: SERVICE NEEDS

In this section we are interested in determining whether children from families with AOD abuse problems have service needs that are different or similar to other children in your program. Please answer all questions based on your personal experience.

F1 In comparison to children from families without AOD abuse problems, are children from families with AOD abuse problems more likely, less likely, or equally likely to require the following services?

Type of service	More likely	Less likely	No difference	Don't know
Food	☐	☐	☐	☐
Shelter for children/youth	☐	☐	☐	☐
Shelter for families	☐	☐	☐	☐
Physical examinations	☐	☐	☐	☐
Medical tests	☐	☐	☐	☐
Nutrition information	☐	☐	☐	☐
Out-of-home placement for children/youth	☐	☐	☐	☐
Home visits	☐	☐	☐	☐
Individual counseling	☐	☐	☐	☐
Individual counseling for parents	☐	☐	☐	☐

Type of service	More likely	Less likely	No difference	Don't know
Legal services	☐	☐	☐	☐
Group counseling for children/youth	☐	☐	☐	☐
Group counseling for parents	☐	☐	☐	☐
Family counseling	☐	☐	☐	☐
Couples counseling	☐	☐	☐	☐
AOD abuse assessment for families	☐	☐	☐	☐
AOD abuse treatment	☐	☐	☐	☐
AOD abuse prevention services	☐	☐	☐	☐
HIV prevention/counseling	☐	☐	☐	☐
GED classes for parents	☐	☐	☐	☐
Education for children with special needs	☐	☐	☐	☐
Employment preparedness/training classes for parents	☐	☐	☐	☐
Homemaker services	☐	☐	☐	☐
Respite care	☐	☐	☐	☐
Parent involvement activities	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	

F2 Do you feel you are able to meet the service needs of children with AOD abuse problems?

- ☐ Almost always
- ☐ Most of the time
- ☐ Some of the time
- ☐ Rarely
- ☐ Very rarely
- ☐ Don't know

F3 Please identify the kinds of problems and their severity that **you** experience in your efforts to serve children from families with AOD abuse problems?

	Severe problem	Moderate problem	Not a problem
Parental denial of AOD abuse problem	☐	☐	☐
Communication barrier with non-English speaking parents	☐	☐	☐
Negative attitudes of program staff toward individuals with AOD abuse problems	☐	☐	☐
Other (specify) _____	☐	☐	☐
_____	☐	☐	☐

F4 For each barrier that is a problem, please indicate how you think it might be addressed.

F5 Compared with 5 years ago, how do you feel the abuse of specific drugs among the families you serve has changed?

	Increased	Decreased	No change	Don't know
Alcohol	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐
Crack	☐	☐	☐	☐
Opiates (heroin, methadone)	☐	☐	☐	☐
Amphetamines (speed, ice)	☐	☐	☐	☐
Sedatives (valium, downers)	☐	☐	☐	☐
Barbiturates	☐	☐	☐	☐
Psychedelics (LSD, mushrooms, peyote)	☐	☐	☐	☐
Inhalants (glue, gasoline)	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐

F6 Does the type of drug being used affect the difficulty you (or your staff) experience in working with families?
Yes ☐ No ☐ Don't know ☐

F7 If yes, please identify which type of AOD abuse is **most difficult to** work with and why.

SECTION G: GENERAL PERSPECTIVES

In this last section, we are interested in determining how you view the problem of family AOD abuse in the context of other family problems that Head Start staff must contend with.

G1 Do you feel that your program has a role in combatting AOD abuse?

Yes ☐ No ☐ Don't know ☐

G2 If you answered yes to the above question, please describe how you see your program's role. If you answered no, please explain why you feel your program does not have a role.

_____

_____

_____

G3 Overall, given the many problems that clients served by your program are facing, how important do you feel it is for your program to confront the problem of family AOD abuse?

- Number one priority of program ☐
- Extremely important ☐
- Moderately important ☐
- slightly important ☐
- Not important ☐
- Don't know ☐

Head Start Social Services Coordinator

RESEARCH QUESTION	ITEM(S)
1a - Concept of AOD abuse	A1, A2
1b - State and local statutes	NA
1c - Service costs	C2, C3, C4
1d - Change in services/demand for services	C2, C3, C4, C5, C6, E5
2a - Number of clients with AOD abuse problems/change	C5, C6
2b - Characteristics	D1, D2, D3, D4, F5
3a - Foster Care	NA
3b - Adoption	NA
4a - Goals/effectiveness	E1, E2, E3
4b - Staffmg	C7, E2, E3, E4, E5
4c - Juvenile court and hospital social workers perspectives	NA
5a - Client needs	F1, F2
5b - Staff effectiveness	C7, E1, E2, E3, E4, F2
5c - Barriers	F3, F4, F6, F7
5d - Roles	G1, G2, G3

Revised: July 3 1, 1992

Head Start: Social Services Coordinator

This questionnaire form is to be completed by the person employed by the Head Start program who is responsible for overseeing and/or providing services to families enrolled in the Head Start program.

Guidelines for completion of the form

Please restrict your responses to impressions that are directly based on your experience as a Head Start social services coordinator. Many of the questions require you to state opinions that are based on your own professional experience. In general you should answer these questions only if:

1) You have had direct contact with children and/or their families.

2) You have discussed cases or client situations with staff members.

3) You have access to records and/or databases containing pertinent information.

Otherwise, you should respond “don’t know”.

SECTION A: DEFINITIONS

As indicated in the cover letter, in this study we are interested in assessing the impact of family or youth alcohol and other drug (AOD) abuse problems on your program. Although the term "AOD abuse problem" can be conceptualized in a variety of ways, we have defined this term in a way that we feel is meaningful for service delivery efforts. We would like you to keep the following definitions in mind while you are completing this questionnaire.

For **the** purposes of this study, AOD refers to alcohol and other drugs with the exception of nicotine, caffeine, and prescription drugs under a doctor's supervision.

AOD **abuse problem** refers to a level of AOD use resulting in the user being unable to meet personal responsibilities, being unable to appropriately fulfill role requirements, and/or engaging in behaviors that are self-destructive or harmful to others.

A1 Does your program define the term **AOD abuse problem in** a similar or different manner?

Similar ❑ Different ❑ Do not have a program definition ❑

A2 If you answered **different**, please describe how your program defines a AOD abuse problem.

_____

_____

_____

_____

SECTION B: RESPONDENT INFORMATION

B1 Name: _____

B2 Contact telephone # (-____)_____ _____

B3 Job title: _____

B4 Do you serve in any other role(s) for Head Start or for other child care programs?
Yes ❑ No ❑

If yes, please list (e.g. social service coordinator, teacher, board member).

_____

_____

_____

B5 What are your primary responsibilities as social services coordinator?

_____

_____

_____

_____

B6 How long have you been employed in this position? _____

B7 What was your previous position and how long were you employed in that position?

Position: _____

Length of time: _____

SECTION C: AOD ABUSE PROBLEM: Impact on Staff Activities

In this section we are concerned with how children and families with AOD abuse problems impact on your activities. All **questions are to be answered based on your own personal experiences as social** services **coordinator.**

C1 What information do you use to determine whether there is a AOD abuse problem?

	Very rarely	Rarely	Sometimes	Frequently	Very frequently
Family needs assessment	☐	☐	c1	☐	☐
Child needs assessment	☐	☐	☐	☐	☐
Discussions with family members	☐	☐	☐	☐	☐
Discussions with child	☐	☐	☐	☐	☐
Discussions with other professionals who have had contact with the family/child	☐	☐	☐	☐	☐
Reports from social service agencies	☐	☐	☐	☐	☐
Medical reports on the child	☐	☐	☐	☐	☐
Medical reports on the family	☐	☐	☐	☐	☐
Observation of family members	☐	☐	☐	☐	☐
Observations of child	☐	☐	☐	☐	☐
Information from staff, neighbors, relatives, etc.	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐

C2 Does developing a Family **Needs** Assessment (FNA) for families with AOD abuse problems require more time than developing FNA for other families?

Cl Almost always requires more time
☐ Frequently requires more tune
•J Sometimes requires more time
☐ Rarely requires more time
☐ Don't know

C2a Does the type of drug being used make a difference?
Yes El No ☐ Don't know ☐

If yes, please explain.

---

c3 Do families with AOD abuse problems require more specialized social services than families without AOD abuse problems?

☐ Almost always require more specialized social services
☐ Frequently require more specialized social services
☐ Sometimes require more specialized social services
☐ Rarely require more specialized social services
☐ Don't know

C3a Does the type of drug being used make a difference?
Yes ☐ No ☐ Don't know ☐

If yes, please explain.

---

c4 Do FNAs require more staff time to implement when families have AOD abuse problems than when families do not have AOD abuse problems?

☐ Almost always require more staff time
☐ Frequently require more staff time
☐ Sometimes require more staff time
☐ Rarely require more staff time
☐ Don't know

C4a Does the type of drug being used make a difference?

Yes ☐ No ☐ Don't know ☐

If yes, please explain.

_____

_____

_____

C5 During your most recent completed program year, approximately what percentage of the families you provided services to had at least one family member with a AOD abuse problem?

Percent of families _____

Reporting from data ☐ Estimating response ☐ Don't know ☐

C6 How has the percentage in C5 changed over the past 5 years?

- ☐ Increased substantially
- ☐ Increased moderately
- ☐ No change
- ☐ Decreased moderately
- ☐ Decreased substantially
- ☐ Don't know

Reporting from data ☐

Estimating response ☐

c7 What types of training do you feel would help you better serve families with AOD abuse problems?

Type of training	Training needed but not available	Traiuiug needed and available	Training not needed
Diffusing potentially violent family situations	☐	☐	☐
Basic drug and alcohol information (appearance, physiological effects, behaviors of those under the influence)	☐	☐	☐
Basic health information	☐	☐	☐
Street drug information/street culture (current street slang)	☐	☐	☐
Family/couples counseling	☐	☐	☐
Codependency information (family dynamics, roles, behaviors)	☐	☐	☐
Dealing with hostile family members	☐	☐	☐
Conducting interventions with individuals with AOD abuse problems	☐	☐	☐
Staff safety/self protection	☐	☐	☐
HIV treatment/prevention	☐	☐	☐
AOD abuse prevention	☐	☐	☐
Conducting AOD abuse needs assessments	☐	☐	☐
Protecting children/reporting to Child Protective Services	☐	☐	☐

Type of training	Training needed but not available	Training needed and available	Training **not** needed
Working with children from AOD abusing families	•J	☐	☐
Supporting parents AOD treatment efforts	☐	☐	cl
Other (specify) _____	☐	☐	☐

SECTION D: AOD ABUSE PROBLEM: Characteristics of families

In this section we are interested in your perceptions of the characteristics of families with AOD abuse problems and how these families differ from other clients. Please answer all questions based on your personal experience in working with these families.

D1 In comparison to families without AOD abuse problems, are families with AOD abuse problems more likely, less likely, or equally likely to exhibit the following characteristics?

Family characteristics	More likely	**Less likely**	No difference	Don't know
To have AFDC as primary support	☐	☐	cl	☐
To have incomes below the poverty level	☐	☐	☐	☐
To be headed by a single parent/mother	☐	☐	El	☐
To be headed by a single parent/father	☐	☐	☐	☐
To have a stepparent	☐	☐	☐	☐
To be headed by an adolescent parent(s)	☐	☐	☐	☐
To have non-family members living in the household	☐	☐	☐	☐
To be from an racial/ethnic minority group	☐	☐	☐	☐
To experience violence among family members	☐	☐	☐	☐
To experience chronic family conflict	☐	☐	☐	☐
To have a family member who has been arrested	☐	☐	☐	☐
To have a child who has been arrested	☐	☐	☐	☐
To move frequently	☐	☐	cl	☐
To be or have been homeless	☐	☐	☐	☐
To physically abuse a child	☐	☐	☐	☐
To sexually abuse a child	cl	☐	☐	☐
To emotionally abuse a child	☐	☐	☐	☐
To neglect a child	☐	☐	☐	☐
To abandon a child	☐	☐	cl	☐

Family characteristics	More likely	Less likely	No difference	Don't know
To experience spouse abuse	☐	El	☐	☐
To have a child who has a learning or developmental disability	☐	☐	☐	☐
To have a child who has emotional/psychological problems	☐	☐	☐	☐
To have family members who have attempted/committed suicide	☐	☐	☐	☐
To have a family member who has been the victim of a violent crime	☐	☐	☐	☐
To have a child who is shy and isolated from peers	☐	☐	☐	☐
To have a child who was placed for adoption	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	
_____	☐	☐	☐	
_____	☐	☐	☐	

D2 In comparison to families without AOD abuse problems, are families with AOD abuse problems more likely, less likely, or equally likely to exhibit the following behaviors?

	More likely	Less likely	No difference	Don't know
To be involved with the program	☐	☐	☐	☐
To have high "no-show" rates	☐	☐	☐	☐
To drop out of the program	☐	☐	☐	☐
To pose a safety threat to staff	c l	•I	☐	c l
To have children who are chronically late for center activities	c l	☐	☐	☐
To have children who have higher absentee rates	☐	☐	☐	☐
To establish contact with the children's teacher	☐	☐	☐	☐
To have children who have physical health problems	☐	☐	☐	•J
Other (specify) _____	☐	☐	☐	
_____	☐	☐	☐	
_____	☐	☐	☐	

D3 Among the families you serve with AOD abuse problems, how many abuse the following drugs?

	Most	Some	Few	None	Don't know
Alcohol	cl	☐	☐	☐	☐
Cocaine	El	☐	☐	☐	☐
Crack	☐	☐	☐	☐	☐
Opiate3 (heroin, methadone)	☐	☐	☐	☐	☐
Amphetamines (speed, ice)	☐	☐	☐	☐	☐
Sedatives (valium, downers)	☐	☐	☐	☐	☐
Barbiturates	☐	☐	☐	☐	☐
Psychedelics (LSD, mushrooms, peyote)	☐	☐	•J	cl	☐
Inhalants (glue, gasoline)	cl	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	cl

D4 Which family member tends to exhibit the AOD abuse problem?

	Very rarely	Rarely	Sometimes	Frequently	Very frequently
Mother/stepmother	☐	•1	☐	☐	☐
Father/stepfather	☐	☐	☐	El	☐
Sibling	☐	☐	☐	☐	☐
Both parents	☐	☐	☐	☐	☐
Non-related resident adult	☐	☐	☐	☐	☐
Related resident adult	☐	☐	☐	cl	☐
Other (specify)_____	☐	☐	☐	☐	☐

SECTION E: AOD ABUSE PROBLEM: Service Effectiveness

This section of the questionnaire refers to the goals of the program with respect to serving children and families with AOD abuse problems, the effectiveness of the staff in attaining these goals, and the services or procedures that may have been implemented to assist staff in attaining their goals. Again, please answer all questions based on your personal experiences as social services coordinator.

El What are your program's goals with respect to serving families with AOD abuse problems and how important do you think these goals are?

	Very important	Moderately important	Somewhat important	Not important	Not a goal
To get family member to acknowledge AOD abuse problem	☐	☐	☐	☐	☐
To get family member to agree to seek treatment	☐	☐	☐	☐	☐
To enroll family member in a treatment program	☐	☐	☐	☐	☐
To enroll family member in counseling for problems related to AOD abuse	☐	☐	☐	☐	☐
To help child cope with a family member who has a AOD abuse problem	☐	☐	☐	☐	☐
To help child understand they are not responsible for family member's AOD abuse problem	☐	☐	☐	☐	☐
To help child overcome problems resulting from living in families with AOD abuse problems	☐	☐	☐	☐	☐
Other goals (specify) _____	☐	☐	☐	☐	☐

E2 How successful do you feel you are with respect to achieving the goals listed in El?

	Very successful	Moderately successful	Somewhat successful	Not successful	Not a goal
To get family member to acknowledge AOD abuse problem	•J	☐	☐	c l	☐
To get family member to agree to seek treatment	☐	☐	☐	☐	☐
To enroll family member in a treatment program	☐	☐	☐	☐	☐
To enroll family member in counseling for problems related to AOD abuse	☐	☐	☐	☐	☐
To help child cope with a family member who has a AOD abuse problem	☐	☐	☐	☐	☐
To help child understand they are not responsible for family member's AOD abuse problem	☐	☐	☐	☐	☐
To help child overcome problems resulting from living in families with AOD abuse problem	☐	☐	☐	☐	☐
Other goals (specify) _____	☐	☐	☐	☐	☐
_____	•I	☐	☐	☐	☐

E3 For each goal that you answered that you are only somewhat successful or **not successful in attaining,** please explain why you feel this way.

To get family member to acknowledge AOD abuse problem

_____

_____

To get family member to agree to seek treatment

_____

_____

To enroll family member in a treatment program

_____

_____

To enroll family member in counseling for problems related to AOD abuse

_____

_____

To help child cope with a family member who has a AOD abuse problem

_____

_____

To help child understand they are not responsible for family member's AOD abuse problem

_____

_____

To help child overcome problems resulting from living in families with AOD abuse problems

_____

_____

Other goals (as specified above)

_____

_____

_____

E4 Please indicate how important you think the following strategies or staffmg practices are in improving your ability to serve families with AOD abuse problems. (Note: Please provide your opinions regarding these practices even if they have not been implemented in your program.)

	Very important	Somewhat important	Not important	Don't know
Build a stronger referral network among community agencies	☐	☐	☐	☐
Work with local AOD abuse treatment services to give priority to Head Start families	☐	☐	☐	☐
Hire a consultant to help staff work with families with AOD abuse problems	☐	☐	☐	☐
Develop a team approach to case management in working with families with AOD abuse problems	☐	☐	☐	☐
Reduce staff workloads	☐	☐	☐	☐
Add new staff specialists to deal with AOD abuse problems	☐	☐	☐	☐
Create staffing teams/special unit to work with families with AOD abuse problems	☐	☐	☐	☐
Provide special AOD abuse-related naming for staff	☐	☐	☐	☐
Provide funds for staff to attend AOD abuse-related workshops	El	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐

ES Please identify the strategies or staffing changes that have been implemented over the past 5 years.

	Has been implemented	Has not been implemented	Was already in place
Build a stronger referral network among community agencies	☐	El	☐
Work with local AOD abuse treatment services to give priority to Head Start families	☐	☐	☐
Hire a consultant to help staff work with families with AOD abuse problems	❑	❑	❑
Develop a team approach to case management in working with families with AOD abuse problems	❑	☐	☐
Reduce staff workloads	•J	☐	❑
Add new staff specialists to deal with AOD abuse problems	•J	☐	❑
Create staffing teams/special unit to work with families with AOD abuse problems	☐	☐	☐
Provide special AOD abuse-related training for staff	❑	c l	❑
Provide funds for staff to attend AOD abuse-related workshops	☐	☐	❑
Other (specify) _____	❑	☐	❑

SECTION F: SERVICE NEEDS

In this section **we are** interested in determining whether families with AOD abuse problems have service needs that are different or similar to the service needs of families without AOD abuse problems. Please answer all questions based on your personal experience.

F1 In comparison to families **without** AOD abuse problems, are families with AOD abuse problems more likely, less likely, or equally likely to require the following services?

Type of service	More likely	Less likely	No difference	Don't know
Food	☐	❑	☐	❑
Shelter for children/youth	❑	❑	❑	❑
Shelter for families	❑	❑	❑	❑
Physical examinations	❑	❑	❑	❑
Medical tests	❑	❑	❑	❑
Nutrition information	❑	❑	❑	❑
Out-of-home placement for children/youth	❑	☐	❑	❑
Jndependent living services	❑	☐	❑	❑
Parenting classes	❑	❑	❑	❑
Income maintenance services	❑	❑	❑	❑
Legal services	❑	❑	❑	❑

Type of service	More likely	Less likely	No difference	Don't know
Child care services	☐	☐	☐	☐
Child development services	☐	☐	☐	☐
Support group for children/youth	☐	☐	☐	☐
Support group for parents	☐	☐	☐	☐
Home visits	☐	☐	☐	☐
Individual counseling for children/youth	☐	☐	☐	☐
Individual counseling for parents	☐	☐	☐	☐
Group counseling for children/youth	☐	☐	☐	☐
Group counseling for parents	☐	☐	☐	☐
Family counseling	☐	☐	☐	☐
Couples counseling	☐	☐	☐	☐
AOD abuse assessment	☐	☐	☐	☐
AOD abuse treatment	☐	☐	☐	☐
AOD abuse prevention services	☐	☐	☐	☐
HIV prevention/counseling	☐	☐	☐	☐
GED classes for youth	☐	☐	☐	☐
GED classes for parents	☐	☐	☐	☐
Education for children with special needs	☐	☐	☐	☐
Employment preparedness/training classes for youth	☐	☐	☐	☐
Employment preparedness/training classes for parents	☐	☐	☐	☐
Homemaker services	☐	☐	☐	☐
Respite care	☐	☐	☐	☐
Parent involvement activities	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	

F2 Do you feel you are able to meet the service needs of children with AOD abuse problems?

- ☐ Almost always
- ☐ Most of the time
- ☐ Some of the time
- ☐ Rarely
- ☐ Very rarely
- ☐ Don't know

F3 What kinds of barriers do you experience in your efforts to serve children and families with AOD abuse problems?

	Severe problem	Moderate problem	Not a problem
Insufficient number of no-cost (accept medicaid) AOD abuse inpatient treatment programs for adults	☐	☐	☐
Insufficient number of no-cost (accept medicaid) AOD abuse inpatient treatment programs for adolescents	☐	☐	☐
Insufficient number of no-cost AOD abuse outpatient treatment programs	☐	☐	☐
Insufficient number of inpatient treatment programs that accept pregnant women	☐	☐	☐
Insufficient number of detoxification services	☐	☐	☐
Insufficient family support services in the community	☐	☐	☐
Insufficient respite care facilities	☐	☐	☐
Insufficient transportation for clients to access services	☐	☐	☐
Insufficient low cost housing for families	☐	☐	☐
Lack of formalized interagency cooperation	☐	☐	☐
Lack of information about relevant resources in the community	☐	☐	☐
Parents fear of losing their children	☐	☐	☐
Negative attitudes of program staff toward individuals with AOD abuse problems	☐	☐	☐
Resistance of parents to accept services	☐	☐	☐
Other (specify) _____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

F4 For each barrier that is a problem, please indicate how you think it might be addressed.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

F5 Compared with 5 years ago, how do you feel the abuse of specific drugs among the families you serve has changed?

	Increased	Decreased	No change	Don't know
Alcohol	☐	☐	cl	☐
Cocaine	☐	☐	☐	☐
Crack	☐	☐	☐	☐
Opiates (heroin, methadone)	☐	☐	☐	☐
Amphetamines (speed, ice)	☐	☐	☐	☐
Sedatives (Valium, downers)	☐	☐	☐	☐
Barbiturates	☐	☐	☐	☐
Psychedelics (LSD, mushrooms, peyote)	☐	☐	☐	☐
Inhalants (glue, gasoline)	☐	☐	☐	☐
Marijuana	El	☐	☐	☐
Other (specify) _____	cl	☐	☐	☐

F6 Does the type of drug being abused affect the difficulty you (or your staff) experience in working with families?
Yes Cl No ☐ Don't know ☐

F7 If yes, please identify which type of AOD abuse is most difficult to work with and why.

_____

_____

SECTION G: GENERAL PERSPECTIVES

In this last section of the questionnaire, we are interested in determining how you view the problem of family AOD abuse in the context of other family problems that Head Start staff must contend with.

G1 Do you feel that your program has a role in combatting AOD abuse?
Yes ☐ No ☐ Don't know Cl

G2 **If you answered yes to the** above question, please describe how you see your program's role. If you answered no, please explain why you feel your program does not have a role.

_____

_____

_____

G3 **Overall,** given the many problems that clients served by your program are facing, how important do you feel it is for Your program to confront the problem of family AOD abuse?

Number one priority of program ☐
Extremely important ☐
Moderately important ☐
slightly important ☐
Not important ☐
Don't know ☐

Runaway and Homeless Youth Program Administrator

RESEARCH QUESTION	ITEM(S)
1a - Concept of AOD abuse	A1, A2
1b - State and local statutes	NA
1c - Service costs	F1, F2, F3, F4
1d - Change in services/demand for services	C3, C4, C5, C6, C8, C9, G4, G5
2a - Number of clients with AOD abuse problems/change	E1 thru E6
2b - Characteristics	NA
3a - Foster Care	NA
3b - Adoption	NA
4a - Goals/effectiveness	G1, G2, G3
4b - Staffing	H1 thru H8
4c - Juvenile court and hospital social workers perspectives	NA
5a - Client needs	NA
5b - Staff effectiveness	NA
5c - Barriers	NA
5d - Roles	I1, I2, I3

Revised July 31, 1992

Runaway and Homeless Youth Program: Administrators

This questionnaire form is to be completed by the Director of the Runaway and Homeless Basic Center. Please feel free to seek assistance in completing this questionnaire from other program staff, particularly with respect to those questions that require statistical information.

Guidelines for completion of the form

Please restrict your responses to impressions that are directly based on your experience as a runaway and homeless basic center director. Many of the questions require you to state opinions that are based on your own professional experience. In general you should answer these questions only if:

1) You have had direct contact with children and/or their families.

2) You have discussed cases or client situations with staff members.

3) You have access to records and/or databases containing pertinent information.

Otherwise, you should respond “don’t know”.

SECTION A: DEFINITIONS

As indicated in the cover letter, in this study we are interested in assessing the impact of family or youth alcohol and other drug (AOD) abuse problems on your program. Although the term "AOD abuse problem" can he conceptualized in a variety of ways, we have defined this term in a way that we feel is meaningful for service delivery efforts. We would like you to keep the following definitions in mind while you are completing this questionnaire.

For the purposes of this study, AOD refers to alcohol and other drugs with the exception of nicotine, caffeine, and prescription drugs under a doctor's supervision.

AOD abuse problem refers to a level of drug use resulting in the user being unable to meet personal responsibilities, being unable to appropriately fulfill role requirements, and/or engaging in behaviors that are self-destructive or harmful to others.

A1 Does your pro&ram define the term AOD abuse problem in a similar or different manner?

similar0 Different ☐ Do not have a program definition ☐

A2 If you answered different, please describe how your program defmes a AOD abuse problem.

_____

_____

_____

_____

SECTION B: RESPONDENT/PROGRAM INFORMATION

B1 Name: _____

B2 Contact telephone # (-____) _____ _____

B3 Job title: _____

B4 What are your primary responsibilities?_____

_____

_____

B5 How long have you been employed in this position? _____

B6 What was your previous position and how long were you employed in that position?

Position: _____

Length of time: _____

B7 What type of residential facility does your program use?

- ☐ Host homes
- ☐ Shelter
- ☐ Both

B8 How many beds do you have? _____

B9 How many beds are available for runaway and homeless youth? _____

B10 What is the annual budget of the Basic Center program? $_____

SECTION C: SERVICE POPULATION

This section solicits information about the clients served in your Basic Center program during your last fiscal year - the fiscal year for which you have completed data. If your program maintains data pertaining to client characteristics, please use these data to answer the questions below. If your data categories are different from those used in the questionnaire, please provide an attachment showing the data using your own data categories.

If your program does not maintain these data, please provide your best estimates based on your own experiences. Also, please indicate by putting an X in the appropriate box if your answer is **from available data** or is an **estimate. If you** do not know an answer, and you feel you cannot make an estimate, put an X in the box labelled "don't know."

Please identify the fiscal year. _____

C1 How many youth received residential **AND** non residential services from your program during your last fiscal year?

Number of youth _____

☐ Reporting from data ☐ Estimating ☐ Don't know

C2 How many youth received **residential** services from your program during your last fiscal year?

Number of youth _____

☐ Reporting from data ☐ Estimating ☐ Don't know

c3 How has the demand for residential services (the number of youth requesting or referred for services) changed over the past 5 years?

- ☐ Increased substantially
- ☐ Increased moderately
- ☐ No change
- ☐ Decreased moderately
- ☐ Decreased substantially
- ☐ Don't know

Reporting from data ☐
Estimating response ☐

c4 If it has increased, to what would you attribute the increase?

- ☐ In small part to an increase in the AOD abuse problem in the community
- ☐ In some part to an increase in the AOD abuse problem in the community
- ☐ In large part to an increase in the AOD abuse problem in the community
- ☐ Largely to factors other than the AOD abuse problem in the community

  Identify other factors _____

  _____

- ☐ Don't know

C5 How has the demand for youth requiring non residential services (the number of youth requesting or referred for services) changed over the past 5 years?

- ☐ Increased substantially
- ☐ Increased moderately
- ☐ No change
- ☐ Decreased moderately
- ☐ Decreased substantially
- ☐ Don't know

Reporting from data ☐
Estimating response ☐

C6 If it has increased, to what would you attribute the increase?

- ☐ In small part to an increase in the AOD abuse problem in the community
- ☐ In some part to an increase in the AOD abuse problem in the community
- ☐ In large part to an increase in the AOD abuse problem in the community
- ☐ Largely to factors other than the AOD abuse problem in the community

  Identify other factors _____

  _____

- ☐ Don't know

c7 How many families received services from your program during your last fiscal year?
Number of families _____

☐ Reporting from data ☐ Estimating ☐ Don't know

C8 How has the demand for services to families (the number of families requesting services) changed over the past 5 years?

- ☐ Increased substantially
- ☐ Increased moderately
- ☐ No change
- ☐ Decreased moderately
- ☐ Decreased substantially
- ☐ Don't know

Reporting from data ☐
Estimating response ☐

C9 If it has increased, to what would you attribute the increase?

- ☐ In small part to an increase in the AOD abuse problem in the community
- ☐ In some part to an increase in the AOD abuse problem in the community
- ☐ In large part to an increase in the AOD abuse problem in the community
- ☐ Largely to factors other than the AOD abuse problem in the community

  Identify other factors _____

  _____

- ☐ Don't know

For youth who received residential services during your last fiscal year, please provide percentages for the following client characteristics.

C10 Household incomes (if youth resided at home prior to running away)

____% Less than $5,000
____% $5,000 - $12,499
____% $12,500 - $24,499
____% $25,000 - $50,000
____% More than $50,000
____% Families receiving AFDC
____% Not applicable

Reporting from data ☐
Estimating response ☐
Don't know ☐

C11 Ages of youth

____% 9 or younger
____% 10 to 12
____% 13 to 15
____% 16 to 17
____% 18 and older

Reporting from data ☐
Estimating response ☐
Don't know ☐

C12 Racial/ethnic backgrounds

____% Caucasian (non-Hispanic)
____% African-American (non-Hispanic)
____% Hispanic/Latino
____% Native American/Alaska Native
____% Asian or Pacific Islander
____% Other (specify) _____

Reporting from dam ☐
Estimating response ☐
Don't know ☐

C13 Who youth resided with prior to contact with program

____% Mother only
____% Mother and stepfather
____% Biological mother and father
____% Father only
____% Father and stepmother
____% Other relative
____% Unrelated adult
____% Foster parent/group home
____% Friend's house
____% Street
____% Other (specify) _____

Reporting from data ☐
Estimating response ☐
Don't know ☐

C14 Primary reason why youth left previous residence

_____% Physical abuse in the home
_____% Sexual abuse in the home
_____% Pushed out of home
_____% Family AOD abuse problem
_____% Conflict with parent
_____% Problems in school
_____% Family homelessness
_____% Foster family no longer wanted youth
_____% Group home would no longer keep youth
_____% Not applicable
_____% Other (specify) _____

Reporting from data ☐
Estimating response ☐
Don't know ☐

SECTION D: SERVICES AND STAFFING

In this section, we are asking for information about the services provided by the Basic Center program to runaway and homeless youth and youth in crisis. We want to know what services the program provides directly to the clients as well as those that are provided by referrals to other agencies or service organizations. Note: This list is standrardized for all programs surveyed for this study. We recognize that some services are not likely to be part of your agency's service system. Also, we recognize that this list may not be exhaustive of all services offered by your agency.

D1 What services are provided by the Basic Center program? Please put an X in the appropriate response for each service. More than one box may be used if appropriate. If services are not provided in any manner, put an X in the box under the column heading **Not provided.**

Type of service	Provided by program staff	Contractual, in-kind, direct purchase	Referred	Not provided	Don't know
Food	☐	☐	☐	☐	☐
Shelter for children/youth	☐	☐	☐	☐	☐
Shelter for families	☐	☐	☐	☐	☐
Physical examinations	☐	☐	☐	☐	☐
Medical tests	☐	☐	☐	☐	☐
Nutrition information	☐	☐	☐	☐	☐
Out-of-home placement for children/youth	☐	☐	☐	☐	☐
Independent living services	☐	☐	☐	☐	☐
Parenting classes	☐	☐	☐	☐	☐
Income maintenance services	☐	☐	☐	☐	☐
Legal services	☐	☐	☐	☐	☐
Child care services	☐	☐	☐	☐	☐
Child development services	☐	☐	☐	☐	☐
Support group for children/youth	☐	☐	☐	☐	☐
Support group for parents	☐	☐	☐	☐	☐
Home visits	☐	☐	☐	☐	☐
Individual counseling for children/youth	☐	☐	☐	☐	☐
Individual counseling for parents	☐	☐	☐	☐	☐
Group counseling for children/youth	☐	☐	☐	☐	☐
Group counseling for parents	☐	☐	☐	☐	☐
Family counseling	☐	☐	☐	☐	☐
Couples counseling	☐	☐	☐	☐	☐

Type of service	Provided by program staff	Contractual, in-kind, direct purchase	Referred	Not provided	Don't know
AOD abuse assessment	☐	☐	☐	☐	☐
AOD abuse treatment	☐	☐	☐	☐	☐
AOD abuse prevention services	c l	☐	☐	☐	☐
HIV prevention/counseling	☐	☐	☐	☐	☐
GED classes for youth	El	☐	☐	☐	☐
GED classes for parents	☐	☐	☐	☐	☐
Education for children with special needs	☐	☐	☐	☐	☐
Employment preparedness/training classes for youth	☐	☐	•II	☐	☐
Employment preparedness/training classes for parents	☐	☐	☐	☐	☐
Homemaker services	☐	☐	☐	☐	☐
Respite care	☐	☐	c l	☐	☐
Parent involvement activities	☐	☐	•I	☐	☐
Other (specify) _____	☐	☐	c l	☐	☐

D2 Please describe the nonclerical staff of your Basic Center Program.

Staff title	Job Description	FTE

SECTION E: AOD ABUSE PROBLEMS: Extent

In this section we are interested in finding out about the extent of AOD abuse problems among the **runaway and homeless youth who received residential services** during your last fiscal year. Please answer all questions based on your personal experience. If your program maintains data on AOD abuse problems, use the data to provide your response. If not, estimate as before.

During your last fiscal year:

E1 What percent of youth who received residential services were assessed as having personal AOD abuse problems? ____ %
Reporting from data ☐ Estimating response Cl Don't know ☐

E2 How does this percent differ from approximately 5 years ago?
Increased ☐ Decreased ☐ No change ☐ Don't know ☐

E3 If you answered increased or decreased to the above question, please provide the percent of these youth approximately 5 years ago. _____%
Reporting from data ☐ Estimating response ☐ Don't know ☐

E4 What percent of youth receiving residential services from your program were assessed to come from families with AOD abuse problems? _____ %
Reporting from data ☐ Estimating response ☐ Don't know ☐

E5 How does this percent differ from approximately 5 years ago?
Increased Cl Decreased ☐ No change ☐ Don't know ☐

E6 If you answered increased or decreased to the above question, please provide the percent of these youth approximately 5 years ago. _____%
Reporting from data ☐ Estimating response ☐ Don't know ☐

SECTION F: AOD ABUSE PROBLEM: Impact on Caseloads

This section pertains to the impact of serving youth and families with AOD abuse problems on caseload activities. Please answer all questions based on your personal experience.

F1 Does serving youth who have personal AOD abuse problems require more of your staff's time than serving other youth?

☐ Almost always requires more time
☐ Frequently requires more time
☐ Sometimes requires more time
☐ Rarely requires more time
☐ Don't know

F2 Do youth who have personal AOD abuse problems require more specialized services from your staff than youth who do not have AOD abuse problems?

Cl Almost always require more specialized services
☐ Frequently require more specialized services
☐ Sometimes require more specialized services
☐ Rarely require more specialized services
☐ Don't know

F3 Does serving youth who do not have personal AOD abuse problems but who are from families with AOD abuse problems require more of your staffs time than serving other youth?

☐ Almost always requires more time
☐ Frequently requires more time
☐ Sometimes requires more time
☐ Rarely requires more time
☐ Don't know

F4 Do youth who do not have personal AOD abuse problems but who are from families with AOD abuse uroblems require more specialized services from your staff than other youth?

- ❑ Almost always require more specialized services
- ❑ Frequently require more specialized services
- ❑ Sometimes require more specialized services
- ❑ Rarely require more specialized services
- ❑ Don't know

SECTION G: SERVICE EFFECTIVENESS

This section of the questionnaire refers to the goals of the program with respect to serving youth and families with AOD abuse problems, the effectiveness of the staff in attaining these goals, and the services or procedures that may have been, or need to be, implemented to assist staff in attaining the goals. Please answer all questions based on your personal experience.

G1 Given that the primary goal of shelter services is to reunify families or find alternative placements for youth, how important are other goals specific to youth with AOD abuse problems?

	Very important	Moderately important	Somewhat important	Not important	Not a goal
To get youth to acknowledge AOD abuse problem	❑	❑	❑	❑	❑
To get youth to agree to seek treatment	❑	❑	❑	❑	❑
To enroll youth in a treatment program	•I	El	❑	❑	❑
To enroll youth in counseling for problems related to AOD abuse	❑	❑	❑	❑	❑
To help youth cope with peer pressure to use drugs	❑	❑	❑	❑	❑
To help family members cope with a AOD abusing youth	❑	c l	❑	❑	❑
To help youth cope with a family member who has a AOD abuse problem	❑	❑	❑	❑	❑
Other goals (specify) _____	❑	❑	❑	❑	❑

G2 How successful do you feel program staff are with respect to achieving the goals listed in G1?

	Very successful	Moderately successful	Somewhat successful	Not successful	Not a goal
To get youth to acknowledge AOD abuse problem	❑	❑	❑	c l	❑
To get youth to agree to seek treatment	❑	❑	c l	❑	❑
To enroll youth in a treatment program	❑	❑	❑	❑	•J
To enroll youth in counseling for problems related to AOD abuse	❑	❑	❑	❑	❑
To help youth cope with peer pressure to use drugs	❑	❑	❑	❑	❑
To help family members cope with a AOD abusing youth	❑	❑	❑	❑	❑
To help youth cope with a family member who has a AOD abuse problem	❑	❑	❑	❑	❑
Other goals (specify) _____	c l	❑	❑	❑	❑

G3 For each goal that you *answered that* staff are only **somewhat successful or not successful** of attaining **for the youth, please explain why you feel this way.**

To get youth to acknowledge AOD abuse problem

To get youth to agree to seek treatment

To enroll youth in a treatment program

To enroll youth in a counseling for problems related to AOD abuse

To help youth cope with peer pressure to use drugs

To help family members cope with a youth who has a AOD abuse problem

To help youth cope with a family member who has a AOD abuse problem

Other goals (as specified above)

G4 **Has your** program implemented any new services in the past 5 years as a result of serving youth with AOD abuse problems and/or from families with AOD abuse problems?

Yes ☐ No ☐ Don't know ☐

G5 If yes, please describe the services that were implemented.

_____

_____

_____

_____

_____

SECTION H: AOD ABUSE: Impact on Staffing

In this section, we are soliciting information about the impact of serving children and families with AOD abuse problems on your program's staffing and staff training. Please answer all questions based on your personal experience.

H1 Does **your** program have difficulties recruiting staff as a result of serving youth with AOD abuse problems?

Yes ☐ No ☐ Don't know ☐

If yes, please explain why._____

_____

H2 Does your program have difficulties retaining staff as a result of serving youth from families with AOD abuse problems?

Yes ☐ No ☐ Don't know ☐

If yes, please explain why. _____

_____

H3 In comparison to working with youth and families without AOD abuse problems, are staff working **with youth and families with** AOD **abuse problems** more likely, less likely, or equally likely to experience the following problems?

	More likely	Less likely	No **difference**	**Don't know**
Personal danger	c l	☐	☐	☐
Emotional 'burnout"	☐	☐	☐	☐
Problems with personal unresolved AOD abuse issues	☐	☐	☐	☐
Other (specify)_____	☐	☐	☐	☐

H4 Do you think your program needs to implement special strategies or staffing changes in order to better serve families with AOD abuse problems?

Yes ☐ No ☐ Don't know ☐

H5 Please indicate the importance of the following strategies or staffing practices in improving your program's ability to serve youth and families with AOD abuse problems. (Note: Please provide your opinions regarding these practices even if they have not been implemented in your-program)

	Very important	Somewhat important	Not important	Don't know
Build a stronger referral network among community agencies	☐	cl	☐	☐
Work with local AOD abuse treatment services to give priority to runaway and homeless youth program clients	cl	☐	•J	☐
Hire a consultant to help staff work with families with AOD abuse problems	☐	☐	☐	☐
Develop a team approach to case management in working with families with AOD abuse problems	☐	☐	☐	☐
Reduce staff caseloads	☐	☐	☐	☐
Add new staff specialists to deal with AOD abuse problems	☐	☐	☐	☐
Create staffing teams/special unit to work with families with AOD abuse problems	☐	☐	☐	☐
Provide special AOD abuse-related training for staff	☐	☐	☐	☐
Provide funds for staff to attend AOD abuse-related workshops	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐

H6 Please identify the strategies or staffing practices that have been implemented or that the program plans to implement.

	Has been implemented	Plan to implement	Do not plan to implement
Build a stronger referral network among community agencies	☐	☐	☐
Work with local AOD abuse treatment services to give priority to runaway and homeless youth program clients	☐	☐	☐
Hire a consultant to help staff work with families with AOD abuse problems	☐	☐	☐
Develop a team approach to case management in working with families with AOD abuse problems	☐	☐	☐
Reduce staff caseloads	☐	☐	☐
Add new staff specialists to deal with AOD abuse problems	☐	☐	☐
Create staffmg teams/special unit to work with families with AOD abuse problems	☐	☐	☐
Provide special AOD abuse-related training for staff	☐	☐	☐
Provide funds for staff to attend AOD abuse-related workshops	☐	☐	☐
Other (specify) _____	☐	☐	☐

H7 Do you think your program needs to provide special training to staff to better serve youth and families with AOD abuse problems?

Yes ☐ No ☐ Don't know Cl

H8 If yes, please identify the training needs.

Type of training	Training needed . and in place	Training needed and planned	Training needed but not planned	Training not needed
Diffusing potentially violent family situations	❑	❑	❑	❑
Basic drug and alcohol information (appearance, physiological effects, behaviors of those under the influence)	❑	❑	❑	❑
Basic health information	❑	❑	❑	❑
Street drug information/street culture (current street slang)	❑	❑	❑	❑
Family/couples counseling	❑	❑	❑	❑
Dealing with hostile family members	❑	❑	❑	❑
Conducting interventions with individuals with AOD abuse problems	❑	❑	❑	❑
Codependency information (family dynamics, roles, behaviors)	❑	❑	❑	❑
Staff safety/self protection	❑	❑	❑	❑
AOD prevention	❑	❑	❑	❑
Conducting AOD assessments	❑	❑	❑	❑
HIV treatment/prevention	❑	❑	❑	❑
Supporting parents AOD treatment efforts	❑	❑	❑	❑
Other (specify) _____	❑	❑	❑	❑

SECTION I: GENERAL PERSPECTIVES

In this last section of the questionnaire, we are interested in determining how you view the problem of family AOD abuse in the context of other family problems that program staff must contend with in working with families. Please answer all questions based on your personal experience.

11 Do you feel that your program has a role in combatting AOD abuse? Yes ❑ No ❑ Don't know Cl

I2 If you answered yes to the above question, please describe how you see your program's role.

_____

_____

_____

13 Overall, given the many problems that clients served by your program are facing, how important do you feel it is for your program to confront the problem of family AOD abuse?

Number one priority of program ❑
Extremely important ❑
Moderately important ❑
slightly important ❑
Not important ❑
Don't know c l

Supervisor/Direct Service Provider - Runaway and Homeless Youth Program

RESEARCH QUESTION	ITEM(S)
1a - Concept of AOD abuse	A1, A2
1b - State and local statutes	NA
1c - Service costs	C2, C3
1d - Change in services/demand for services	C2, C3, C4, C5, C6, C7, E5
2a - Number of clients with AOD abuse problems/change	C4, C5, C6, C7
2b - Characteristics	D1, D2, D3, D4, F5
3a - Foster Care	NA
3b - Adoption	NA
4a - Goals/effectiveness	E1, E2, E3
4b - Staffing	C8, E2, E3, E4, E5
4c - Juvenile court and hospital social workers perspectives	NA
5a - Client needs	F1, F2
5b - Staff effectiveness	C8, E1, E2, E3, E4, F2
5c - Barriers	F3, F4, F6, F7
5d - Roles	G1, G2, G3

Revised July 31, 1992

Runaway and Homeless Youth Basic Center Program: Supervisor/Direct Service Provider

This questionnaire form is to be completed by a direct service provider and a supervisor in the residential services component of the Runaway and Homeless Youth Basic Center Program. If the Project Director is the only supervisor for direct service providers, please have two direct service providers complete the questionnaire instead of a supervisor and a direct service provider.

Guidelines for completion of the form

Please *restrict your* responses to impressions that are directly based on your experience as a runaway and homeless youth basic center service provider or supervisor. Many of the questions require you to state opinions that are based on your own professional experience. In general you should answer these questions **only if**:

1) You have had direct contact with children and/or their families.

2) You have discussed cases or client situations with staff members.

3) You have access to records and/or databases containing pertinent information.

Othewise, you should respond “don’t know”.

SECTION A: DEFINITIONS

As indicated in the cover letter, in this study we are interested in assessing the impact of family or youth alcohol and other drug (AOD) abuse problems on your program or agency. Although the term "AOD abuse problem" can be conceptualized in a variety of ways, we have defined this term in a way that we feel is meaningful for service delivery efforts. We would like you to keep the following definitions in mind while you are completing this questionnaire.

For the purposes of this study, AOD refers to alcohol and other drugs with the exception of nicotine, caffeine, and prescription drugs under a doctor's supervision.

AOD **abuse problem** refers to a level of AOD use resulting in the user being unable to meet personal responsibilities, being unable to appropriately fulfill role requirements, and/or engaging in behaviors that are self-destructive or harmful to others.

A1 Does your agency/program define the term AOD abuse **problem in** a similar or different manner?

Similar ☐ Different ☐ Do not have a program definition ☐

A2 If you answered different, please describe how your program defines a AOD abuse problem.

_____

_____

_____

_____

SECTION B: RESPONDENT INFORMATION

B1 Name: _____

B2 Contact telephone # (-____)_____ _____

B3 Job title: _____

B4 What are your primary responsibilities?_____

_____

_____

B5 How long have you been employed in this position? _____

B6 What was your previous position and how long were you employed in that position?

Position: _____

Length of time: _____

SECTION C: AOD ABUSE PROBLEM: Impact on Caseload

In this section we are concerned with how youth and families with AOD abuse problems impact on your caseload activities. Please answer all questions based on your personal experience. For each question, indicate your answer by putting an X in the appropriate box.

C1 What information do you use to determine whether a youth has a AOD abuse problem?

	Very rarely	Rarely	Sometimes	Frequently	**Very** frequently
Intake inter-view with youth	☐	☐	c l	☐	☐
Assessment instrument	☐	☐	☐	☐	☐
Interview with parent or other family members	☐	☐	☐	☐	☐
Informal conversations with youth	☐	☐	☐	☐	☐
Information from other clients	☐	☐	☐	☐	☐
Information from referral source	☐	☐	☐	☐	☐
Reports from other social service agencies	☐	☐	☐	☐	☐
Reports from hospitals	☐	☐	☐	☐	☐
Reports from law enforcement	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐

C2 Does serving youth who have personal AOD abuse problems require more of your (or your staff's) time than serving other youth?

☐ Almost always requires more time
☐ Frequently requires more time
☐ Sometimes requires more time
☐ Rarely requires more time
Cl Don't know

C2a Does the type of drug being used make a difference?
Yes Cl No ☐ Don't know ☐

If yes, please explain.

_____

_____

_____

_____

c3 Does serving youth who do not have personal AOD abuse problems but who are from families with AOD abuse problems require more of your (or your staffs) time than serving other youth?

- ☐ Almost always requires more time
- ☐ Frequently requires more time
- Cl Sometimes requires more time
- ☐ Rarely requires more time
- ☐ Don't know

C3a Does the type of drug being used make a difference?

Yes ☐ No ☐ Don't know ☐

If yes, please explain.

_____

_____

_____

_____

c4 During the past year, approximately what percent of your youth caseload had personal AOD abuse problems? _____%

Reporting from data ☐ Estimating response ☐ Don't know ☐

C5 How has the percentage in C4 changed over the past 5 years?

- ☐ Increased substantially
- Cl Increased moderately
- ☐ No change
- ☐ Decreased moderately
- ☐ Decreased substantially
- ☐ Don't know

Reporting from data ☐
Estimating response ☐

C6 During the past year, approximately what percent of your youth caseload did not have personal AOD abuse problems but came from families with AOD abuse problems? _____%

c7 How has the percentage in C6 changed over the past 5 years?

- ☐ Increased substantially
- ☐ Increased moderately
- ☐ No change
- ☐ Decreased moderately
- ☐ Decreased substantially
- ☐ Don't know

Reporting from data ☐
Estimating response ☐

C8 What types of training do you feel would help you better serve youth with AOD abuse problems or youth from families with AOD abuse problems?

Type of training	Training needed but not available	Training needed and available	Training not needed
Diffusing potentially violent family situations	☐	☐	☐
Basic drug and alcohol information (appearance, physiological effects, behaviors of those under the influence)	☐	☐	☐
Basic health information	☐	☐	☐
Street drug information (current street slang)	☐	☐	☐
Family/couples counseling	☐	☐	☐
Codependency information (family dynamics, roles, behaviors)	☐	☐	El
Dealing with hostile family members	☐	☐	☐
Conducting interventions with individuals with AOD abuse problems	☐	☐	☐
Staff safety/self protection	☐	☐	☐
AOD prevention	☐	☐	c l
Conducting AOD assessments	☐	☐	☐
HIV treatment/prevention	☐	☐	☐
Supporting parents AOD treatment efforts	☐	☐	☐
Other (specify) _____	☐	☐	☐

SECTION D: AOD ABUSE PROBLEM: Characteristics of clients

In this section we are interested in your perceptions of the characteristics of youth with AOD abuse problems and whether these youth differ from the other runaway and homeless youth (RHY) you serve in your residential program. Please answer all questions based on your personal experience in working with these youth.

D1 In comparison to runaway and homeless youth without personal AOD abuse problems, are RHY youth with personal AOD abuse problems more likely, less likely, or equally likely to exhibit the following characteristics? Put an X in the appropriate box.

Youth charactersitics	More likely	Less likely	No difference	Don't know
Come from families with AFDC as primary support	☐	☐	☐	☐
Come from families with incomes below the poverty level	☐	☐	☐	c l
Come from families headed by a single parent/mother	☐	☐	☐	☐
Come from families headed by a single parent/father	☐	☐	☐	☐
Come from families with a stepparent	☐	☐	☐	☐
Come from families headed by an adolescent parent(s)	☐	☐	☐	☐

Youth characteristics	More likely	Less likely	No difference	Don't know
Come from families with non-family members living in the household	☐	☐	☐	☐
Be from an racial/ethnic minority group	☐	☐	☐	☐
Have a mother figure who has a AOD abuse problem	☐	☐	☐	☐
Experience threats or physical violence from family member	☐	☐	☐	☐
Experience chronic family conflict	☐	☐	☐	☐
Have family members who have been arrested	☐	☐	☐	☐
Have been arrested	☐	☐	☐	☐
Have moved frequently	☐	☐	☐	☐
Have lived on the streets at some time	☐	☐	☐	☐
Have experienced physical abuse from a family member	☐	☐	☐	☐
Have experienced sexual abuse from a family member	☐	☐	☐	☐
Have experienced emotional abuse from a family member	☐	☐	☐	☐
Have been abandoned/pushed out	☐	☐	☐	☐
Have experienced spouse abuse	☐	☐	☐	☐
Have experienced neglect	☐	☐	☐	☐
Have been expelled or suspended from school	☐	☐	☐	☐
Have been failed to pass a grade in school	☐	☐	☐	☐
Have received special school services for a learning or developmental disability	☐	☐	☐	☐
Have emotional/psychological problems	☐	☐	☐	☐
Be shy and isolated from peers	☐	☐	☐	☐
Have attempted suicide	☐	☐	☐	☐
Come from a family where a member was a victim of a violent crime	☐	☐	☐	☐
Come from a family where a member has attempted/ committed suicide	☐	☐	☐	☐
Are involved with gangs or deviant peer groups	☐	☐	☐	☐
Have been pregnant or become a parent	☐	☐	☐	☐
Are reunited with families after running away	☐	☐	☐	☐
Have runaway more than once	☐	☐	☐	☐
Require alternative long-term placements after leaving the shelter	☐	☐	☐	☐
Other (specify)_____	☐	☐	☐	

D2 Among the youth you serve with personal AOD abuse problems, how many are abusing the following drugs?

	Most	Some	Few	None	Don't know
Alcohol	☐	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐	☐
Crack	☐	☐	☐	☐	☐
Opiates (heroin, methadone)	☐	☐	☐	☐	☐
Amphetamines (speed, ice)	☐	☐	☐	☐	☐
Sedatives (valium, downers)	☐	☐	☐	☐	☐
Barbiturates	☐	☐	☐	☐	☐
Psychedelics (LSD, mushrooms, peyote)	☐	☐	☐	☐	☐
Inhalants (glue, gasoline)	☐	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐

D3 Among the families you serve with AOD abuse problems, how many are abusing the following drugs?

	Most	Some	Few	None	Don't know
Alcohol	☐	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐	☐
Crack	☐	☐	☐	☐	☐
Opiates (heroin, methadone)	☐	☐	☐	☐	☐
Amphetamines (speed, ice)	☐	☐	☐	☐	☐
Sedatives (valium, downers)	☐	☐	☐	☐	☐
Barbiturates	☐	☐	☐	☐	☐
Psychedelics (LSD, mushrooms, peyote)	☐	☐	☐	☐	☐
Inhalants (glue, gasoline)	☐	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐

D4 Which family member tends to exhibit the AOD abuse problem?

	Very rarely	Rarely	Sometimes	Frequently	Very frequently
Mother/stepmother	☐	☐	☐	☐	☐
Father/stepfather	☐	☐	☐	☐	☐
Sibling	☐	☐	☐	☐	☐
Both parents	☐	☐	☐	☐	☐
Non-related resident adult	☐	☐	☐	☐	☐
Related resident adult	☐	☐	☐	☐	☐
Other (specify)_____	☐	☐	☐	☐	☐

SECTION E: SERVICE EFFECTIVENESS

This section focuses on your goals with respect to serving youth with AOD abuse problems or youth from families with AOD abuse problems. We are interested in how effective you feel you or your staff are in attaining these goals. It is important to note that questions regarding effectiveness are not intended to obtain information critical of the abilities of direct service providers but rather to identify areas where programs may need to make changes to help direct service providers meet program goals. Please answer all questions based on your personal experience.

El Given that the primary goal of runaway and homeless youth basic center programs is to reunify families or find alternative placements for children, how important are other goals specific to serving youth with AOD abuse problems?

	Very important	Moderately important	Somewhat important	Not important	Not a goal
To get youth to acknowledge AOD abuse problem	☐	El	☐	☐	☐
To get youth to agree to seek treatment	☐	☐	☐	☐	☐
To enroll youth in a treatment program	☐	☐	☐	☐	☐
To enroll youth in counseling for problems related to AOD abuse	☐	☐	☐	☐	☐
To help youth cope with peer pressure to use drugs	☐	☐	☐	☐	☐
To help family members cope with a youth who has a AOD abuse problem	☐	☐	☐	☐	☐
To help youth cope with a family member who has a AOD abuse problem	☐	☐	☐	☐	☐
Other goals (specify) _____	☐	☐	☐	☐	☐

E2 How successful do you feel you (or your staff) are in achieving the goals listed in El?

	Very successful	Moderately successful	Somewhat successful	Not successful	Not a goal
To get youth to acknowledge AOD abuse problem	☐	cl	☐	☐	☐
To get youth to agree to seek treatment	☐	☐	☐	☐	☐
To enroll youth in a treatment program	☐	☐	☐	☐	☐
To enroll youth in counseling for problems related to AOD abuse	El	☐	☐	cl	☐
To help youth cope with peer pressure to use drugs	☐	☐	☐	☐	☐
To help family members cope with a youth who has a AOD abuse problem	☐	☐	☐	☐	☐
To help youth cope with a family member who has a AOD abuse problem	☐	cl	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐

E3 For each goal that you feel you (or your staff) are only somewhat **successful or not successful in attaining, please** explain why you feel this way.

To get youth to acknowledge AOD abuse problem

To get youth to agree to seek treatment

To enroll youth in a treatment program

To enroll youth in counseling for problems related to AOD abuse

To help youth cope with peer pressure to use drugs

To help family members cope with a youth who has a AOD abuse problem

To help youth cope with a family member who has a AOD abuse problem

Other goals (as specified above)

E4 Please identify the strategies or staffing practices that you think are important to improving your ability to serve youth with AOD abuse problems or youth from families with AOD abuse problems.

	Very important	Somewhat important	Not important	Don't know
Build a stronger referral network among community agencies	☐	☐	☐	☐
Work with local AOD abuse treatment services to give priority to runaway and homeless youth program clients	☐	☐	☐	☐
Hire a consultant to help staff work with families with AOD abuse problems	☐	☐	☐	☐
Develop a team approach to case management in working with families with AOD abuse problems	☐	☐	•J	cl
Reduce staff caseloads	☐	☐	☐	☐
Add new staff positions to deal with AOD abuse problems	cl	cl	☐	☐
Create staffing teams/special unit to work with families with AOD abuse problems	☐	☐	☐	☐
Provide special AOD abuse-related naming for staff	☐	☐	☐	☐
Provide funds for staff to attend AOD abuse-related workshops	☐	☐	☐	☐
Other (specify) _____	☐	cl	☐	cl

E5 Please identify the strategies or staffing changes that have been implemented over the past 5 years.

	Has been implemented	Has not been implemented	Was already in place
Build a stronger referral network among community agencies	cl	☐	☐
Work with local AOD abuse treatment services to give priority to runaway and homeless youth program clients	☐	☐	☐
Hire a consultant to help staff work with families with AOD abuse problems	☐	☐	☐
Develop a team approach to case management in working with families with AOD abuse problems	☐	☐	☐
Reduce staff caseloads	☐	☐	☐
Add new staff positions to deal with AOD abuse problems	☐	☐	☐
Create staffing teams/special unit to work with families with AOD abuse problems	☐	☐	☐
Provide special AOD abuse-related training for staff	☐	☐	☐
Provide funds for staff to attend AOD abuse-related workshops	☐	☐	☐
Other (specify) _____	☐	☐	☐

SECTION F: SERVICE NEEDS

In this section, we are interested in determining whether youth with AOD abuse problems or youth from families with AOD abuse problems have service needs that are different or similar to the service needs of youth without AOD abuse problems. Please answer all questions based on your personal experience.

F1 In comparison to youth without AOD abuse problems, are youth with AOD abuse problems more likely, less likely, or equally likely to require the following services?

Type of service	More likely	Less likely	No difference	Don't know
Food	❑	❑	❑	❑
Shelter for children/youth	❑	❑	❑	❑
Shelter for families	❑	❑	❑	❑
Physical examinations	❑	❑	❑	❑
Medical tests	❑	❑	❑	❑
Nutrition information	❑	❑	❑	❑
Out-of-home placement for children/youth	❑	❑	❑	❑
Independent living services	❑	❑	❑	❑
Parenting classes	❑	❑	❑	❑
Income maintenance services	❑	❑	❑	❑
Legal services	❑	❑	❑	❑
Child care services	❑	❑	❑	❑
Child development services	❑	❑	❑	❑
Support group for children/youth	❑	❑	❑	❑
Support group for parents	❑	❑	❑	❑
Home visits	❑	❑	❑	❑
Individual counseling for children/youth	❑	❑	❑	❑
Individual counseling for parents	❑	❑	❑	❑
Group counseling for children/youth	❑	❑	❑	❑
Group counseling for parents	❑	❑	❑	❑
Family counseling	❑	❑	❑	❑
Couples counseling	❑	❑	❑	❑
AOD abuse assessment	❑	❑	❑	❑
AOD abuse treatment	❑	❑	❑	❑
AOD abuse prevention services	❑	❑	❑	❑
HIV prevention/counseling	❑	❑	❑	❑
GED classes for youth	❑	❑	❑	❑

Type of service	More likely	Less likely	No difference	Don't know
GED classes for parents	❑	❑	❑	❑
Education for children with special needs	❑	❑	❑	❑
Employment preparedness/training classes for youth	❑	❑	❑	❑
Employment preparedness/training classes for parents	❑	❑	❑	❑
Homemaker services	❑	❑	❑	❑
Respite care	❑	❑	❑	❑
Parent involvement activities	❑	❑	❑	❑
Other (specify) _____	❑	❑	❑	

F2 Do you feel you (or your staff) are able to meet the service needs of youth with AOD abuse problems?

- ❑ Almost always
- ❑ Most of the time
- ❑ Some of the time
- ❑ Rarely
- ❑ Very rarely
- ❑ Don't know

F2a Does the type of drug being abused make a difference in whether you or your staff can meet service needs?

Yes ❑ No ❑ Don't know ❑

If yes, please explain.

_____

_____

_____

_____

F3 What kinds of barriers do you confront in serving children and families with AOD abuse problems?

	Severe problem	Moderate problem	Not a problem
Insufficient number of no-cost (accept medicaid) AOD abuse inpatient treatment programs for adults	☐	☐	☐
Insufficient number of no-cost (accept medicaid) AOD abuse inpatient treatment programs for adolescents	☐	☐	☐
Insufficient number of no-cost AOD abuse outpatient treatment programs	☐	☐	☐
Insufficient number of inpatient treatment programs that accept pregnant women	☐	☐	☐
Insufficient number of detoxification services	☐	☐	☐
Insufficient family support services in the community	☐	☐	☐
Insufficient respite care facilities	☐	☐	☐
Insufficient transportation for clients to access services	☐	☐	☐
Insufficient low cost housing for families	☐	☐	☐
Lack of formalized interagency cooperation	☐	☐	☐
Lack of information about relevant resources in the community	☐	☐	☐
Parents fear of losing their children	☐	☐	☐
Negative attitudes of program staff toward individuals with AOD abuse problems	☐	☐	☐
Resistance of parents to accept services	☐	☐	☐
Other (specify) _____	☐	☐	☐

F4 For each barrier that is a problem, please indicate how it might be addressed_

F5 Compared with 5 years ago, how do you feel the abuse of specific drugs among your client population has changed?

	Increased	Decreased	No change	Don't know
Alcohol	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐
Crack	☐	☐	☐	☐
Opiates (heroin, methadone)	☐	☐	c l	☐
Amphetamines (speed, ice)	☐	a	☐	c l
Sedatives (valium, downers)	☐	☐	☐	☐
Barbiturates	☐	c l	☐	☐
Psychedelics (LSD, mushrooms, peyote)	☐	☐	☐	☐
Inhalants (glue, gasoline)	c l	☐	☐	☐
Marijuana	☐	El	☐	☐
Other (specify) _____	☐	☐	☐	☐

F6 Does the type of drug being abused affect the difficulty you (or your staff) experience in working with families?
Yes ☐ No ☐ Don't know ☐

F7 If yes, please identify which type of AOD abuse is mast difficult to work with and why.

_____

_____

SECTION G: GENERAL PERSPECTIVES

In this last section, we are interested in determining how you view the problem of family AOD abuse in the context of other family problems that runaway and homeless youth service staff must contend with.

G1 Do you feel that your agency has a role in combatting AOD abuse?
Yes ☐ No ☐ Don't know ☐

G2 If you answered yes to the above question, please describe how you see your agency's role. If you answered no, Please explain why you feel your agency does not have a role.

_____

_____

_____

G3 Overall, given the marry problems that clients served by your agency are facing, how important do you feel it is for your agency to confront the problem of youth or family AOD abuse?

Number one priority of agency	☐
Extremely important	c l
Moderately important	☐
Slightly important	☐
Not important	☐
Don't know	☐

State Child Welfare Agency Director

RESEARCH QUESTION	ITEM(S)
1a - Concept of AOD abuse	A1, A2
1b - State and local statutes	C1, C2, C3
1c - Service costs	NA
1d - Change in services/demand for services	NA
2a - Number of clients with AOD abuse problems/change	E3, E4, E5, E6, F2, F3, F4, F5, G3, G4, G5, G6, G7, G8, H2, H3
2b - Characteristics	NA
3a - Foster Care	NA
3b - Adoption	H4, H5, H6
4a - Goals/effectiveness	NA
4b - Staffing	NA
4c - Juvenile court and hospital social workers perspectives	NA
5a - Client needs	NA
5b - Staff effectiveness	NA
5c - Barriers	NA
5d - Roles	NA
AOD abuse program or public policy initiatives	I1, I2, I3

Revised July 31, 1992

State Child Welfare Agency Directors

This questionnaire form is to be completed by the individual at the State social services agency who is responsible for the administration of child protection, foster care, and adoption services. We recognize that agencies overseeing these services have different names in different States. For purposes of this study we are using the general term *Child Welfare Agency*.

Guidelines for completion of the form

Please restrict your responses to impressions that are directly based on your experience as a State child welfare agency director. Many of the questions require you to state opinions that are based on your own professional experience. In general you should answer these questions **only if:**

1) You have had direct contact with children and/or their families.

2) *You* have discussed cases or client situations with staff members.

3) *You* have access to records and/or databases containing pertinent information.

Otherwise, you should respond "don't know".

Please feel free to have other members of your staff complete portions of this questionnaire, particularly with respect to items requesting specific statistical information.

SECTION A: DEFINITIONS

As indicated in the cover letter, in this study we are interested in assessing the impact of family or youth alcohol and other drug (AOD) abuse problems on your program or agency. Although the term "AOD abuse problem" can be conceptualized in a variety of ways, we have defined this term in a way that we feel is meaningful for service delivery efforts. We would like you to keep the following definitions in mind while you are completing this questionnaire.

For the purposes of this study, AOD refers to alcohol and other drugs with the exception of nicotine, caffeine, and prescription drugs under a doctor's supervision.

AOD abuse problem refers to a level of AOD use resulting in the user being unable to meet personal responsibilities, being unable to appropriately fulfill role requirements, and/or engaging in behaviors that are self-destructive or harmful to others.

A1 Does your agency define the term AOD abuse problem in a similar or different manner?
similar ☐ Different ☐ Do not have an agency definition ☐

A2 If you answered different, please describe how your agency defines a AOD abuse problem.

_____

_____

_____

SECTION B: RESPONDENT INFORMATION

In this section of the questionnaire, we are interested in finding out about your experience and about your agency's relationship to local child welfare agencies.

B1 Name: _____

B2 Contact telephone # (-____)_____ _____

B3 Job title: _____

B4 What are your primary responsibilities?_____

_____

_____

B5 How long have you been employed in this position? _____

B6 What was your previous position and how long were you employed in that position?

Position: _____

Length of time: _____

SECTION C: PROGRAM INFORMATION

C1 Which child welfare policies and practices are established by the State and which **are established by the county?** (Please put an X in the appropriate box.)

	State	county
Child abuse and neglect reporting requirements	☐	cl
Child abuse and neglect investigations procedures	☐	cl
Designation of cases eligible for child welfare services	☐	☐
Salaries of employees in child welfare agencies	☐	☐
Eligibility criteria for employment in child welfare agencies	☐	☐
Training of employees in child welfare agencies	cl	☐
Cost of substitute or foster care placements	☐	cl
Cost of services	☐	cl
Policies pertaining to cross-racial adoptions	cl	☐
Policies pertaining to cross-racial foster care placements	☐	El
Length of tune for investigations	cl	☐
Length of time families can receive services	cl	☐
Policies pertaining to foster care payments to relatives	☐	cl

Note: For those established by the State, please enclose copies of the written policies with your completed questionnaire.

c2 Over the past 5 years, have any of the following State policies been revised in response to the problem of family AOD abuse?

	Revised because of AOD abuse abuse problem	Revised but not because of AOD abuse problem	Not Revised
Policies regarding termination of parental rights	☐	☐	☐
Policies regarding child abuse and neglect reporting requirements	☐	☐	☐
Policies regarding investigations of child abuse and neglect reports	☐	cl	cl
Policies regarding investigations activities	☐	☐	cl
Policies regarding reasons for removal of children from their homes	☐	cl	☐
Other (specify) _____	☐	cl	☐

SECTION D: DATA AVAILABILITY

During the last fiscal year for which you have completed data:

D1 Did your State MIS system maintain information about child maltreatment investigations?
Yes ☐ No ☐ Don't know ☐

D2 Did your State MIS system maintain descriptive information about ongoing treatment cases involving child welfare services to families with children in the at home (i.e., are not placed in substitute care)?
Yes Cl No ❑ Don't know ☐

Does this information include family AOD abuse problems?
Yes ☐ No ❑ Don't know ☐

D3 Did your State MIS system maintain descriptive information about children placed in foster care?
Yes El No ☐ Don't know ☐

Does this information include family AOD abuse problems?
Yes Cl No ☐ Don't know ☐

D4 Did your State MIS system maintain descriptive information about children available for adoption through your services?
Yes ☐ No ☐ Don't know ☐

Does this information include family AOD abuse problems?
Yes ☐ No ☐ Don't know •1

D5 Does foster care information include children placed with relatives?
Yes Cl No ☐ Don't know Cl

If yes, do relatives receive payments?
Yes ☐ No ☐ Don't know ☐

SECTION E: CPS INVESTIGATIONS

In this section, we are interested in finding out about the clients served by the State child welfare agency during your past fiscal year (the last 12 month period for which you have completed data). We expect that most of the questions can be answered using data from your agency's annual report or management information system (MIS). If your MIS does not maintain data relevant to a particular question, please indicate that in the box adjacent to each question. Also, if your MIS uses different categories than those used in the questionnaire, please provide an attachment using your categories.

According to your State's most recent NCANDS data report, your State had _____ substantiated child abuse or neglect cases in _____ (year).

El What percent of the substantiated cases involved families with AOD abuse problems?
Percent of substantiated reports _____ Data not available ☐

E2 How does the percentage in E3 differ from 5 years ago?

☐ Increased substantially
☐ Increased moderately
☐ No change
☐ Decreased moderately
☐ Decreased substantially
☐ Don't know

Reporting from data ☐
Estimating response ❑

E3 What percent of the substantiated cases involved infants exposed or addicted to AOD in utero?
Percent of substantiated cases _____ Data not available ☐

E4 How does the percentage in E5 differ from 5 years ago?

- ❑ Increased substantially
- Cl Increased moderately
- ❑ No change
- Cl Decreased moderately
- ☐ Decreased substantially
- Cl Don't know

Reporting from data ☐
Estimating response ❑

SECTION F: ONGOING CPS TREATMENT CASES

During your last fiscal year:

F1 How many ongoing treatment/in-home services cases were opened?
Number of cases _____ Data not available ☐

F2 What percent of these cases involved families with AOD abuse problems?
Percent of cases _____ Data not available ☐

F3 How does the percentage in F2 differ from 5 years ago?

- ☐ Increased substantially
- ☐ Increased moderately
- ❑ No change
- ❑ Decreased moderately
- ☐ Decreased substantially
- Cl Don't know

Reporting from data ☐
Estimating response Cl

F4 What percent of cases opened for ongoing treatment services involved infants exposed or addicted to AOD in utero?
Percent of cases _____ Data not available ❑

F5 How does the percentage in F4 differ from 5 years ago?

- ☐ Increased substantially
- ☐ Increased moderately
- ☐ No change
- ☐ Decreased moderately
- ☐ Decreased substantially
- ❑ Don't know

Reporting from data ☐
Estimating response ❑

SECTION G: FOSTER CARE PLACEMENTS

During your last fiscal year:

G1 How many children were in foster care on an average day during your last fiscal year?
Number of children _____ Data not available ☐

G2 How many children entered the foster care system during your last fiscal year?
Number of children _____ Data not available ☐

G3 What percentage of the children entering the foster care system came from families with AOD abuse problems?
Percent of children _____ Data not available ❑

G4 How does the percentage in G3 differ from 5 years ago?

- ☐ Increased substantially
- •J Increased moderately
- ☐ No change
- Cl Decreased moderately
- ☐ Decreased substantially
- ☐ Don't know

Reporting from data ☐
Estimating response ☐

G5 What percent of the children entering the substitute care system were infants exposed or addicted to AOD in utero?
Percent of children _____ Data not available ☐

G6 How does the percentage in G5 differ from 5 years ago?

- ☐ Increased substantially
- ☐ Increased moderately
- ☐ No change
- ☐ Decreased moderately
- ☐ Decreased substantially
- ☐ Don't know

Reporting from data ☐
Estimating response ☐

G7 What percent of children entering the substitute care system had personal AOD abuse problems?
Percent of children _____ Data not available ☐

G8 How does the percentage in G7 differ from 5 years ago?

- ☐ Increased substantially
- ☐ Increased moderately
- ☐ No change
- ☐ Decreased moderately
- ☐ Decreased substantially
- ❑ Don't know

Reporting from data ❑
Estimating response ☐

SECTION H: ADOPTION

During your last fiscal year:

H1 How many children became classified as waiting to be adopted? _____

H2 What percent of children who were classified as waiting to be adopted came from families with a AOD abuse problem?
Percent of children _____ Data not available ☐

H3 How does the percentage in H2 differ from 5 years ago?

- ☐ Increased substantially
- ☐ Increased moderately
- ☐ No change
- ☐ Decreased moderately
- ☐ Decreased substantially
- ☐ Don't know

Reporting from data ☐
Estimating response ☐

H4 What percent of children who became available for adoption have special medical and/or educational needs resulting from prenatal AOD abuse?

Percent of children _____ Data not available ☐

H5 How does the percentage in H4 differ from 5 years ago?

☐ Increased substantially
☐ Increased moderately
☐ No change
☐ Decreased moderately
☐ Decreased substantially
☐ Don't know

Reporting from data ☐
Estimating response ☐

H6 How has the Federal Adoption Assistance Program affected the ability of the agency to find adoptive families for the following children?

	Increased placements significantly	Increased placements moderately	No effects on placements	Don't know
Placement with adoptive families of AOD-addicted infants	☐	cl	cl	☐
Placement with adoptive families of AOD-exposed infants	cl	☐	☐	☐
Placement with adoptive families of HIV-positive infants	cl	cl	☐	cl
Placement with adoptive families of children with special physical, emotional, or educational needs resulting from prenatal alcohol or drug exposure	cl	cl	☐	☐
Other (specify) _____	cl	cl	☐	cl

SECTION I: AOD ABUSE PROGRAM OR PUBLIC POLICY INITIATIVES

In this section we are interested in past, present, or planned changes in state-level child welfare programs specifically addressing, or specifically in response to, the impact of alcohol or drug abuse on these child welfare programs.

11 Over the last five years, has your state started any new programs or initiatives to specifically address the impact of family AOD abuse on the CPS, foster care, or adoptions systems in your state(e.g., new training programs, new treatment or intervention programs, etc.)?

Yes ☐ No ☐

If yes, please briefly describe these new programs or initiatives in terms of the approach, the child welfare area addressed (e.g., foster care), and anything you can tell us in terms of how successfull you feel the program or initiative has been.

_____

_____

_____

_____

_____

_____

_____

I2 Does your state have specific plans to start any new programs or initiatives to specifically address the impact of family AOD abuse on the CPS, foster care, or adoptions systems in your state(e.g., new training programs, new treatment or intervention programs, etc.)?

Yes ❑ **- -No** ❑

If yes, please briefly describe these new programs or initiatives in terms of the approach and the child welfare area addressed (e.g., foster care).

I3 What new public policy strategies, approaches, or programs would you recommend to address the impact of AOD abuse on the child welfare system in your state?

County/City Child Welfare Agency Directors

RESEARCH QUESTION	ITEM(S)
1a - Concept of AOD abuse	A1, A2
lb - State and local statutes	Cl, C2, c3
1c - Service costs	H1, H2, H3, H4, H5
1d - Change in services/demand for services	E1 thru E7, E13 thru E16, E23 thru E26, J3, J4, K6
2a - Number of clients with AOD abuse problems/change	G1 thru G20
2b - Characteristics	NA
3a - Foster Care	I1, I2, I5, I6
3b - Adoption	I3, I4, G17, G18, G19, G20
4a - Goals/effectiveness	J1, J2
4b - Staffing	K1, K2, K3, K4, K5, K6, K7, K8
4c - Juvenile court and hospital social workers perspectives	NA
5a - Client needs	NA
5b - Staff effectiveness	NA
5c - Barriers	NA
5d - Roles	L1, L2, L3

Revised July 3 1, 1992

County/City Child Welfare Agency Directors

This questionnaire form is to be completed by the individual at the county social services agency who is responsible for the administration of services that include child protection, foster care, and adoption **services.** We recognize that agencies overseeing these services have different names in different localities. For purposes of this study we are using the term *Child Welfare Agency*.

Guidelines for completion of the form

Please restrict your responses to impressions that are directly based on your experience as a county/city child welfare agency director. Many of the questions require you to state opinions that are based on your own professional experience. In general you should answer these questions **only if:**

1) You have had direct contact with children and/or their families.

2) You have discussed cases or client situations with staff members.

3) You have access to records and/or databases containing pertinent information.

Otherwise, you should respond "don't know".

Please feel free to have other members of your staff complete portions of this questionnaire, particularly with respect to items requesting specific statistical information. However, we would like you to complete questions soliciting opinions and beliefs.

SECTION A: DEFINITIONS

As indicated in the cover letter, in this study we are interested in assessing the impact of family or youth alcohol and other drug (AOD) abuse problems on your program or agency. Although the term "AOD abuse problem" can be conceptualized in a variety of ways, we have defined this term in a way that we feel is meaningful for service delivery efforts. We would like you to keep the following definitions in mind while you are completing this questionnaire.

For the purposes of this study, AOD refers to alcohol and other drugs with the exception of nicotine, caffeine, and prescription drugs taken under a doctor's supervision.

AOD abuse problem refers to a level of AOD use resulting in the user being unable to meet personal responsibilities, being unable to appropriately fulfill role requirements, and/or engaging in behaviors that are self-destructive or harmful to others.

A1 Does your agency/program define the term AOD abuse problem in a similar or different manner?
Similar ☐ Different cl Do not have a agency definition Cl

A2 If you answered different, please describe how your agency defines a AOD abuse problem.

_____

_____

_____

_____

SECTION B: RESPONDENT INFORMATION

B1 Name: _____

B2 Contact Telephone-# ( ) _____ _____

B3 Job title: _____

B4 What are your primary responsibilities? _____

_____

_____

B5 How long have you been employed in this position? _____

B6 What was your previous position and how long were you employed in that position?

Position: _____

Length of time: _____

SECTION C: PROGRAM INFORMATION

In this section we are interested in obtaining general information about your agency's policy and practices. Please answer each question by putting an X in the appropriate box.

C1 Which child welfare policies and practices are established by the State and which are established by the county?

	State	County
Child abuse and neglect reporting requirements	☐	☐
Child abuse and neglect investigations procedures	☐	☐
Designation of cases eligible for child welfare services	☐	☐
Salaries of employees in child welfare agencies	☐	cl
Eligibility criteria for employment in child welfare agencies	cl	cl
Training of employees in child welfare agencies	cl	☐
Cost of substitute or foster care placements	☐	☐
Cost of services	☐	☐
Policies pertaining to cross-racial adoptions	☐	☐
Policies pertaining to cross-racial foster care placements	☐	☐
Length of time for investigations	cl	cl
Length of time for families can receive services	cl	cl
Policies pertaining to foster care payments for relatives	☐	cl

C2 Over the past 5 years, have any of the following State policies been revised in response to the problem of family AOD abuse?

	Revised because of AOD abuse abuse problem	Revised but not because of AOD abuse problem	Not Revised
Policies regarding termination of parental rights	☐	cl	cl
Policies regarding child abuse and neglect reporting requirements	❑	El	☐
Policies regarding investigations of child abuse and neglect reports	❑	cl	☐
Policies regarding investigations activities	☐	cl	☐
Policies regarding reasons for removal of children from their homes	☐	☐	☐
Other (specify) _____	☐	•1	cl

c3 Are mandated reporters currently required to report the following situations? (Put an X in the appropriate box)

	Yes	No	Don't know
A pregnant woman known to be using AOD	☐	cl	☐
An infant identified as drug or alcohol addicted through hospital tests	☐	☐	☐
An infant identified as drug or alcohol exposed but not addicted	cl	☐	☐
An infant born to a mother who acknowledged using drugs (but tests do not indicate infant drug or alcohol exposure)	☐	☐	☐
Parental AOD abuse leading the reporter to suspect abuse or neglect (although there is no	☐	☐	☐

observation of abuse or neglect)

SECTION D: DATA AVAILABILITY

This section of the questionnaire requests information about the kinds of data that you maintain in your own agency or that you submit to the State regarding your service population.

D1 Did your agency maintain or submit to the State information about child maltreatment investigations?
Yes Cl No ☐ Don't know ☐

D2 Did your agency maintain or submit to the State descriptive information about ongoing treatment cases involving child welfare'services to families whose children remain at home (i.e., are not placed in substitute care)?
Yes ☐ No ☐ Don't know ☐

D3 Did your agency maintain or submit to the State descriptive information about children placed in foster care?
Yes ☐ No ☐ Don't know Cl

D4 Does this include placements with relatives?
Yes ☐ No ❑ Don't know ☐

If no, please explain why?

_____

_____

D5 Did your agency maintain or submit to the State descriptive information about children available for adoption through your services?
Yes •l No ❑ Don't know Cl

D5 Did your agency maintain or submit to the State information about the AOD abuse problems of families and adults in foster care?
Yes El No ☐ Don't know Cl

SECTION E: SERVICE POPULATION

This section solicits information about the clients served in your Child Welfare agency during your last fiscal year - the fiscal year for which you have completed data. If your agency or State maintains data pertaining to client characteristics, please use these dam to answer the questions below. If your data categories are different from those used in the questionnaire, please provide an attachment showing the data using your own data categories.

If your agency or State does not maintain these data, please provide your best estimates based on your own experiences. Also, please indicate by putting an X in the appropriate box if your answer is **from available data** or is an **estimate. If you** do not know an answer, and you feel you cannot make an estimate, put an X in the box labelled "don't know."

Please indicate the fiscal year that you are reporting _____

The following questions pertain to investigations/intake cases begun during the last fiscal year for which you have completed data.

E1 How many child abuse and neglect reports were investigated during your last fiscal year? _____
Reporting from data ☐ Estimating ☐ Don't know ☐

E2 How many cases were substantiated? _____
Reporting from data ☐ Estimating ☐ Don't know ☐

E3 How has the number of substantiated cases changed over the past 5 years?

☐ Increased substantially
☐ Increased moderately
☐ No change
☐ Decreased moderately
☐ Decreased substantially
☐ Don't know

Reporting from data ☐
Estimating response ☐

E4 If it has increased, to what would you attribute the increase?

☐ In small part to an increase in AOD abuse problem in the community
☐ In some part to an increase in the AOD abuse problem in the community
☐ In large part to an increase in the AOD abuse problem in the community
☐ Largely to factors other than the AOD abuse problem in the community
(identify other factors) _____

_____

☐ Don't know

The following questions pertain to ongoing treatment cases (families who receive services while children remain at home) opened during the last fiscal year for which you have completed data.

E5 **How** many ongoing treatment cases were opened during your last fiscal year? _____
Reporting from data ❑ Estimating ❑ Don't know Cl

E6 **How** has the number in **E5** changed over the past **5 years?**

- ❑ Increased substantially
- ❑ Increased moderately
- ❑ No change
- ❑ Decreased moderately
- ❑ Decreased substantially
- ❑ Don't know

Reporting from data ❑
Estimating response ❑

E7 **If** it has increased, to what would you attribute the increase?

- ❑ In small part to an increase in AOD abuse problem in the community
- ❑ In some part to an increase in the AOD abuse problem in the community
- ❑ In large part to an increase in the AOD abuse problem in the community
- ❑ Largely to factors other than the AOD abuse problem in the community

(identify other factors) _____

_____

❑ Don't know

For ongoing treatment cases please provide percentages for the following client characteristics based on cases opened during your last fiscal year.

E8 Family incomes

% Less than $5,000
% $5,000 - $12,499
$12,500 - $24,999
$25,000 - $50,000
More than $50,000
Families receiving AFDC

Reporting from data ❑
Estimating El
Don't know ❑

E9 Ages of the children

% < 1 month
1 month to 2 years or younger
% 3-5
% 6-12
% 13-15
16 and older

Reporting from data ❑
Estimating ❑
Don't know ❑

E10 Racial/ethnic backgrounds of the children

____% Caucasian (non-Hispanic)
____% African-American (non-Hispanic)
____% Hispanic/Latino
____% Native American/Alaska Native
____% Asian or Pacific Islander
____% Other (specify) _____

Reporting from data ❑
Estimating ❑
Don't know cl

E11 Primary reasons for contact with the child welfare system

_____% Physical abuse
_____% Sexual abuse
_____% Emotional abuse
_____% Physical neglect
_____% Abandonment
_____% Family homelessness
_____% Medical neglect
_____% Status offenses
_____% CHINS petitions
_____% Primary caretaker hospitalized
_____% Primary caretaker incarcerated
_____% Drug exposed/addicted prenatally
_____% Other (specify) _____

Reporting from dam ☐
Estimating ☐
Don't know ☐

E12 Who child resided with at the tune of contact with child welfare

_____% Mother only
_____% Mother and stepfather
_____% Biological mother and father
_____% Father only
_____% Father and stepmother
_____% Other relative
_____% Unrelated adult
_____% Foster parent/group home
_____% Friend's home
_____% street
_____% Other (specify) _____

Reporting from data ☐
Estimating ☐
Don't know ☐

The following questions pertain to children who entered out-of-home placement during the last fiscal year for which you have completed data.

El3 How many children were in foster care on an average day during your last fiscal year? _____
Reporting from data ☐ Estimating ☐ Don't know ☐

Does this include children in relative care? Yes ☐ No ☐
If no, please explain why? _____

_____

El4 How many children entered the foster care system during your last fiscal year? _____
Reporting from data ☐ Estimating ☐ Don't know ☐

El5 How has the number in El4 changed over the past 5 years?

☐ Increased substantially
☐ Increased moderately
☐ No change
☐ Decreased moderately
☐ Decreased substantially
☐ Don't know

Reporting from data ☐
Estimating response ☐

E16 If it has increased, to what would you attribute the increase?

- ☐ In small part to an increase in the AOD abuse problem in the community
- ☐ In some part to an increase in the AOD abuse problem in the community
- ☐ In large part to an increase in the AOD abuse problem in the community
- ☐ Largely to factors other than an increase in the AOD abuse problem in the community (identify other factors)_____

_____

- ☐ Don't know

For foster care cases entering the system in your last fiscal year, please provide percentages for the following characteristics.

E17 Family incomes

% Less than $5,000	Reporting from data	☐
$5,000%- $12,499	Estimating	cl
____% $12500 - $24,999	Don't know	cl
% $25,000 - $50,000		
Mor% than $50,000		
Fam%ies receiving AFDC		

E18 Ages of the children

% < 1 month		
2 ye%ars or younger	Reporting from data	☐
% 3 - 5	Estimating	☐
% 6 - 12	Don't know	☐
% 12 - 15		
16 %nd older		

E19 Racial/ethnic backgrounds of the children

___% Caucasian (non-Hispanic)	Reporting from data	☐
___% African-American (non-Hispanic)	Estimating	☐
____% Hispanic/Latino	Don't know	cl
___% Native American/Alaska Native		
___% Asian or Pacific Islander		
___% Other (specify) _____		

E20 Primary reasons for placement

_____% Physical abuse	Reporting from data	☐
_____% Sexual abuse	Estimating	☐
_____% Emotional abuse	Don't know	☐
_____% Physical neglect		
_____% Abandonment		
_____% Family homelessness		
_____% Medical neglect		
_____% Status offenses		
_____% CHINS petitions		
_____% Primary caretaker hospitalized		
_____% Primary caretaker incarcerated		
_____% Drug exposed/addicted prenatally		
_____% Other (specify) _____		

E21 **Who** child resided with at the time of placement

_____% Mother only
_____% Mother and stepfather
_____% Biological mother and father
_____% Father only
_____% Father and stepmother
_____% Other relative
_____% unrelated adult
_____% Foster parent/group home
_____% Friend's home
_____% street
_____% Other (specify) _____

Reporting from data ☐
Estimating ☐
Don't know ☐

E22 **Initial placements**

_____% Emergency foster family
_____% Regular foster family
_____% Emergency shelter
_____% Group home
_____% Residential treatment facility
_____% Psychiatric facility
_____% Drug treatment facility
_____% Relatives
_____% Other (specify)_____

Reporting from data ☐
Estimating ☐
Don't know ☐

The following questions pertain to children who became available for adoption during the last fiscal year for which you have completed data.

E23 In your agency, how many children became classified as "waiting to be adopted" adoption during the past fiscal year?
Number of children _____

Reporting from data ☐ Estimating ☐ Don't know ☐

E24 How has the number in E23 changed over the past 5 years?

☐ Increased substantially
Cl Increased moderately
☐ No change
☐ Decreased moderately
☐ Decreased substantially
☐ Don't know

Reporting from data ☐
Estimating response ☐

E25 If it has increased, to what would you attribute the increase?

☐ In small part to an increase in the AOD abuse problem in the community
☐ In some part to an increase in the AOD abuse problem in the community
☐ In large part to an increase in the AOD abuse problem in the community
☐ Largely to factors other than an increase in the AOD abuse problem in the community
(identify other factors) _____

_____

☐ Don't know

E26 During your last fiscal yaer, what percent of children waiting to be adopted were placed in adoptive homes?
Percent of children _____

Reporting from data ☐ Estimating ☐ Don't know Cl

For cases of children who became available for adoption during the last fiscal year, please provide percentages for the following client characteristics.

E27 Family incomes

% Less than $5,000
% $5,000 - $12,499
$12,500 - $24,999
% $25,000 - $50,000
More than $50,000
% Families receiving AFDC

Reporting from data ☐
Estimating ☐
Don't know ☐

E28 Ages of the children

% < 1 month
1 month to 2 years or younger
% 3 - 5
6 - 12
% 13 - 15
% 16 and older

Reporting from data ☐
Estimating ☐
Don't know ☐

E29 Racial/ethnic backgrounds of the children

___% Caucasian (non-Hispanic)
___% African-American (non-Hispanic)
___% Hispanic/Latino
___% Native American/Alaska Native
___% Asian or Pacific Islander
___% Other (specify) _____

Reporting from data ☐
Estimating ☐
Don't know ☐

E30 Primary reasons for contact with the child welfare system

_____% Physical abuse
_____% Sexual abuse
_____% Emotional abuse
_____% Physical neglect
_____% Abandonment
_____% Family homelessness
_____% Medical neglect
_____% Status offenses
_____% CHINS petitions
_____% Primary caretaker hospitalized
_____% Primary caretaker incarcerated
_____% Drug exposed/addicted prenatally
_____% Other (specify) _____

Reporting from data ☐
Estimating ☐
Don't know ☐

E31 Who child resided with at the time of availability for adoption

_____% Mother only
_____% Mother and stepfather
_____% Biological mother and father
_____% Father only
_____% Father and stepmother
_____% Other relative
_____% Unrelated adult
_____% Foster parent/group home
_____% Friend's home
_____% Hospital
_____% Other (specify) _____

Reporting from data ☐
Estimating ☐
Don't know ☐

SECTION F: SERVICES AND STAFFING

In this section, we are asking for information about the services provided to child welfare agency clients and your agency staff analysts. We want to know what services the agency provides directly to clients, provides through contract, and provides by referrals to other agencies or service organizations. **Note: This** list is standardized for all programs surveyed for this study. We recognize that some services are not likely to be part of child welfare service sytem. Also, we recognize that this list is not exhaustive of all services provided by child welfare.

F1 Which of these services are provided by the child welfare agency? Please put an X in the appropriate box for each service. More than one box may be used if necessary. If services are not provided in any manner, put an X in the box under the column headed **Not provided.**

Type of service	Provided by agency staff	Contractual, in-kind, direct purchase	Referred	Not provided	Don't know
Food	☐	☐	☐	☐	☐
Shelter for children/youth	☐	☐	☐	☐	☐
Shelter for families	☐	☐	☐	☐	☐
Physical examinations	☐	☐	☐	☐	☐
Medical tests	☐	☐	☐	☐	☐
Nutrition information	☐	☐	☐	☐	☐
Out-of-home placement for children/youth	☐	☐	☐	☐	☐
Independent living services	☐	☐	☐	☐	☐
Parenting classes	☐	☐	☐	☐	☐
Income maintenance services	☐	☐	☐	☐	☐
Legal services	☐	☐	☐	☐	☐
Child care services	☐	☐	☐	☐	☐
Child development services	☐	☐	☐	☐	☐
Support group for children/youth	☐	☐	☐	☐	☐

Type of service	Provided by agency staff	Contractual, in-kind, direct purchase	Referred	Not provided	Don't know
Support group for parents	☐	cl	☐	☐	☐
Home visits	☐	❑	☐	☐	☐
Individual counseling for children/youth	☐	☐	☐	☐	☐
Individual counseling for parents	☐	☐	☐	☐	☐
Group counseling for children/youth	☐	☐	☐	☐	☐
Group counseling for parents	☐	cl	☐	☐	☐
Family counseling	☐	☐	☐	cl	☐
Couples counseling	☐	cl	☐	El	☐
AOD abuse assessment	☐	☐	☐	☐	☐
AOD abuse treatment	☐	☐	☐	cl	☐
AOD abuse prevention services	☐	☐	☐	cl	☐
GED classes for youth	☐	cl	☐	☐	☐
GED classes for parents	☐	☐	☐	cl	☐
Education for children with special needs	☐	☐	☐	☐	☐
Employment preparedness/training classes for youth	☐	☐	☐	☐	☐
Employment preparedness/training classes for parents	☐	☐	☐	☐	☐
Homemaker services	☐	☐	☐	•J	☐
Respite care	☐	☐	☐	cl	☐
Parent involvement activities	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐

The **following questions pertain to your agency's staffing**

F2 How many full-time equivalent intake/investigations caseworker positions does your agency have? _____
What is their average caseload size? _____

F3 How many full-time equivalent foster care caseworker positions does your agency have? _____
What is their average caseload sire?

F4 How many full-time equivalent foster care and adoption homefinder positions does your agency have?

F5 How many full-time equivalent adoption specialist positions does your agency have?
What is their average caseload sire? _____

F6 How many full-time equivalent ongoing treatment caseworker positions does your agency have? _____
What is their average caseload size? _____

F7 What other staff positions does your agency have (other than clerical staff)?

Job title	Number of positions
_____	_____
_____	_____
_____	_____

SECTION G: AOD ABUSE PROBLEM: Extent

In this section we are interested in finding out about the extent of AOD abuse problems among the families who came into contact with child welfare during your Iast fiscal year. If your agency or State maintains data on AOD abuse problems, please use the data to provide your response. If not, please estimate as before.

During your last fiscal year:

G1 What percent of substantiated child maltreatment reports involved families with AOD abuse problems? _____%
Reporting from data ❑ Estimating response ❑ Don't know ❑

G2 How does the percentage in G1 differ from approximately 5 years ago?
Increased ❑ Decreased ❑ No change ❑ Don't know ❑

G3 If you answered increased or decreased to the above question, please provide the percent of these families approximately 5 years ago. _____%
Reporting from data ❑ Estimating response ❑ Don't know Cl

G4 What percent of ongoing services cases (families who received services while their children remained at home) in your last fiscal year involved children or families with AOD abuse problems? _____%
Reporting from data ❑ Estimating response ❑ Don't know ❑

G5 How does the percentage in G4 differ from approximately 5 years ago?
Increased ❑ Decreased ❑ No change ❑ Don't know ❑

G6 If you answered increased or **decreased** to the above question, please provide the percent of these families approximately 5 years ago. _____%
Reporting from data ❑ Estimating response ❑ Don't know ❑

[Foster Care only]
G7 What percent of children who entered foster care during your last fiscal year came from families with AOD abuse problems? _____%
Reporting from data ❑ Estimating response ❑ Don't know ❑

G8 How does the percentage in G7 differ from approximately 5 years ago?
Increased ❑ Decreased ❑ No change ❑ Don't know ❑

G9 If you answered increased or decreased to the above question, please provide the percent of children in substitute care 5 years ago who came from families with AOD abuse problems. _____%
Reporting from data ❑ Estimating response ❑ Don't know ❑

[Infants]

G10 What percent of the children who were reported to child welfare during the last fiscal year were infants who were addicted or exposed to AOD in utero? _____%

Reporting from data ❑ Estimating response ☐ Don't know ☐

G11 How does the percentage in G10 differ from 5 years ago?

Increased ☐ Decreased ☐ No change ☐ Don't know ☐

G12 If you answered **increased** or **decreased** to the above question, please provide the percent of infants who came into contact with child welfare 5 years ago who were prenatally AOD-addicted or exposed. _____%

Reporting from data ☐ Estimating response ☐ Don't know cl

[Adoption]

G13 What percent of children who were classified as waiting for adoption during the past fiscal year came from families with AOD abuse problems? _____%

Reporting from data ☐ Estimating response ❑ Don't know ☐

G14 How does the percentage in G13 differ from approximately 5 years ago?

Increased Cl Decreased ☐ No change ☐ Don't know ☐

G15 If you answered **increased or decreased** to the above question, please provide the percent of children who became available for adoption 5 years ago who came from families with AOD abuse problems. _____%

Reporting from data ☐ Estimating response ☐ Don't know ☐

G16 What percent of the waiting children from families with AOD abuse problems were placed with adoptive families? _____%

Reporting from data ☐ Estimating response ☐ Don't know ☐

G17 What percent of the children who were classified as waiting to be adopted during your last fiscal year have special medical and/or educational needs resulting from prenatal AOD abuse? _____%

Reporting from data ☐ Estimating response ❑ Don't know ☐

G18 How does the percentage in G17 differ from approximately 5 years ago?

Increased ☐ Decreased ☐ No change ❑ Don't know ☐

G19 If you answered increased or **decreased** to the above question, please provide the percent of waiting children with special needs resulting from prenatal AOD abuse 5 years ago. _____%

Reporting from data ☐ Estimating response ☐ Don't know ☐

G20 What is the impact of the Federal Adoption Assistance Program on placing these children?

☐ Increased ability to place children
☐ No change
❑ Decreased ability to place children
☐ Don't know

SECTION H: AOD ABUSE PROBLEM: Impact on Caseloads

In this section we are concerned with how children and families with AOD abuse problems impact on caseload activities. For each question, please indicate your answer by putting an X in the appropriate box.

H1 Do investigations/intakes involving children from families with AOD abuse problems require more caseworker time than other cases?

- ☐ Almost always require more caseworker time
- ☐ Frequently require more caseworker time
- ☐ Sometimes require more caseworker time
- ☐ Rarely require more caseworker time
- Cl Don't know

H1a Does the type of drug being used make a difference?

Yes ☐ No ☐ Don't know ☐

If yes, please explain.

_____

_____

_____

_____

H2 Do ongoing services cases involving families with AOD abuse problems require more caseworker time than other cases?

- ☐ Almost always require more caseworker time
- ☐ Frequently require more caseworker time
- Cl Sometimes require more caseworker time
- Cl Rarely require more caseworker time
- ☐ Don't know

H2a Does the type of drug being used make a difference?

Yes ☐ No ☐ Don't know ☐

If yes, please explain.

_____

_____

_____

_____

H3 Do ongoing services cases involving families with AOD abuse problems require specialized services for a longer period of time than other cases?

- ☐ Almost always require specialized services for a longer period of time
- ☐ Frequently require specialized services for a longer period of time
- ☐ Sometimes require specialized services for a longer period of time
- ☐ Rarely require specialized services for a longer period of time
- ☐ Don't know

H3a Does the type of drug being used make a difference?
Yes ☐ No ☐ Don't know ☐

If yes, please explain.

_____

_____

_____

_____

H4 Do children from families with AOD abuse problems remain in foster care for longer periods of time than other children?

- ☐ Almost always remain in care longer
- ☐ Frequently remain in care longer
- ☐ Sometimes remain in care longer
- ☐ Rarely remain in care longer
- ☐ Don't know

H4a Does the type of drug being used make a difference?
Yes ☐ No ☐ Don't know ☐

If yes, please explain.

_____

_____

_____

_____

H5 Do children from families with AOD abuse problems in foster care have more specialized service needs than other children in foster care?

- ☐ Almost always require more specialized services
- ☐ Frequently require more specialized services
- ☐ Sometimes require more specialized services
- ☐ Rarely require more specialized services
- ☐ Don't know

H5a Does the type of drug being used make a difference?
Yes ☐ No ☐ Don't know ☐

If yes, please explain.

_____

_____

_____

_____

SECTION I: AOD ABUSE PROBLEM: Impact on foster care and adoptive family recruitment and retention

In this section we are interested in determining whether serving children and families with AOD abuse problems has had an impact on recruitment or retention of foster care families.

11 How has recruitment of foster care families changed over the past 5 years?

☐ Become substantially more difficult to recruit
☐ Become moderately more difficult to recruit
☐ Not changed
☐ Become moderately less difficult to recruit
☐ Become substantially less difficult to recruit
☐ Don't know

Reporting from data ☐
Estimating response ☐

I2 If it has become more difficult, to what would you attribute the increased difficulty?

☐ In small part to increases in the number of children from families with AOD abuse problems
☐ In some part to increases in the number of children from families with AOD abuse problems
☐ In large part to increases in the number of children from families with AOD abuse problems
☐ Largely to factors other than increase in the number of children from families with AOD abuse problems
(identify other factors) _____

_____

☐ Don't know

13 How has recruitment of adoptive families changed over the past 5 years?

☐ Become substantially more difficult to recruit
☐ Become moderately more difficult to recruit
☐ Not changed
☐ Become moderately less difficult to recruit
☐ Become substantially less difficult to recruit
☐ Don't know

Reporting from data ☐
Estimating response ☐

14 If it has become more difficult, to what would you attribute the increased difficulty?

- ☐ In small part to increases in the number of children from families with AOD abuse problems
- ☐ In some part to increases in the number of children from families with AOD abuse problems
- ☐ In large part to increases in the number of children from families with AOD abuse problems
- ☐ Largely to factors other than increase in the number of children from families with AOD abuse problems (identify other factors) _____

_____

- ☐ Don't know

I5 How has the retention of foster care families changed over the past 5 years?

- ☐ Become substantially more difficult
- ☐ Become moderately more difficult
- ☐ Not changed
- ☐ Become moderately less difficult
- ☐ Become substantially less difficult
- ☐ Don't know

Reporting from data ☐
Estimating response ☐

16 If it has become more difficult, to what would you attribute the increased difficulty?

- ☐ In small part to increases in the number of children from families with AOD abuse problems
- ☐ In some part to increases in the number of children from families with AOD abuse problems
- ☐ In large part to increases in the number of children from families with AOD abuse problems
- ☐ Largely to factors other than increase in the number of children from families with AOD abuse problems (identify other factors) _____

_____

- ☐ Don't know

I7 How has the number of failed adoptions changed over the past 5 years?

- ☐ Increased substantially
- ☐ Increased moderately
- ☐ No change
- ☐ Decreased moderately
- ☐ Decreased substantially
- ☐ Don't know

Reporting from data ☐
Estimating response ☐

18 If it has increased, to what would you attribute the increase to?

_____

_____

_____

SECTION J: SERVICE EFFECTIVENESS

This section focuses on the goals of the agency with respect to serving children and families with AOD abuse problems, the effectiveness of the staff in attaining these goals, and the services or procedures that may have been, or need to be, implemented to assist staff in attaining their goals.

J1 Given that the primary goal of child welfare is to ensure the safety of the child, how important are other goals specific to **families with** AOD abuse problems?

	Very important	Moderately important	Somewhat important	Not important	Not a goal
To get AOD abuser to acknowledge his/her abuse problem	cl	☐	☐	cl	☐
To ensure that someone else in the family is in the home when the AOD abuser is present	☐	☐	☐	❑	☐
To get AOD abuser to agree to seek treatment	cl	☐	☐	☐	☐
To enroll AOD abuser in a treatment program	cl	☐	☐	cl	☐
To enroll AOD abuser in counseling for problems related to AOD abuse	cl	☐	☐	☐	☐
To help family members cope with a child who has a AOD abuse problem	☐	☐	☐	☐	cl
To help child cope with a family member who has a AOD abuse problem	☐	☐	☐	cl	☐
Other goals (specify) _____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	cl

J2 How successful do you feel child welfare staff are in achieving the goals listed in J1?

	Very successful	Moderately successful	Somewhat successful	Not successful	Not a goal
To get AOD abuser to acknowledge his/her AOD abuse problem	☐	cl	cl	☐	❑
To ensure that someone else in the family is in the home when the abuser is present	cl	cl	☐	El	☐
To get AOD abuser to agree to seek treatment	☐	cl	cl	cl	cl
To enroll AOD abuser in a treatment program	☐	cl	❑	☐	☐
To enroll AOD abuser in counseling for problems related to AOD abuse	❑	❑	cl	☐	☐
To help family members cope with a child who has a AOD abuse problem	❑	☐	☐	☐	cl
To help child cope with a family member who has a AOD abuse problem	❑	❑	cl	cl	☐
Other (specify) _____	El	☐	cl	cl	cl

J3 Has your agency implemented any new services in the past 5 years specifically as a result of serving children and families with AOD abuse problems?

Yes ☐ No ☐ Don't know ☐

J4 If yes, please describe the services that were implemented.

_____

_____

_____

_____

SECTION K: AOD ABUSE PROBLEM: **Impact on Staffing**

In this section, we are soliciting information about the impact of serving children and families with AOD abuse problems on agency staffing arrangements and staff training.

K1 Does your agency have difficulties recruiting staff as a result of serving families with AOD abuse problems?
Yes ☐ No ☐ Don't know Cl

If yes, please explain why.

_____

_____

K2 Does your agency have difficulties retaining staff as a result of serving families with AOD abuse problems?
Yes ☐ No ☐ Don't know ☐

If yes, please explain why.

_____

_____

K3 In comparison to working with families without AOD abuse problems, are staff working with youth and families with **AOD** abuse problems more likely, less likely, or equally likely to experience the following problems?

	More likely	**Less likely**	**No** difference	**Don't know**
Personal danger	☐	☐	☐	cl
Emotional "burnout"	☐	☐	☐	☐
Problems with personal unresolved AOD abuse issues	☐	☐	☐	☐
Other (specify)_____	☐	☐	☐	cl

K4 Do you think your agency needs to implement special strategies or staffing changes in order to better serve families with AOD abuse problems?
Yes ☐ No ☐ Don't know Cl

K5 **Please indicate the importance of the following strategies or staffing practices in improving your program's ability to serve children from families with** AOD abuse problems. (Note: Please provide your opinions regarding these practices even if they have not been implemented in your agency.)

	Very important	Somewhat important	Not important	Don't know
Build a stronger referral network among community agencies	cl	☐	El	☐
Work with local AOD abuse treatment services to give priority to child welfare agency clients	cl	☐	☐	☐
Hire a consultant to help staff work with families with AOD abuse problems	cl	☐	cl	☐
Develop a team approach to case management in working with families with AOD abuse problems	❑	☐	☐	☐
Reduce caseworker caseloads	☐	☐	cl	cl
Add new caseworker positions to deal with AOD abuse problems	❑	☐	☐	☐
Create staffing teams/special unit to work with families with AOD abuse problems	cl	☐	cl	cl
Provide funds for staff to attend AOD abuse-related workshops	☐	☐	❑	❑
Other (specify) _____	cl	☐	cl	☐

K6 Please identify the strategies or staffing changes that have been implemented over the past 5 years.

	Has been implemented	Has not been implemented	Was already in place
Build a stronger referral network among community agencies	☐	cl	cl
Work with local AOD abuse treatment services to give priority to child welfare agency clients	cl	☐	☐
Hire a consultant to help caseworker work with families with AOD abuse problems	☐	cl	☐
Develop a team approach to case management in working with families with AOD abuse problems	☐	☐	❑
Reduce caseworker caseloads	☐	☐	☐
Add new caseworker positions to deal with AOD abuse problems	☐	☐	cl
Create staffing teams/special unit to work with families with AOD abuse problems	☐	cl	☐
Provide funds for staff to attend AOD abuse-related workshops	☐	☐	☐
Other (specify) _____	☐	☐	☐

K7 Do you mink your agency needs to implement special training for staff in order to better serve families with AOD abuse problems?

Yes ☐ No ☐ Don't know ☐

K8 If yes, **please identify the training** needs.

	Training needed and in place	Training needed and planned	Training needed but not planned	Training not needed
Diffusing potentially violent family situations	❑	☐	☐	☐
Basic drug and alcohol information (appearance, physiological effects, behaviors of those under the influence)	☐	☐	❑	☐
Basic health information	☐	☐	☐	❑
Street drug information/street culture (current street slang)	☐	☐	☐	❑
Family/couples counseling	☐	☐	☐	☐
Dealing with hostile family members	☐	☐	☐	☐
Conducting interventions with individuals with AOD abuse problems	☐	☐	☐	☐
Codependency information (family dynamics, roles, behaviors)	☐	☐	☐	☐
Staff safety/self protection	☐	☐	☐	☐
Dealing with police-investigator and courts	☐	☐	☐	☐
Supporting clients AOD treatment efforts	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐

SECTION L: GENERAL PERSPECTIVES

In this last section of the questionnaire, we are interested in determining how you view the problem of family AOD abuse in the context of other family problems that agency caseworkers must contend with in working with families.

L1 Do you feel that your agency has a role in combatting AOD abuse?
Yes Cl No ☐ Don't know Cl

L2 If you answered yes to the above question, please describe how you see your agency's role. If you answered no, please explain why you feel your agency does not have a role.

_____

_____

_____

_____

L3 Overall, given the many problems that clients served by your agency are facing, how important do you feel it is for your agency to confront the problem of family AOD abuse?

Number one priority of agency ❑
Extremely important ❑
Moderately important El
slightly important ☐
Not important ❑
Don't know ❑

Unit Supervisor/Caseworker - Adoption

RESEARCH QUESTION	ITEM(S)
1a - Concept of AOD abuse	A1, A2
1b - State and local statutes	NA
1c - Service costs	C2 thru C7
1d - Change in services/demand for services	C2 thru C9, E5, F7
2a - Number of clients with AOD abuse problems/change	C6, C7, C8, C9
2b - Characteristics	D1, D2, D3, F4
3a - Foster Care	NA
3b - Adoption	E1, E2, F5, F6, F7, F8
4a - Goals/effectiveness	E3
4b - Staffing	C10, E3, E4, E5
4c - Juvenile court and hospital social workers perspectives	NA
5a - Client needs	F1, F2
5b - Staff effectiveness	C10, E4, F2
5c - Barriers	F3, F5, F6
5d - Roles	G1, G2, G3

Revised July 30, 1992

Unit Supervisor/Caseworker - Adoption

This questionnaire form is to be completed by an adoption caseworker and a supervisor in the child welfare agency who is responsible for adoption caseworkers. For purposes of this study, adoption caseworkers are responsible for managing caseloads of children available for adoption, monitoring and providing services to adoptive families during the trial period, and writing reports to the court concerning the appropriateness of a finalized adoption.

Guidelines for completion of the form

If you are responsible for supervising other staff as well as adoption caseworkers, please answer this questionnaire only with respect to your work with adoption caseworkers. Please restrict your responses to impressions that are directly based on your experience as an adoption supervisor or caseworker. Many of the questions require you to state opinions that are based on your own professional experience. In general you should answer these questions only if:

1) You have had direct contact with children and/or their families.

2) You have discussed cases or client situations with staff members.

3) You have access to records and/or databases containing pertinent information.

Otherwise, you should respond “don’t know”.

SECTION A: DEFINITIONS

As indicated in the cover letter, in this study we are interested in assessing the impact of family or youth alcohol and other drug (AOD) abuse problems on child welfare services. Although the term "AOD abuse problem" can be conceptualized in a variety of ways, we have defined this term in a way that we feel is meaningful for service delivery efforts. We would like you to keep the following definitions in mind while you are completing this questionnaire.

For the purposes of this study, AOD refers to alcohol and other drugs with the exception of nicotine, caffeine, and prescription drugs under a doctor's supervision.

AOD abuse problem refers to a level of drug use resulting in the user being unable to meet personal responsibilities, being unable to appropriately fulfill role requirements, and/or engaging in behaviors that are self-destructive or harmful to others.

A1 Does your agency/program define the term **AOD abuse problem in** a similar or different manner?

Similar ☐ Different ☐ Do not have an agency definition ☐

A2 **If you answered different,** please describe how your agency defines a AOD abuse problem.

_____

_____

_____

_____

SECTION B: RESPONDENT INFORMATION

B1 Name: _____

B2 Contact telephone # (-____)_____ _____

B3 Job title: _____

B4 What are your primary responsibilities? _____

_____

_____

B5 How long have you been employed in this position? _____

B6 What was your previous position and how long were you employed in that position?

Position: _____

Length of time: _____

SECTION C: AOD ABUSE PROBLEM: Impact on Caseload

In this section we are concerned with how children and families with AOD abuse problems impact on caseworker activities. Please answer all questions based on your personal experience. For each question, please indicate your answer by putting an X in the appropriate box.

Cl What information do you use to determine whether there is a AOD abuse problem in a child's biological family?

	Very rarely	Rarely	Sometimes	Frequently	Very frequently
Report received from hospitals	☐	☐	☐	☐	☐
Report received from foster care caseworker	cl	cl	☐	cl	☐
Discussions with child	☐	☐	☐	cl	☐
Discussions with family members	☐	☐	☐	cl	☐
Formal assessment instrument	☐	☐	☐	☐	☐
Reports from law enforcement	☐	☐	☐	☐	cl
Reports from the court	☐	☐	☐	cl	☐
Case reports of prior agency contacts	☐	☐	☐	cl	cl
Observations of family members	☐	☐	☐	cl	☐
Observations of child	☐	☐	☐	cl	☐
Other (specify) _____	☐	☐	☐	cl	cl

C2 Do waiting children from biological families with AOD abuse problems require more of your (or your caseworker's) time than other cases?

- ☐ Almost always require more time
- ☐ Sometimes require more time
- ☐ Rarely require more time
- ☐ Almost never require more time
- ☐ Don't know

C2a Does the type of drug being used make a difference?

Yes ☐ No ☐ Don't know ☐

If yes, please explain.

_____

_____

_____

_____

c3 Do waiting children from biological families with AOD abuse problems require more specialized services than other children?

- ☐ Almost always require more specialized services
- ☐ Frequently require more specialized services
- ☐ Sometimes require more specialized services
- ☐ Rarely require more specialized services
- ☐ Don't know

C3a Does the type of drug being used make a difference?
Yes ☐ No ☐ Don't know ☐

If yes, please explain.

_____

_____

_____

_____

c4 Are waiting children from families with AOD abuse problems more difficult to place in adoptive homes than other children?

- ☐ Almost always more difficult
- ☐ Frequently more difficult
- ☐ Somewhat more difficult
- ☐ Rarely more difficult
- ☐ Don't know

C4a Does the type of drug being used make a difference?
Yes Cl No ☐ Don't know ☐

If yes, please explain.

_____

_____

_____

_____

C5 If they are more difficult to place, please explain why.

_____

_____

C6 What percent of your (or your caseworker's) caseload involve waiting children from biological families with AOD abuse problems? _____%
Reporting from data ☐ Estimating response ☐ Don't know ☐

c7 How has the percentage in C6 changed over the past 5 years?

- ☐ Increased substantially
- •I Increased moderately
- ☐ No change
- ☐ Decreased moderately
- ☐ Decreased substantially
- Cl Don't know

Reporting from data ☐
Estimating response ☐

C8 What percent of your average caseload involves infant prenatally exposed or addicted to drugs? _____%
Reporting from data ☐ Estimating response ☐ Don't know ☐

C9 How has the percentage in C8 changed over the past 5 years?

- ☐ Increased substantially
- ☐ Increased moderately
- ☐ No change
- ☐ Decreased moderately
- ☐ Decreased substantially
- ☐ Don't know

Reporting from data ☐
Estimating response ☐

C10 What types of training do you feel would help you better serve children from families with AOD abuse problems?

Type of training	Training needed but not available	Training needed and available	Training not needed
Diffusing potentially violent family situations	☐	☐	☐
Basic drug and alcohol information (appearance, physiological effects, behaviors of those under the influence)	cl	☐	cl
Basic health information	☐	☐	☐
Street drug information (current street slang)	☐	☐	☐
Family/couples counseling	cl	☐	☐
Codependency information (family dynamics, roles, behaviors)	cl	cl	cl
Dealing with hostile family members	cl	☐	El
Conducting interventions with individuals with AOD abuse problems	cl	☐	cl
Staff safety/self protection	☐	☐	cl
Supporting parents AOD treatment efforts	cl	cl	cl
Other (specify) _____	☐	☐	☐

SECTION D: AOD ABUSE PROBLEM: Client Characteristics

In this section we are interested in your perceptions of the characteristics of clients with AOD abuse problems and how these clients differ from other clients. Please answer all questions based on your personal experience in working with these clients.

D1 In comparison to waiting children from biological families without AOD abuse problems, are waiting children from families with AOD abuse problems more likely, less likely, or equally likely to exhibit the following characteristics?

Child characteristics	More likely	Less likely	No difference	Don't know
To be from an racial/ethnic minority group	❑	❑	❑	❑
To have experienced family violence	❑	❑	❑	❑
To have experienced chronic family conflict	❑	❑	❑	❑
To have moved frequently	❑	❑	❑	❑
To have been homeless	❑	❑	❑	❑
To have been physically abused	❑	❑	❑	❑
To have been sexually abused	❑	❑	❑	❑
To have been emotionally abused	❑	❑	❑	❑
To have been neglected	❑	❑	❑	❑
To have failed to pass a grade in school	❑	❑	❑	❑
To have received special school services for a learning or developmental disability	❑	❑	❑	❑
To have emotional/psychological problems	❑	❑	❑	❑
To have a developmental disability	❑	❑	❑	❑
To be shy and isolated from peers	❑	❑	❑	❑
Other (specify)_____	❑	❑	❑	
_____	❑	❑	❑	
_____	❑	❑	❑	

D2 Among the families you serve with AOD abuse problems whose children were classified as waiting for adoption, how many abuse the following drugs?

	Most	Some	Few	None	Don't know
Alcohol	☐	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐	☐
Crack	☐	☐	☐	☐	☐
Opiates (heroin, methadone)	☐	☐	☐	☐	☐
Amphetamines (speed, ice)	☐	☐	☐	☐	☐
Sedatives (valium, downers)	☐	☐	☐	☐	☐
Barbiturates	☐	☐	☐	☐	☐
Psychedelics (LSD, mushrooms, peyote)	☐	☐	☐	☐	☐
Inhalants (glue, gasoline)	☐	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐

D3 Among families you serve with AOD abuse problems whose children were made available for adoption, which family member exhibits a AOD abuse problem?

	Very rarely	Rarely	Sometimes	Frequently	Very frequently
Mother/stepmother	☐	☐	☐	☐	☐
Father/stepfather	☐	☐	☐	☐	☐
Sibling	☐	☐	☐	☐	☐
Both parents	☐	☐	☐	☐	☐
Non-related resident adult	☐	☐	☐	☐	☐
Related resident adult	☐	☐	☐	☐	☐
Other (specify)_____	☐	☐	☐	☐	☐

SECTION E: SERVICE EFFECTIVENESS

This section focuses on your goals with respect to serving families with AOD abuse problems and how effective you feel you or your caseworkers are in attaining these goals. It is important to note that questions regarding effectiveness are not intended to obtain information critical of caseworker abilities but rather to identify areas where prograrns may need to make changes to help caseworkers meet goals.

E1 What kinds of problems do adoption caseworkers and supervisors confront in finding adoptive homes for waiting children from families with AOD abuse problems and how severe do you feel these problems are?

	Severe problem	Moderate problem	Somewhat of a problem	Not a problem	Don't know
Families are unwilling to take children because they fear they may have physical or mental impairments the family cannot handle	☐	☐	☐	☐	☐
Families are unwilling to take children because they fear they may have emotional problems the family cannot handle	☐	☐	☐	☐	☐
Families are unwilling to take children because they are concerned about the costs of providing physical, psychological, or educational services	☐	☐	☐	☐	☐
Families are unwilling to take children because they are concerned about the instability of the biological parents	☐	☐	☐	☐	☐
Families take children but adoption fails	☐	☐	☐	☐	☐
Other reasons (specify)_____	☐	☐	☐	☐	☐

E2 **In** comparison to waiting children **from** families without AOD abuse problems, are staff **working with adoptive families of children from families with** AOD abuse problems more likely, less likely, or **equally** likely to experience the following problems?

	More likely	Less likely	No difference	Don't know
Failed adoptions	cl	cl	☐	cl
Unprepared families	cl	☐	☐	☐
Adoptive family's problems with personal unresolved AOD abuse issues	cl	☐	☐	0
Other (specify)_____	cl	☐	cl	cl

E3 What kinds of service **goals** do you have with respect to biological families with AOD abuse?

_____

_____

_____

_____

_____

E4 Please identify the strategies or **staffing** practices that you think are important to improving your ability to serve children and families with AOD abuse problems.

	Very important	Somewhat important	Not important	Don't know
Build a stronger referral network among **community** agencies	☐	☐	☐	☐
Work with local AOD abuse treatment services to give priority to child welfare agency clients	☐	☐	☐	☐
Hire a consultant to help caseworkers work with families with AOD abuse problems	☐	☐	☐	☐
Develop a team approach to case management in working with families with AOD abuse problems	☐	☐	☐	☐
Reduce caseworker caseloads	☐	☐	☐	☐
Add new caseworker positions to deal **with** AOD abuse problems	☐	☐	☐	☐
Create staffing teams/special unit to work with families with AOD abuse problems	☐	☐	☐	☐
Provide special AOD abuse-related training for staff	☐	☐	☐	☐
Provide funds for staff to attend AOD abuse-related workshops	☐	☐	☐	☐
Other **(specify)** _____	☐	☐	☐	☐

E5 Please identify the strategies or staffing changes that have been implemented over the past 5 years.

	Has been implemented	Has not been implemented	Was already in place
Build a stronger referral network among community agencies	☐	cl	☐
Work with local AOD abuse treatment services to give priority to child welfare agency clients	☐	cl	cl
Hire a consultant to help caseworkers work with families with AOD abuse problems	☐	cl	cl
Develop a team approach to case management in working with families with AOD abuse problems	cl	☐	☐
Reduce caseworker caseloads	☐	☐	☐
Add new caseworker positions to deal with AOD abuse problems	cl	☐	cl
Create staffing teams/special unit to work with families with AOD abuse problems	☐	cl	cl
Provide special AOD abuse-related training for staff	cl	•l	cl
Provide funds for staff to attend AOD abuse-related workshops	☐	☐	☐
Other (specify) _____	☐	cl	☐

SECTION F: SERVICE NEEDS

In this section, we are interested in determining whether adoptive families of children from families with AOD abuse problems have service needs that are different or similar to service needs of adoptive families of children from families without AOD abuse problems. Please answer all questions based on your personal experience.

F1 In comparison to adoptive families of children from families without AOD abuse problems, are adoptive families of children from families with AOD abuse problems more likely, less likely, or equally likely to require the following services?

Type of service	More likely	Less likely	No difference	Don't know
Medical services for child	☐	cl	☐	cl
Parenting classes for parents	☐	☐	☐	❑
Legal services	☐	☐	☐	☐
Child care services	☐	☐	☐	cl
Child development services	☐	☐	☐	☐
Support group for adoptive parents	☐	cl	☐	cl
Support group for adoptive children	☐	☐	☐	☐
Home visits	☐	❑	☐	☐
Individual counseling for children	☐	☐	☐	❑
Individual counseling for parents	☐	El	☐	☐

Type of service	More likely	Less likely	No difference	Don't know
Couples counseling for parents	☐	☐	☐	☐
Individual counseling for siblings	☐	☐	☐	☐
Family counseling	☐	☐	☐	☐
AOD abuse treatment	☐	☐	☐	☐
Education for children with special needs	☐	☐	☐	☐
Financial assistance for children's medical problems	☐	☐	☐	☐
Financial assistance for children's psychological problems	☐	☐	☐	☐
Parent involvement activities	☐	☐	☐	☐
Other (specify)_____	☐	☐	☐	

F2 Do you feel that you (or your caseworkers) are able to meet all of the service needs of adoptive families of children from families with AOD abuse problems?

- ☐ Almost always
- ☐ Most of the time
- ☐ Some of the time
- ☐ Rarely
- ☐ Very rarely
- ☐ Don't know

F3 What kinds of barriers do you confront in serving children and families with AOD abuse problems?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

F4 Compared with 5 years ago, how do you feel the abuse of specific drugs among biological parents in your client population has changed?

	Increased	Decreased	No change	Don't know
Alcohol	cl	☐	☐	☐
Cocaine	cl	☐	☐	☐
Crack	☐	☐	☐	☐
Opiates (heroin, methadone)	❑	☐	☐	☐
Amphetamines (speed, ice)	☐	☐	☐	☐
Sedatives (valium, downers)	cl	☐	☐	☐
Barbiturates	☐	☐	☐	☐
Psychedelics (LSD, mushrooms, peyote)	☐	☐	☐	☐
Inhalants (glue, gasoline)	☐	☐	☐	☐
Marijuana	☐	❑	☐	☐
Other (specify)_____	☐	☐	☐	☐

F5 Does the type of drug abused by biological parents affect the difficulty you (or your caseworkers) experience in finding homes for children from families with AOD abuse problems?

Yes ☐ No ☐ Don't know ☐

F6 If yes, please identify which type of AOD abuse is most difficult to work with and why.

_____

_____

_____

F7 Has your agency changed its adoption services in any way over the past 5 years as a result of serving children from families with AOD abuse problems?

Yes Cl No ☐ Don't know ☐

If yes, please describe the changes that have been made.

_____

_____

_____

F8 What has been the impact of the Federal Adoption Assistance Program on your ability to recruit adoptive families and reduce failed adoption?

_____

_____

_____

_____

SECTION G: GENERAL PERSPECTIVES

In this last section of the questionnaire, we are interested in determining how you view the problem of family AOD abuse in the context of other family problems that investigations/intake caseworkers must contend with.

G1 Do you feel that your agency has a role in combatting AOD abuse?
Yes Cl No ☐ Don't know ☐

G2 If you answered yes to the above question, please describe how you see your agency's role. If you answered no, please explain why you feel your agency does not have a role.

_____

_____

_____

G3 Overall, given the many problems that clients served by your agency are facing, how important do you feel it is for your agency to confront the problem of family AOD abuse?

Number one priority of agency	cl
Extremely important	☐
Moderately important	El
slightly important	☐
Not important	☐
Don't know	☐

Unit Supervisor/Caseworker - Foster Cm

RESEARCH QUESTION	ITEM(S)
1a - Concept of AOD abuse	A1, A2
1b - State and local statutes	NA
1c - Service costs	C2, C3, C4
1d - Change in services/demand for services	C2, C3, C4, C5, C6, E5
2a - Number of clients with AOD abuse problems/change	C5, C6
2b - Characteristics	D1, D2, D3, F5
3a - Foster Care	G1, G2, G3, G4
3b - Adoption	NA
4a - Goals/effectiveness	E1, E2, E3
4b - Staffing	C7, E2, E3, E4, E5
4c - Juvenile court and hospital social workers perspectives	NA
5a - Client needs	F1, F2
5b - Staff effectiveness	C7, E1, E2, E3, E4, F2
5c - Barriers	F3, F4, F6, F7
5d - Roles	H1, H2, H3

Revised July 31, 1992

Unit Supervisor/Caseworker - Foster Care

This questionnaire form is to be completed by a foster care caseworker and supervisor in the child welfare agency who is responsible for foster care caseworkers. For purposes of this study, foster care caseworkers are responsible for monitoring the children in out-of-home placements, meeting the needs of foster care families, ensuring that children in placement get the services they need, and monitoring the progress of biological parents in meeting the court-ordered requirements for reunification.

Guidelines for completion of the form

If you supervise workers who provide ongoing treatment services to families whose children remain in the home as well as foster care services, please answer this questionnaire only with regard to the foster care caseload activities of the caseworkers you supervise.

Similarly if your caseload includes cases other than foster care caseload services, please answer this questionnaire only with regard to your foster care services activities.

Please restrict your responses to impressions that are directly based on your experience as a foster care supervisor or caseworker. Many of the questions require you to state opinions that are based on your own professional experience. In general you should answer these questions **only** if:

1) You have had direct contact with children and/or their families.

2) You have discussed cases or client situations with staff members.

3) You have access to records and/or databases containing pertinent information.

Otherwise, you should respond “don’t know”.

SECTION A: DEFINITIONS

As indicated in the cover letter, in this study we are interested in assessing the impact of family or youth alcohol and other drug (AOD) abuse problems on child welfare services. Although the term "AOD abuse problem" can be conceptualized in a variety of ways, we have defined this term in a way that we feel is meaningful for service delivery efforts. We would like you to keep the following definitions in mind while you are completing this questionnaire.

For the purposes of this study, AOD refers to alcohol and other drugs with the exception of nicotine, caffeine, and prescription drugs under a doctor's supervision.

AOD abuse problem refers to a level of drug use resulting in the user being unable to meet personal responsibilities, being unable to appropriately fulfill role requirements, and/or engaging in behaviors that are self-destructive or harmful to others.

A1 Does your agency/program define the term AOD abuse problem in a similar or different manner?

Similar ☐ Different c1 Do not have an agency definition ☐

A2 If you answered different, please describe how your agency defines a AOD abuse problem.

_____

_____

_____

_____

SECTION B: RESPONDENT INFORMATION

B1 Name: _____

B2 Contact telephone #(-____)_____ _____

B3 Job title: _____

B4 What are your primary responsibilities?_____

_____

_____

B5 How long have you been employed in this position? _____

B6 What was your previous position and how long were you employed in that position?

Position: _____

Length of time: _____

SECTION C: AOD ABUSE PROBLEM: Impact on Caseload

In this section we are concerned with how children and families with AOD abuse problems impact on caseworker activities. Please answer all questions based on your personal experience. For each question, please indicate your answer by putting an X in the appropriate box.

C1 What information do you use to determine whether there is a family AOD abuse problem?

	Very rarely	Rarely	Sometimes	Frequently	Very frequently
Report received from investigations/intake caseworker	☐	cl	cl	☐	☐
Discussions with child	☐	☐	☐	☐	☐
Discussions with family members	☐	cl	☐	☐	☐
Formal assessment instrument	☐	☐	☐	☐	☐
Discussions with other professionals who have had contact with the family/child	❑	❑	☐	☐	☐
Reports from law enforcement	☐	☐	☐	☐	☐
Reports from hospitals	☐	☐	☐	☐	☐
Reports from the court	☐	☐	☐	☐	☐
Case reports of prior agency contacts	☐	☐	☐	☐	☐
Observations of family members	☐	☐	❑	☐	☐
Observations of child	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐

C2 Do foster care cases involving families with AOD abuse problems require more of your (or your caseworker's) time than other foster care cases?

- ☐ Almost always require more time
- ☐ Frequently require more time
- ☐ Sometimes require more time
- ☐ Rarely require more time
- ☐ Don't know

C2a Does the type of drug being used make a difference?
Yes Cl No ☐ Don't know ☐

If yes, please explain.

_____

_____

_____

_____

C3 Do children from families with AOD abuse problems remain in foster care for longer periods of time than other children in foster care?

- ☐ Almost always remain in foster care for longer periods of time
- ☐ Frequently remain in foster care for longer periods of time
- ☐ Sometimes remain in foster care for longer periods of time
- ☐ Rarely remain in foster care for longer periods of time
- ☐ Don't know

C3a Does the type of drug being used make a difference?
Yes Cl No ☐ Don't know ☐

If yes, please explain.

_____

_____

_____

c4 Do children in foster care from families with AOD abuse problems have more service needs than other children in foster care?

- ☐ Almost always have more service needs
- ☐ Frequently have more service needs
- ☐ Sometimes have more service needs
- ☐ Rarely have more service needs
- ☐ Don't know

C4a Does the type of drug being used make a difference?
Yes ☐ No ☐ Don't know ☐

If yes, please explain.

_____

_____

_____

c5 What percent of your (or your caseworker's) caseload involve children from families with AOD abuse problems?
_____%
Reporting from data ☐ Estimating response ☐ Don't know Cl

C6 How has the percentage in C5 changed over the past 5 years?

- ☐ Increased substantially
- ☐ Increased moderately
- ☐ No change
- ☐ Decreased moderately
- ☐ Decreased substantially
- ☐ Don't know

Reporting from data ☐
Estimating response ☐

C7 What types of training do you feel would help you better serve children from families with AOD abuse problems?

Type of training	Training needed but not available	Training needed and available	Training not needed
Diffusing potentially violent family situations	☐	☐	☐
Basic drug and alcohol information (appearance, physiological effects, behaviors of those under the influence)	☐	☐	☐
Basic health information	☐	☐	☐
Street drug information (current street slang)	☐	☐	☐
Family/couples counseling	☐	☐	☐
Codependency information (family dynamics, roles, behaviors)	☐	☐	☐
Dealing with hostile family members	☐	☐	☐
Conducting interventions with individuals with AOD abuse problems	☐	☐	☐
Staff safety/self protection	☐	☐	☐
Supporting parents AOD treatment efforts	☐	☐	☐
Other (specify) _____	☐	☐	☐

SECTION D: AOD ABUSE PROBLEM: Characteristics of Clients

In this section we are interested in your perceptions of the characteristics of families with AOD abuse problems and how these families differ from other clients. Please answer all questions based on your personal experience in working with these clients.

D1 In comparison to families without AOD abuse problems, are families with AOD abuse problems who children entered foster care more likely, less likely, or equally likely to exhibit the following characteristics? Put an X in the appropriate box.

Family characteristics	More likely	Less likely	No difference	Don't know
To have AFDC as primary support	☐	☐	☐	☐
To have children age two or younger in the home	☐	☐	☐	☐
To have incomes below the poverty level	☐	☐	☐	☐
To be headed by a single parent/mother	☐	☐	☐	☐
To be headed by a single parent/father	☐	☐	☐	☐
To have a stepparent	☐	☐	☐	☐
To be headed by an adolescent parent(s)	☐	☐	☐	☐
To have non-family members living in the household	☐	☐	☐	☐
To be from an racial/ethnic minority group	☐	☐	☐	☐
To experience violence among family members	☐	☐	☐	☐
To experience chronic family conflict	☐	☐	☐	☐

Family characteristics	More likely	Less likely	No difference	Don't know
To have a parent who has been arrested	☐	☐	☐	☐
To have a child who has been arrested	☐	☐	☐	☐
To move frequently	☐	☐	☐	☐
To be homeless	☐	☐	☐	☐
To neglect a child	☐	☐	☐	☐
To abandon a child	☐	☐	☐	☐
To physically abuse a child	☐	☐	☐	☐
To sexually abuse a child	☐	☐	☐	☐
To emotionally abuse a child	☐	☐	☐	☐
To experience spouse abuse	☐	☐	☐	☐
To have a child who has a learning or developmental disability	☐	☐	☐	☐
To have a child who has emotional/psychological problems	☐	☐	☐	☐
To have family members who have attempted/committed suicide	☐	☐	☐	☐
To have a child who is shy and isolated from peers	☐	☐	☐	☐
To be reunited with their children after out-of-home placement	☐	☐	☐	☐
To have a child who was placed for adoption	☐	☐	☐	☐
Other (specify)_____	☐	☐	☐	
_____	☐	☐	☐	
_____	☐	☐	☐	

D2 Among the families you serve with AOD abuse problems whose children entered foster care, how many of your cases involve abuse of the following drugs?

	Most	Some	Few	None	Don't know
Alcohol	☐	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐	☐
Crack	☐	☐	☐	☐	☐
Opiates (heroin, methadone)	☐	☐	☐	☐	☐
Amphetamines (speed, ice)	☐	☐	☐	☐	☐
Sedatives (Valium, downers)	☐	☐	☐	☐	☐
Barbiturates	☐	☐	☐	☐	☐
Psychedelics (LSD, mushrooms, peyote)	☐	☐	☐	☐	☐
Inhalants (glue, gasoline)	☐	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐

D3 Among children in foster care from families that have AOD abuse **problems, which family member tends to exhibit the** AOD abuse problem?

	Very rarely	Rarely	Sometimes	Frequently	Very frequently
Mother/stepmother	☐	☐	cl	☐	cl
Father/stepfather	❑	☐	cl	☐	☐
Sibling	☐	☐	☐	☐	El
Both parents	cl	cl	☐	cl	☐
Non-related resident adult	☐	☐	El	cl	cl
Related resident adult	☐	cl	❑	☐	cl
Other (specify)_____	cl	☐	❑	❑	☐

SECTION E: SERVICE EFFECTIVENESS

This section focuses on your goals with respect to serving families with AOD abuse problems and how effective you feel you or your caseworkers are in attaining these goals. It is important to note that questions regarding effectiveness are not intended to obtain information critical of caseworker abilities but rather to identify areas where programs may need to make changes to help caseworkers meet goals. Please answer all questions based on your personal experience.

El Given that the primary goal of foster care caseworkers is to reunify children with their families, how important are other goals specific to families with AOD abuse problems?

	Very important	Moderately important	Somewhat important	Not important	Not a goal
To get AOD abuser to acknowledge AOD abuse problem	☐	cl	☐	☐	☐
To get AOD abuser to agree to seek treatment	cl	☐	☐	☐	☐
To enroll AOD abuser in a treatment program	cl	cl	cl	cl	☐
To enroll AOD abuser in counseling for problems related to AOD abuse	cl	☐	☐	☐	☐
To help family members cope with a child who has a AOD abuse problem	☐	☐	☐	☐	☐
To help child cope with a family member who has a AOD abuse problem	cl	☐	☐	☐	☐
Other goals (specify) _____	☐	☐	El	cl	☐
_____	☐	❑	cl	☐	☐

E2 How successful do you feel you (or your caseworkers) are in achieving the goals listed in El?

	Very successful	Moderately successful	Somewhat sllccessful	Not successful	Not a goal
To get AOD abuser to acknowledge AOD abuse problem	☐	☐	☐	☐	☐
To get AOD abuser to agree to seek treatment	❑	cl	cl	☐	☐
To enroll AOD abuser in a treatment agency	☐	❑	❑	cl	☐
To enroll AOD abuser in counseling for problems related to AOD abuse	☐	☐	☐	cl	☐
To help family members cope with a child who has a AOD abuse problem	☐	☐	☐	cl	☐
To help child cope with a family member who has a AOD abuse problem	cl	☐	❑	☐	☐
Other (specify) _____	cl	☐	cl	☐	☐

E3 For each goal that you answered that you (or your caseworkers) are only **somewhat successful or not successful of attaining, please explain why you feel this way.**

To get AOD abuser to acknowledge AOD abuse problem

To get AOD abuser to agree to seek treatment

To enroll AOD abuser in a treatment program

To enroll AOD abuser in counseling for problems related to AOD abuse

To help family members cope with a child who has a AOD abuse problem

To help child cope with a family member who has a AOD abuse problem

Other goals (as specified above)

E4 Please identify the strategies or staffing practices that you mink are important to improving your ability to serve children and **families** with AOD abuse problems.

	Very important	Somewhat important	Not important	Don't know
Build a stronger referral network among community agencies	❑	☐	☐	☐
Work with local AOD abuse treatment services to give priority to child welfare agency clients	❑	cl	cl	cl
Hire a consultant to help caseworkers work with families with AOD abuse problems	❑	☐	☐	❑
Develop a team approach to case management in working with families with AOD abuse problems	❑	cl	❑	❑
Reduce caseworker caseloads	❑	❑	☐	❑
Add new caseworker positions to deal with AOD abuse problems	❑	☐	☐	❑
Create staffiig teams/special unit to work with families with AOD abuse problems	☐	☐	cl	☐
Provide special AOD abuse-related training for staff	❑	☐	☐	☐
Provide funds for staff to attend AOD abuse-related workshops	❑	☐	☐	☐
Other (specify) _____	☐	☐	❑	☐

E5 Please identify the strategies or staffing changes that have been implemented over the past 5 years.

	Has been implemented	Has not be-en implemented	Was already in place
Build a stronger referral network among community agencies	❑	❑	☐
Work with local AOD abuse treatment services to give priority to child welfare agency clients	El	☐	☐
Hire a consultant to help caseworker work with families with AOD abuse problems	☐	☐	❑
Develop a team approach to case management in working with families with AOD abuse problems	cl	☐	❑
Reduce caseworker caseloads	cl	☐	❑
Add new caseworker positions to deal with AOD abuse problems	☐	cl	❑
Create staffing teams/special unit to work with families with AOD abuse problems	cl	cl	☐
Provide special AOD abuse-related training for staff	cl	☐	❑
Provide funds for staff to attend AOD abuse-related workshops	☐	cl	☐
Other (specify) _____	El	☐	☐

SECTION F: SERVICE NEEDS

In this section, we are interested in determining whether families with AOD abuse problems have service needs that are different or similar to the service needs of families without AOD abuse problems. Please answer all questions based on your personal experience.

F1 In comparison to families without AOD abuse problems, are families with AOD abuse problems more likely, less likely, or equally likely to require the following services?

Type of service	More likely	Less likely	No difference	Don't know
Food	☐	☐	☐	☐
Shelter for children/youth	☐	☐	☐	☐
Shelter for families	☐	☐	☐	☐
Physical examinations	☐	☐	☐	☐
Medical tests	☐	☐	☐	☐
Nutrition information	☐	☐	☐	☐
Out-of-home placement for youth	☐	☐	☐	☐
Independent living services	☐	☐	☐	☐
Parenting classes	☐	☐	☐	☐
Income maintenance services	☐	☐	☐	☐
Legal services	☐	☐	☐	☐
Child care services	☐	☐	☐	☐
Child development services	☐	☐	☐	☐
Support group for children/youth	☐	☐	☐	☐
Support group for parents	☐	☐	☐	☐
Home visits	☐	☐	☐	☐
Individual counseling for children/youth	☐	☐	☐	☐
Individual counseling for parents	☐	☐	☐	☐
Group counseling for children/youth	☐	☐	☐	☐
Group counseling for parents	☐	☐	☐	☐
Family counseling	☐	☐	☐	☐
Couples counseling	☐	☐	☐	☐
AOD abuse assessment	☐	☐	☐	☐
AOD abuse treatment	☐	☐	☐	☐
AOD abuse prevention services	☐	☐	☐	☐
GED classes for youth	☐	☐	☐	☐
GED classes for parents	☐	☐	☐	☐

Type of service	More likely	Less likely	No difference	Don't know
Education for children with special needs	❑	❑	❑	❑
Employment preparedness/training classes for youth	☐	❑	❑	❑
Employment preparedness/training classes for parents	❑	❑	❑	❑
Homemaker services	❑	☐	❑	❑
Respite care	☐	☐	❑	☐
Other (specify)_____	☐	❑	❑	

F2 Do you feel that you (or your caseworkers) are able to meet all of the service needs of children and families with AOD abuse problems?

- ☐ Almost always
- ❑ Most of the tune
- ☐ Some of the time
- cl Rarely
- ☐ Very rarely
- ☐ Don't know

F3 What kinds of barriers do you confront in serving children and families with AOD abuse problems?

	Severe problem	Moderate problem	Not a problem
Insufficient number of no-cost (accept medicaid) AOD abuse inpatient treatment programs for adults	☐	cl	❑
Insufficient number of no-cost (accept medicaid) AOD abuse inpatient treatment programs for adolescents	☐	☐	☐
Insufficient number of no-cost AOD abuse outpatient treatment programs	☐	☐	☐
Insufficient number of treatment programs that accept pregnant women	☐	☐	☐
Insufficient number of inpatient treatment programs that accept women	☐	☐	☐
Insufficient number of detoxification services	☐	☐	☐
Insufficient family support services in the community	☐	☐	☐
Insufficient respite care facilities	☐	☐	☐
Insufficient transportation for clients to access services	☐	☐	☐
Insufficient low cost housing for families	☐	☐	☐
Lack of formalized interagency cooperation	☐	☐	☐
Lack of information about relevant resources in the community	☐	☐	☐
Parents fear of losing their children	☐	☐	☐
Negative attitudes of program staff toward individuals with AOD abuse problems	☐	☐	☐
Insufficient number of foster families willing to take children who were exposed to alcohol or other drugs in utero	☐	☐	☐
Resistance of parents to accept services	☐	☐	☐
Other (specify) _____	☐	☐	☐

F4 For each barrier that is a problem, please indicate how it might be addressed.

F5 Compared with 5 years ago, how do you feel the abuse of specific drugs among your client population has changed?

	Increased	Decreased	No change	Don't know
Alcohol	☐	cl	☐	☐
Cocaine	☐	☐	☐	☐
Crack	☐	cl	cl	cl
Opiate-s (heroin, methadone)	☐	☐	❑	❑
Amphetamines (speed, ice)	☐	☐	☐	☐
Sedatives (valium, downers)	cl	5	☐	☐
Barbiturates	☐	☐	☐	☐
Psychedelics (LSD, mushrooms, peyote)	❑	cl	☐	☐
Inhalants (glue, gasoline)	☐	cl	☐	❑
Marijuana	cl	☐	☐	☐
Other (specify) _____	☐	☐	☐	❑

F6 Does the type of drug being abused affect the difficulty you (or your caseworkers) experience in working with families?
Yes ☐ No ☐ Don't know ☐

F7 If yes, please identify which type of AOD abuse is most difficult to work with and why.

SECTION G: AOD ABUSE PROBLEM: Impact on Foster Care Family Recruitment and Retention

In this section we are interested in determining whether serving children and families with AOD abuse problems has had an impact on recruitment or retention of foster care families.

G1 How has recruitment of foster care families changed over the past 5 years?

- ❑ Become substantially more difficult to recruit
- ☐ Become somewhat more difficult to recruit
- ☐ Not changed
- ☐ Become somewhat less difficult to recruit
- ☐ Become substantially less difficult to recruit
- ☐ Don't know

Reporting from data ☐
Estimating response ☐

G2 If it has become more difficult, to what would you attribute the increased difficulty?

- ☐ In small part to increases in the number of children from families with AOD abuse problems
- ❑ In some part to increases in the number of children from families with AOD abuse problems
- ☐ In large part to increases in the number of children from families with AOD abuse problems
- ☐ Largely to factors other than increase in the number of children from families with AOD abuse problems
- Cl Don't know

G3 How has the retention of foster care families changed over the past 5 years?

- ☐ Become substantially more difficult
- ☐ Become somewhat more difficult
- ☐ Not changed
- ☐ Become somewhat less difficult
- ☐ Become substantially less difficult
- ☐ Don't know

Reporting from dam ☐
Estimating response ☐

G4 If it has become more difficult, to what would you attribute the increased difficulty?

- ☐ In small part to increases in the number of children from families with AOD abuse problems
- ☐ In some part to increases in the number of children from families with AOD abuse problems
- ☐ In large part to increases in the number of children from families with AOD abuse problems
- ☐ Largely to factors other than increase in the number of children from families with AOD abuse problems
- ❑ Don't know

SECTION H: GENERAL PERSPECTIVES

In this last section of the questionnaire, we are interested in determining how you view the problem of family AOD abuse in the context of other family problems that foster care caseworkers must contend with. Please answer all questions based on youe personal experience.

H1 Do you feel that your agency has a role in combatting AOD abuse?
Yes ☐ No ☐ Don't know ☐

H2 If you answered yes to the above question, please describe how you see your agency's role. If you answered no, please explain why you feel your agency does not have a role.

_____

_____

_____

H3 Overall, given the many problems that clients served by your agency are facing, how important do you feel it is for your agency to confront the problem of family AOD abuse?

Number one priority of agency	☐
Extremely important	☐
Moderately important	☐
Slightly important	☐
Not important	cl
Don't know	cl

Unit Supervisor/Caseworker - Intake/Investigation

RESEARCH QUESTION	ITEM(S)
1a - Concept of AOD abuse	A1, A2
lb - State and local statutes	C7 thru C13
1c - Service costs	C2, C3, C4
1d - Change in services/demand for services	C2, C3, C4, C5, C6, E5
2a - Number of clients with AOD abuse problems/change	C5, C6
2b - Characteristics	D1, D2, D3, F5
3a - Foster Care	NA
3b - Adoption	NA
4a - Goals/effectiveness	E1, E2, E3
4b - Staffmg	C14, E2, E3, E4, E5
4c - Juvenile court and hospital social workers perspectives	NA
5a - Client needs	F1, F2
5b - Staff effectiveness	C14, E1, E2, E3, E4, F2
5c - Barriers	F3, F4, F6, F7
5d - Roles	G1, G2, G3

Revised: July 31, 1992

Unit Supervisor/Caseworker - Intake/Investigations

This questionnaire form is to be completed by an intake/investigations caseworker and a supervisor in the child welfare agency who is responsible for intake or investigations caseworkers. For purposes of this study, intake/investigations caseworkers are responsible for investigating child maltreatment reports, conducting risk assessments, and determining whether the child is to be maintained in the home or placed in out-of-home substitute care.

Guidelines for completion of the form

If you supervise workers who provide other types of services as well as conduct intakes or investigations, please answer this questionnaire only with regard to the intakes or investigations activities of the caseworkers you supervise.

Similarly if your caseload includes cases other than intakes or investigations services cases, please answer this questionnaire only with regard to your intake and investigations activities.

Please restrict your responses to impressions that are directly based on your experience as an intake/investigations supervisor or caseworker. Many of the questions require you to state opinions that are based on your own professional experience. In general you should answer these questions **only** if:

1) You have had direct contact with children and/or their families.

2) You have discussed cases or client situations with staff members.

3) You have access to records and/or databases containing pertinent information.

Otherwise, you should respond “don’t know”.

SECTION A: DEFINITIONS

As indicated in the cover letter, in this study we are interested in assessing the impact of family or youth alcohol and other drug (AOD) abuse problems on child welfare services. Although the term "AOD abuse problem" can be conceptualized in a variety of ways, we have defined this term in a way that we feel is meaningful for service delivery efforts. We would like you to keep the following definitions in mind while you are completing this questionnaire.

For the purposes of this study, AOD refers to alcohol and other drugs with the exception of nicotine, caffeine, and prescription drugs under a doctor's supervision.

AOD abuse problem refers to a level of AOD use resulting in the user being unable to meet personal responsibilities, being unable to appropriately fulfill role requirements, and/or engaging in behaviors that are self-destructive or harmful to others.

A1 Does your agency/program define the term AOD abuse problem in a similar or different manner?

Similar ☐ Different ☐ Do not have an agency definition ☐

A2 If you answered different, please describe how your agency defines an AOD abuse problem.

_____

_____

_____

_____

SECTION B: RESPONDENT INFORMATION

B1 Name: _____

B2 Contact telephone # (-____)_____ _____

B3 Job title: _____

B4 What are your primary responsibilities?_____

_____

_____

B5 How long have you been employed in this position? _____

B6 What was your previous position and how long were you employed in that position?

Position: _____

Length of time: _____

SECTION C: AOD ABUSE PROBLEM: Impact on Caseload

In this section we are concerned with how children and families with AOD abuse problems impact on caseworker activities. Please answer all questions based on your personal experience. For each question, indicate your answer by putting an X in the appropriate box.

Cl What information do you use to determine whether there is a family AOD abuse problem?

	Very rarely	Rarely	Sometimes	Frequently	Very frequently
Discussions with mandated reporter	cl	☐	☐	☐	☐
Discussions with child	☐	☐	☐	☐	cl
Discussions with family members	☐	☐	☐	El	El
Formal assessment instrument	☐	☐	☐	☐	☐
Reports from law enforcement	☐	☐	☐	☐	cl
Reports from hospitals	☐	☐	☐	☐	cl
Reports from the court	☐	☐	☐	☐	☐
Case reports of prior agency contacts	☐	☐	☐	☐	☐
Observations of family members	☐	☐	❑	☐	cl
Observations of child	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐

c2 Do intake/investigations involving children from families with AOD abuse problems require more of your (or your caseworker's) time than other cases?

☐ Almost always require more caseworker time
☐ Frequently require more caseworker time
☐ Sometimes require more caseworker time
☐ Rarely require more caseworker time
El Don't know

C2a Does the type of drug being used make a difference?
Yes ☐ No ☐ Don't know ❑

If yes, please explain.

_____

_____

_____

_____

c3 Do intake/investigations involving families with AOD abuse problems require a different kind of investigations process than other cases?

- ❑ Almost always require a different kind of investigations process
- ❑ Frequently require a different kind of investigations process
- ❑ Sometimes require a different kind of investigations process
- ☐ Rarely require a different kind of investigations process
- ❑ Don't know

C3a Does the type of drug being used make a difference?
Yes ❑ No ❑ Don't know ☐

If yes, please explain.

_____

_____

_____

_____

c4 If they do require a different kind of investigations process, please describe how it differs.

_____

_____

C5 What percent of your (or your caseworker's) caseload are children from families with AOD abuse problems? _____%
Reporting from data ☐ Estimating response Cl Don't know Cl

C6 How has the percentage in C5 changed over the past 5 years?

- ☐ Increased substantially
- ☐ Increased moderately
- ☐ No change
- ☐ Decreased moderately
- ☐ Decreased substantially
- ☐ Don't know

Reporting from data ☐
Estimating response ☐

c7 If you receive a report of a pregnant woman who is known to have a AOD abuse problem, is the agency required to conduct an investigation?
Yes Cl No ☐ Don't know ☐

C8 If your agency receives a report of a mother who is known to have a AOD abuse problem and who is leaving the hospital with her newborn infant, is the agency required to conduct an investigation?
Yes ☐ No ❑ Don't know El

C9 Under State and local regulations, which of the following infants are required to be reported? (Check all that apply)

- ☐ Fetal Alcohol Syndrome
- ☐ Infants exposed to AOD prenatally
- cl Infants born addicted to AOD
- cl Abandoned infants
- ☐ Other (specify)_____

C10 Is infant in utero AOD exposure considered sufficient cause for removal of the infant after birth?
Yes ☐ No ☐ Don't know ☐

C11 Do you think that reporting requirements have been a barrier to serving children and families with AOD abuse problems?
Yes ☐ No ☐ Don't know ☐

C12 If you answered yes to the above question, please explain why you feel reporting requirements have been a barrier to serving children and families with AOD abuse problems

C13 If you do not investigate reports of parental AOD abuse or reports of AOD abuse by pregnant women, do you refer these cases to other community service or legal agencies?
Yes ☐ No ☐ Not applicable ☐

If yes, to what agencies?

Do you do any followup on these referrals? Yes ☐ No ☐ Sometimes ☐ (explain circumstances)

C14 What types of training do you feel would help you better serve children from families with AOD abuse problems?

Type of training	Training needed but not available	Training needed and available	Training not needed
Diffusing potentially violent family situations	☐	cl	cl
Basic drug and alcohol information (appearance, physiological effects, behaviors of those under the influence)	cl	cl	cl
Basic health information	cl	cl	☐
Street drug information (current street slang)	☐	cl	☐
Family/couples counseling	☐	☐	cl
Codependency information (family dynamics, roles, behaviors)	cl	☐	☐
Dealing with hostile family members	☐	☐	cl
Conducting interventions with individuals with AOD abuse problems	☐	cl	cl
Staff safety/self protection	El	☐	☐
AOD prevention	☐	☐	❑
Conducting AOD assessments	☐	☐	☐
Other (specify) _____	❑	cl	☐

SECTION D: AOD ABUSE PROBLEM: Characteristics of Clients

In this section we are interested in your perceptions of the characteristics of families with AOD abuse problems and how these families differ from other clients. Please answer all questions based on your personal experience in working with these clients.

D1 In comparison to families without AOD abuse problems, are families with AOD abuse problems more likely, less likely, or equally likely to exhibit the following characteristics? Put an X in the appropriate box.

Family characteristics	More likely	Less likely	No difference	Don't know
To have AFDC as primary support	☐	☐	☐	☐
To have children age two or younger in the home	☐	☐	☐	☐
To have incomes below the poverty level	☐	☐	☐	☐
To be headed by a single parent/mother	☐	☐	☐	☐
To be headed by a single parent/father	☐	☐	☐	☐
To have a stepparent	☐	☐	☐	☐
To be heeded by an adolescent parent(s)	☐	☐	☐	☐
To have non-family members living in the household	☐	☐	☐	☐
To be from an racial/ethnic minority group	☐	☐	☐	☐
To experience violence among family members	☐	☐	☐	☐
To experience chronic family conflict	☐	☐	☐	☐
To have a parent who has been arrested	☐	☐	☐	☐
To have a child who has been arrested	☐	☐	☐	☐
To move frequently	☐	☐	☐	☐
To be homeless	☐	☐	☐	☐
To neglect a child	☐	☐	☐	☐
To abandon a child	☐	☐	☐	☐
To physically abuse a child	☐	☐	☐	☐
To sexually abuse a child	☐	☐	☐	☐
To emotionally abuse a child	☐	☐	☐	☐
To experience spouse abuse	☐	☐	☐	☐
To have a child who has a learning or developmental disability	☐	☐	☐	☐
To have a child who has emotional/psychological problems	☐	☐	☐	☐
To have family members who have attempted/committed suicide	☐	☐	☐	☐
To have a child who is shy and isolated from peers	☐	☐	☐	☐

Family characteristics	More likely	Less likely	No difference	Don't know
To be reunited with their children after out-of-home placement	☐	☐	☐	☐
To have a child who was placed for adoption	☐	☐	☐	☐
Other (specify)_____	☐	☐	☐	
_____	☐	☐	☐	
_____	☐	☐	☐	

D2 Among substantiated maltreatment cases involving family AOD abuse problems, how many of your cases involve abuse of the following drugs?

	Most	Some	Few	None	Don't know
Alcohol	☐	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐	☐
Crack	☐	☐	☐	☐	☐
Opiates (heroin, methadone)	☐	☐	☐	☐	☐
Amphetamines (speed, ice)	☐	☐	☐	☐	☐
Sedatives (valium, downers)	☐	☐	☐	☐	☐
Barbiturates	☐	☐	☐	☐	☐
Psychedelics (LSD, mushrooms, peyote)	☐	☐	☐	☐	☐
Inhalants (glue, gasoline)	☐	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐

D3 Among substantiated maltreatment cases involving family AOD abuse problems, which family member exhibits a AOD abuse problem?

	Very rarely	Rarely	Sometimes	Frequently	Very frequently
Mother/stepmother	☐	☐	☐	☐	☐
Father/stepfather	☐	☐	☐	☐	☐
Sibling	☐	☐	☐	☐	☐
Both parents	☐	☐	☐	☐	☐
Non-related resident adult	☐	☐	☐	☐	☐
Related resident adult	☐	☐	☐	☐	☐
Other (specify)_____	☐	☐	☐	☐	☐

SECTION E: SERVICE EFFECTIVENESS

This section focuses on your goals with respect to serving families with AOD abuse problems and how effective you feel you or your caseworkers are in attaining these goals. It is important to note that questions regarding effectiveness are not intended to obtain information critical of caseworker abilities but rather to identify areas where programs may need to make changes to help caseworkers meet goals. Please answer all questions based on your personal experience.

El Given that the primary goal of intake/investigations caseworkers is to ensure the safety of the child, how important are other goals specific to families with AOD abuse problems?

	Very important	Moderately important	**Somewhat** important	**Not** important	**Not a goal**
To get AOD abuser to acknowledge his/her abuse problem	❑	❑	cl	cl	**cl**
To ensure that someone else in the family is in the home when the AOD abuser is present	❑	❑	❑	❑	❑
To get AOD abuser to agree to seek treatment	❑	❑	❑	❑	❑
To enroll AOD abuser in a treatment program	❑	❑	❑	❑	0
To enroll AOD abuser in counseling for problems related to AOD abuse	❑	❑	❑	❑	❑
To help family members cope with a child who has a AOD abuse problem	❑	❑	❑	❑	❑
To help child cope with a family member who has a AOD abuse problem	❑	❑	❑	❑	❑
Other goals (specify) _____	❑	❑	❑	❑	❑
_____	❑	❑	❑	❑	❑

E2 How successful do you feel you (or your caseworkers') are in achieving the goals listed in El?

	Very successful	**Moderately successful**	**Somewhat successful**	**Not successful**	**Not a goal**
To get AOD abuser to acknowledge his/her AOD abuse problem	❑	❑	❑	❑	❑
To ensure that someone else in the family is in the home when the abuser is present	❑	❑	❑	❑	❑
To get AOD abuser to agree to seek treatment	❑	❑	❑	❑	❑
To enroll AOD abuser in a treatment program	❑	❑	❑	❑	❑
To enroll AOD abuser in counseling for problems related to AOD abuse	❑	❑	❑	❑	❑
To help family members cope with a child who has a AOD abuse problem	❑	❑	❑	❑	❑
To help child cope with a family member who has a AOD abuse problem	❑	❑	❑	❑	❑
Other (specify) _____	❑	❑	❑	❑	❑

E3 For each goal that you answered that ongoing treatment caseworkers are only somewhat successful or **not successful in** attaining, please explain why you feel this way.

To get AOD abuser to acknowledge AOD abuse problem

To ensure that someone else in the family is in the home with the child when the AOD abuser is present

To get AOD abuser to agree to seek treatment

To enroll AOD abuser in a treatment program

To enroll AOD abuser in counseling for problems related to AOD abuse

To help family members cope with a child who has a AOD abuse problem

To help child cope with a family member who has a AOD abuse problem

Other goals (as specified above)

E4 Please identify the strategies or staffing practices that you think are important to improving your ability to serve children and families with AOD abuse problems.-

*	Very important	Somewhat important	Not important	Don't know
Build a stronger referral network among community agencies	☐	cl	☐	0
Work with local AOD abuse treatment services to give priority to child welfare agency clients	☐	cl	☐	0
Hire a consultant to help caseworkers work with families with AOD abuse problems	❑	☐	☐	0
Develop a team approach to case management in working with families with AOD abuse problems	☐	cl	☐	0
Reduce caseworker caseloads	☐	☐	☐	☐
Add new caseworker positions to deal with AOD abuse problems	❑	☐	cl	☐
Create staffing teams/special unit to work with families with AOD abuse problems	☐	☐	cl	☐
Provide special AOD abuse-related training for staff	☐	El	☐	☐
Provide funds for staff to attend AOD abuse-related workshops	☐	❑	☐	0
Other (specify) _____	☐	☐	☐	cl

E5 Please identify the strategies or staffing changes that have been implemented over the past 5 years.

	Has been implemented	Has not been implemented	Was already in place
Build a stronger referral network among community agencies	☐	☐	cl
Work with local AOD abuse treatment services to give priority to child welfare agency clients	☐	☐	☐
Hire a consultant to help caseworker work with families with AOD abuse problems	☐	☐	☐
Develop a team approach to case management in working with families with AOD abuse problems	☐	☐	☐
Reduce caseworker caseloads	☐	❑	☐
Add new caseworker positions to deal with AOD abuse problems	❑	❑	☐
Create staffing teams/special unit to work with families with AOD abuse problems	❑	☐	El
Provide special AOD abuse-related training for staff	☐	☐	cl
Provide funds for staff to attend AOD abuse-related workshops	☐	☐	cl
Other (specify) _____	☐	❑	☐

SECTION F: SERVICE NEEDS

In this section, we are interested in determining whether families with AOD abuse problems have service needs that are different or similar to the service needs of families without AOD abuse problems. Please answer all questions based on your personal experience.

F1 In comparison to families **without** AOD abuse problems, are families with AOD abuse problems more likely, less likely, or equally likely to require the following services?

Type of service	More likely	Less likely	No difference	Don't know
Food	☐	☐	☐	☐
Shelter for children/youth	☐	☐	☐	☐
Shelter for families	☐	☐	☐	☐
Physical examinations	☐	☐	☐	☐
Medical tests	☐	☐	☐	☐
Nutrition information	☐	☐	☐	☐
Out-of-home placement for youth	☐	☐	☐	☐
Independent living services	☐	☐	☐	☐
Parenting classes	☐	☐	☐	☐
Income maintenance services	☐	☐	☐	☐
Legal services	☐	☐	☐	☐
Child care services	☐	☐	☐	☐
Child development services	☐	☐	☐	☐
Support group for children/youth	☐	☐	☐	☐
Support group for parents	☐	☐	☐	☐
Home visits	☐	☐	☐	☐
Individual counseling for children/youth	☐	☐	☐	☐
Individual counseling for parents	☐	☐	☐	☐
Group counseling for children/youth	☐	☐	☐	☐
Group counseling for parents	☐	☐	☐	☐
Family counseling	☐	☐	☐	☐
Couples counseling	☐	☐	☐	☐
AOD abuse assessment	☐	☐	☐	☐
AOD abuse treatment	☐	☐	☐	☐
AOD abuse prevention services	☐	☐	☐	☐
GED classes for youth	☐	☐	☐	☐
GED classes for parents	☐	☐	☐	☐

Type of Service	More likely	Less likely	No difference	Don't know
Education for children with special needs	☐	☐	☐	☐
Employment preparedness/training classes for youth	☐	☐	☐	☐
Employment preparedness/training classes for parents	☐	☐	☐	☐
Homemaker services	☐	☐	☐	☐
Respite care	☐	☐	☐	☐
Other (specify)_____	☐	☐	☐	

F2 Do you feel that you (or your caseworkers) are able to meet all of the needs of children and families with AOD abuse problems?

El Almost always
☐ Most of the time
☐ Some of the time
☐ Rarely
Cl Very rarely
☐ Don't know

F3 What kinds of barriers do you confront in serving children and families with AOD abuse problems?

	Severe problem	Moderate problem	Not a problem
Insufficient number of no-cost (accept medicaid) AOD abuse inpatient treatment programs for adults	☐	cl	☐
Insufficient number of no-cost (accept medicaid) AOD abuse inpatient treatment programs for adolescents	☐	☐	☐
Insufficient number of no-cost AOD abuse outpatient treatment programs	☐	☐	☐
Insufficient number of treatment programs that accept pregnant women	☐	☐	☐
Insufficient number of inpatient treatment programs that accept women	☐	☐	☐
Insufficient number of detoxification services	☐	☐	☐
Insufficient family support services in the community	☐	☐	☐
Insufficient respite care facilities	☐	☐	☐
Insufficient transportation for clients to access services	☐	☐	☐
Insufficient low cost housing for families	☐	☐	☐
Lack of formalized interagency cooperation	☐	☐	☐
Lack of information about relevant resources in the community	☐	☐	☐
Parents fear of losing their children	☐	☐	☐
Negative attitudes of program staff toward individuals with AOD abuse problems	☐	☐	☐
Insufficient number of foster families willing to take children who were exposed to alcohol or other drugs in utero	☐	☐	☐
Resistance of parents to accept services	☐	☐	☐
Other (specify) _____	☐	☐	☐

F4 For each barrier that is a problem, please indicate how it might be addressed_

F5 Compared with 5 years ago, how do you feel the abuse of specific drugs among your client population has changed?

	Increased	Decreased	No change	Don't know
Alcohol	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐
Crack	☐	☐	☐	☐
Opiates (heroin, methadone)	☐	☐	☐	☐
Amphetamines (speed, ice)	☐	☐	☐	☐
Sedatives (valium, downers)	☐	☐	☐	☐
Barbiturates	☐	☐	☐	☐
Psychedelics (LSD, mushrooms, peyote)	☐	☐	☐	☐
Inhalants (glue, gasoline)	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐
Other (specify) _____	c l	☐	☐	☐

F6 Does the type of drug being abused affect the difficulty you (or your caseworkers) experience in working with families?
Yes ☐ No ☐ Don't know ☐

F7 If yes, please identify which type of AOD abuse is most difficult to work with and why.

SECTION G: GENERAL PERSPECTIVES

In this last section of the questionnaire, we are interested in determining how you view the problem of family AOD abuse in the context of other family problems that intake/investigations caseworkers must contend with. Please answer all questions based on your personal experience.

G1 Do you feel that your agency has a role in combatting AOD abuse?
Yes •J No ❑ Don't know ☐

G2 If you answered yes to the above question, please describe how you see your agency's role. If you answered no, please explain why you feel your agency does not have a role.

_____

_____

_____

G3 Overall, given the many problems that clients served by your agency are facing, how important do you feel it is for your agency to confront the problem of family AOD abuse?

Number one priority of agency ☐
Extremely important ☐
Moderately important ☐
Slightly important ☐
Not important cl
Don't know ☐

Unit Supervisor/Caseworker - Ongoing Treatment

RESEARCH QUESTION	ITEM(S)
1a - Concept of AOD abuse	A1, A2
1b - State and local statutes	NA
1c - Service costs	C2, C3
1d - Change in services/demand for services	C2, C3, C4, C5, E5
2a - Number of clients with AOD abuse problems/change	C4, C5
2b - Characteristics	D1, D2, D3, F5
3a - Foster Care	NA
3b - Adoption	NA
4a - Goals/effectiveness	E1, E2, E3
4b - Staffing	C6, E2, E3, E4, E5
4c - Juvenile court and hospital social workers perspectives	NA
5a - Client needs	F1, F2
5b - Staff effectiveness	C6, E1, E2, E3, E4, F2
5c - Barriers	F3, F4, F6, F7
5d - Roles	G1, G2, G3

C6 How capable do you feel the local child welfare agency is in meeting the needs of youth with AOD abuse problems (I.E. do they have adequate staff, do they have sufficient resources, etc.)?

- ❑ Very capable
- ❑ Somewhat capable
- ❑ Somewhat incapable
- ❑ Very incapable
- ❑ Don't know

c7 What do you feel are the barriers that child welfare agencies confront in attempting to serve families with AOD abuse problems?

	Major barrier	Moderate barrier	Slight barrier	Not a barrier	Don't know
Insufficient training of staff in working with families with AOD abuse problems	❑	cl	cl	☐	☐
Lack of funds for child welfare agencies to provide needed services	❑	☐	☐	☐	cl
Insufficient low cost or no-cost inpatient AOD abuse treatment facilities	❑	☐	☐	☐	☐
Insufficient low cost or no-cost outpatient AOD abuse treatment facilities	❑	☐	☐	☐	☐
Resistance of families to receive services	❑	☐	☐	☐	❑
Resistance of family members to acknowledge AOD abuse problem	❑	☐	☐	☐	☐
Insufficient transportation for family members to access services	❑	☐	☐	☐	cl
Insufficient homebased services	☐	☐	☐	☐	cl
Insufficient high quality placements for children	❑	☐	☐	☐	☐
Lack of effective interagency relationships	❑	☐	☐	☐	☐
Other (specify) _____	❑	☐	☐	☐	cl
_____	❑	☐	☐	☐	❑
_____	☐	☐	☐	☐	☐

Revised July 3 1, 1992

Unit Supervisor/Caseworker - Ongoing Treatment/In Home Services

This questionnaire form is to be completed by an ongoing treatment caseworker and a supervisor in the child welfare agency who is responsible for ongoing treatment caseworkers. For purposes of this study, ongoing treatment caseworkers are responsible for providing services to the families of children who remain in their homes and ensuring compliance with court ordered requirements for children to remain at home.

Guidelines for completion of the form

If you supervise workers who provide foster care services or conduct investigations as well as providing ongoing treatment services, please answer this questionnaire only with regard to the ongoing treatment activities of the caseworkers you supervise.

Similarly if your caseload includes cases other than ongoing services cases, please answer this questionnaire only with regard to your ongoing services activities.

Please **restict** your responses to impressions that are directly based on your experience as an ongoing treatment/in-home services supervisor or caseworker. Many of the questions require you to state opinions that are based on your own professional experience. In general you should answer these questions **only if:**

1) You have had direct contact with children and/or their families.

2) You have discussed cases or client situations with staff members.

3) You have access to records and/or databases containing pertinent information.

Otherwise, you should respond “don’t know”.

SECTION A: DEFINITIONS

As indicated in the cover letter, in this study we are interested in assessing the impact of family or youth alcohol and other drug (AOD) abuse problems on child welfare services. Although the term "AOD abuse problem" can be conceptualized in a variety of ways, we have defined this term in a way that we feel is meaningful for service delivery efforts. We would like you to keep the following definitions in mind while you are completing this questionnaire.

For the purposes of this study, AOD refers to alcohol and other drugs with the exception of nicotine, caffeine, and prescription drugs under a doctor's supervision.

AOD **abuse problem** refers to a level of drug use resulting in the user being unable to meet personal responsibilities, being unable to appropriately fulfill role requirements, and/or engaging in behaviors that are self-destructive or harmful to others.

A1 Does your agency/program define the **term AOD abuse problem in** a similar or different manner?

Similar ☐ Different cl Do not have an agency definition ☐

A2 If you answered **different,** please describe how your agency defines a AOD abuse problem.

_____

_____

_____

_____

SECTION B: RESPONDENT INFORMATION

B1 Name: _____

B2 Contact telephone # (____) _____ _____

B3 Job title: _____

B4 What are your primary responsibilities? _____

_____

_____

B5 How long have you been employed in this position? _____

B6 What was your previous position and how long were you employed in that position?

Position: _____

Length of time: _____

SECTION C: AOD ABUSE PROBLEM: **Impact on Caseload**

In this section we are concerned with how children and families with AOD abuse problems impact on caseworker activities. Please answer all questions based on your personal experience. For each question, please indicate your answer by putting an X in the appropriate box.

Cl What information do you use to determine **whether there** is a family AOD abuse problem?

	Very rarely	**Rarely**	**Sometimes**	**Frequently**	**Very frequently**
Report received from investigations/intake caseworker	cl	☐	cl	☐	☐
Discussions with child	☐	☐	cl	☐	☐
Discussions with family members	☐	☐	☐	☐	☐
Formal assessment instrument	☐	☐	☐	☐	☐
Reports from law enforcement	☐	☐	☐	☐	☐
Reports from hospitals	☐	☐	☐	☐	☐
Reports from the court	☐	☐	☐	☐	☐
Case reports of prior agency contacts	☐	☐	☐	☐	☐
Observations of family members	☐	☐	☐	☐	☐
Observations of child	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐

c2 Do ongoing services cases involving families with AOD abuse problems require more of your (or your caseworker's) time than other cases?

☐ Almost always require more caseworker time
☐ Frequently require more caseworker time
☐ Sometimes require more caseworker time
☐ Rarely require more caseworker time
☐ Don't know

C2a Does the type of drug being used by the family make a difference?
Yes Cl No ☐ Don't know Cl

If yes, please explain.

_____

_____

_____

_____

c3 Do ongoing services cases involving families with AOD abuse problems require services for a longer period of time than other cases?

- ☐ Almost always require services for a longer period of time
- ☐ Frequently require services for a longer period of time
- ☐ Sometimes require services for a longer period of time
- ☐ Rarely require services for a longer period of time
- ☐ Don't know

C3a Does the type of drug being used by the family make a difference?
Yes ☐ No ☐ Don't know ☐
If yes, please explain.

_____

_____

_____

c4 What percent of your (or your caseworker's) caseload are cbildren from families with AOD abuse problems? _____%
Reporting from data ☐ Estimating response ☐ Don't know ☐

C5 How has the percentage in C4 changed over the past 5 years?

- ☐ Increased substantially
- Cl Increased moderately
- ☐ No change
- ☐ Decreased moderately
- ☐ Decreased substantially
- ☐ Don't know

Reporting from data ☐
Estimating response Cl

C6 What types of training do you feel would help you better serve children from families with AOD abuse problems?

Type of training	Training needed but not available	Training needed and available	Training not needed
Diffusing potentially violent family situations	cl	☐	☐
Basic drug and alcohol information (appearance, physiological effects, behaviors of those under the influence)	☐	cl	☐
Basic health information	cl	cl	☐
Street drug information (current street slang)	cl	cl	☐
Family/couples counseling	cl	☐	cl
Codependency information (family dynamics, roles, behaviors)	☐	☐	cl
Dealing with hostile family members	cl	☐	cl
Conducting interventions with individuals with AOD abuse problems	☐	☐	☐
Staff safety/self protection	☐	☐	☐
AOD prevention	El	El	☐
Conducting AOD assessments	☐	cl	☐
Other (specify) _____	☐	☐	☐

SECTION D: AOD ABUSE PROBLEM: Characteristics of Clients

In this section we are interested in your perceptions of the characteristics of families with AOD abuse problems and how these families differ from other clients. Please answer all questions based on your personal experience in working with these clients.

D1 In comparison to families without AOD abuse problems, are families with AOD abuse problems more likely, less likely, or equally likely to exhibit the following characteristics? Put an X in the appropriate box.

Family characteristics	More likely	Less likely	No difference	Don't know
To have AFDC as primary support	☐	☐	☐	☐
To have children age two or younger in the home	☐	☐	☐	☐
To have incomes below the poverty level	☐	☐	☐	☐
To be headed by a single parent/mother	☐	☐	☐	☐
To be headed by a single parent/father	☐	☐	☐	☐
To have a stepparent	☐	☐	☐	☐
To be headed by an adolescent parent(s)	cl	☐	☐	☐
To have non-family members living in the household	☐	☐	☐	☐
To be from an racial/ethnic minority group	cl	☐	☐	☐
To experience violence among family members	cl	☐	☐	☐
To experience chronic family conflict	cl	☐	☐	☐
To have a parent who has been arrested	cl	☐	☐	☐
To have a child who has been arrested	☐	☐	☐	☐
To move frequently	cl	☐	☐	☐
To be homeless	☐	☐	☐	☐
To neglect a child	cl	☐	☐	☐
To abandon a child	☐	☐	☐	☐
To physically abuse a child	☐	☐	☐	☐
To sexually abuse a child	☐	☐	☐	☐
To emotionally abuse a child	☐	☐	☐	☐
To experience spouse abuse	cl	☐	☐	☐
To have a child who has a learning or developmental disability	☐	☐	☐	☐
To have a child who has emotional/psychological problems	☐	☐	☐	☐
To have family members who have attempted/committed suicide	☐	☐	☐	☐
To have a family member who has been the victim of a violent crime	☐	☐	☐	☐

Family charcteristics	More likely	Less likely	No difference	Don't know
To have a child who is shy and isolated from peers	☐	☐	☐	☐
To be reunited with their children after out-of-home placement	☐	☐	☐	☐
To have a child who was placed for adoption	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	
_____	☐	☐	☐	
_____	☐	☐	☐	

D2 Among the families you serve with AOD abuse problems, how many of your cases involve abuse of the following drugs?

	Most	Some	Few	None	Don't know
Alcohol	cl	El	☐	☐	☐
Cocaine	☐	☐	☐	☐	☐
Crack	☐	☐	☐	☐	cl
Opiates (heroin, methadone)	El	☐	☐	☐	☐
Amphetamines (speed, ice)	☐	☐	☐	☐	☐
Sedatives (valium, downers)	☐	☐	☐	☐	☐
Barbiturates	☐	El	☐	☐	cl
Psychedelics (LSD, mushrooms, peyote)	cl	☐	☐	☐	cl
Inhalants (glue, gasoline)	cl	☐	☐	☐	cl
Marijuana	cl	cl	☐	☐	cl
Other (specify) _____	☐	☐	☐	☐	cl

D3 Among the families you serve who have AOD abuse problems, which family member exhibits a AOD abuse problem?

	Very rarely	Rarely	Sometime5	Frequently	Very frequently
Mother/stepmother	☐	☐	☐	☐	cl
Father/stepfather	☐	☐	cl	☐	cl
Sibling	☐	☐	cl	☐	cl
Both parents	☐	☐	cl	cl	☐
Non-related resident adult	☐	☐	☐	☐	☐
Related resident adult	☐	cl	☐	☐	☐
Other (specify) _____	☐	cl	☐	☐	☐

SECTION E: SERVICE EFFECTIVENESS

This section focuses on your goals with respect to serving families with AOD abuse problems and how effective you feel you or your caseworkers are in attaining these goals. It is important to note that questions regarding effectiveness are not intended to obtain information critical of caseworker abilities but rather to identify areas where programs may need to make changes to help caseworkers meet goals. Please answer all questions based on your personal experience.

E1 Given that the primary goal of ongoing treatment services is to ensure the safety of the child, how important are other goals specific to families with AOD abuse problems?

	Very important	Moderately important	Somewhat important	Not important	Not a goal
To get AOD abuser to acknowledge AOD abuse problem	☐	☐	☐	☐	☐
To ensure that someone else in the family is in the home when the AOD abuser is present	☐	☐	☐	☐	☐
To get AOD abuser to agree to seek treatment	☐	☐	☐	☐	☐
To enroll AOD abuser in a treatment program	☐	☐	☐	☐	☐
To enroll AOD abuser in counseling for problems related to AOD abuse	☐	☐	☐	☐	☐
To help family members cope with a child who has a AOD abuse problem	☐	☐	☐	☐	☐
To help child cope with a family member who has a AOD abuse problem	☐	☐	☐	☐	☐
Other goals (specify) _____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

E2 How successful do you feel you (or your caseworkers) are in achieving the goals listed in El?

	Very successful	Moderately successful	Somewhat successful	Not successful	Not a goal
To get AOD abuser to acknowledge AOD abuse problem	☐	☐	☐	☐	☐
To ensure that someone else in the family is in the home when the abuser is present	☐	☐	☐	☐	☐
To get AOD abuser to agree to seek treatment	☐	☐	☐	☐	☐
To enroll AOD abuser in a treatment program	☐	☐	☐	☐	☐
To enroll AOD abuser in counseling for problems related to AOD abuse	☐	☐	☐	☐	☐
To help family members cope with a child who has a AOD abuse problem	☐	☐	☐	☐	☐
To help child cope with a family member who has a AOD abuse problem	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

E3 For **each goal that you** answered that you (or ongoing treatment caseworkers) are only **somewhat successful or not successful of attaining, please** explain why you feel this way.

To **get** AOD abuser to acknowledge AOD abuse problem

To ensure that someone else in the family is in the home with the child when the AOD abuser is present

To get AOD abuser to agree to seek treatment

To enroll AOD abuser in a treatment program

To enroll AOD abuser in counseling for problems related to AOD abuse

To help family members cope with a child who has a AOD abuse problem

To help child cope with a family member who has a AOD abuse problem

Other goals (as specified above)

E4 Please identify the strategies or staffing practices that you think are important to improving your (or your caseworker's) ability to serve children and families with AOD abuse problems.

	Very important	Somewhat important	Not important	Don't know
Build a stronger referral network among community agencies	cl	☐	cl	☐
Work with local AOD abuse treatment services to give priority to child welfare agency clients	☐	cl	☐	☐
Hire a consultant to help caseworkers work with families with AOD abuse problems	El	cl	❑	☐
Develop a team approach to case management in working with families with AOD abuse problems	❑	☐	☐	☐
Reduce caseworker caseloads	❑	☐	☐	☐
Add new caseworker positions to deal with AOD abuse problems	☐	☐	☐	☐
Create staffing teams/special unit to work with families with AOD abuse problems	☐	☐	☐	☐
Provide special AOD abuse-related training for staff	☐	☐	☐	☐
Provide funds for staff to attend AOD abuse-related workshops	❑	❑	☐	☐
Other (specify) _____	cl	☐	☐	☐

E5 Please identify the strategies or staffing changes that have been implemented over the past 5 years.

	Has been implemented	Has not been implemented	Was already in place
Build a stronger referral network among community agencies	☐	☐	☐
Work with local AOD abuse treatment services to give priority to child welfare agency clients	cl	El	❑
Hire a consultant to help caseworker work with families with AOD abuse problems	❑	☐	☐
Develop a team approach to case management in working with families with AOD abuse problems	☐	❑	☐
Reduce caseworker caseloads	❑	☐	☐
Add new caseworker positions to deal with AOD abuse problems	❑	☐	☐
Create staffing teams/special unit to work with families with AOD abuse problems	❑	☐	☐
Provide special AOD abuse-related training for staff	❑	☐	☐
Provide funds for staff to attend AOD abuse-related workshops	☐	☐	☐
Other (specify) _____	❑	❑	❑

SECTION F: SERVICE NEEDS

In this section, we are interested in determining whether families with AOD abuse problems have service needs that are different or similar to the service needs of families without AOD abuse problems. Please answer all questions based on your personal experience.

F1 In comparison to families without AOD abuse problems, are families with AOD abuse problems more likely, less likely, or equally likely to require the following services?

Type of service	More likely	Less likely	No difference	Don't know
Food	☐	☐	☐	☐
Shelter for children/youth	☐	☐	☐	☐
Shelter for families	☐	☐	☐	☐
Physical examinations	☐	☐	☐	☐
Medical tests	☐	☐	☐	☐
Nutrition information	☐	☐	☐	☐
Out-of-home placement for youth	☐	☐	☐	☐
Independent living services	☐	☐	☐	☐
Parenting classes	☐	☐	☐	☐
Income maintenance services	☐	☐	☐	☐
Legal services	☐	☐	☐	☐
Child care services	☐	☐	☐	☐
Child development services	☐	☐	☐	☐
Support group for children/youth	☐	☐	☐	☐
Support group for parents	☐	☐	☐	☐
Home visits	☐	☐	☐	☐
Individual counseling for children/youth	☐	☐	☐	☐
Individual counseling for parents	☐	☐	☐	☐
Group counseling for children/youth	☐	☐	☐	☐
Group counseling for parents	☐	☐	☐	☐
Family counseling	☐	☐	☐	☐
Couples counseling	☐	☐	☐	☐
AOD abuse assessment	☐	☐	☐	☐
AOD abuse treatment	☐	☐	☐	☐
AOD abuse prevention services	☐	☐	☐	☐
GED classes for youth	☐	☐	☐	☐
GED classes for parents	☐	☐	☐	☐

Type of service	More likely	Less likely	No difference	Don't know
Education for children with special needs	☐	☐	☐	☐
Employment preparedness/training classes for youth	☐	☐	☐	☐
Employment preparedness/training classes for parents	☐	☐	☐	☐
Homemaker services	☐	☐	☐	☐
Respite care	☐	☐	☐	☐
Other (specify)_____	☐	☐	☐	

F2 Do you feel you (or your caseworkers) are able to meet the service needs of children and families with AOD abuse problems?

☐ Almost always
☐ Most of the time
☐ Some of the time
☐ Rarely
☐ Very rarely
☐ Don't know

F3 What kinds of barriers do you confront in serving children and families with AOD abuse problems?

	Severe problem	Moderate problem	Not a problem
Insufficient number of no-cost (accept medicaid) AOD abuse inpatient treatment programs for adults	☐	☐	☐
Insufficient number of no-cost (accept medicaid) AOD abuse inpatient treatment programs for adolescents	☐	☐	☐
Insufficient number of no-cost AOD abuse outpatient treatment programs	☐	☐	☐
Insufficient number of treatment programs that accept pregnant women	☐	☐	☐
Insufficient number of inpatient treatment programs that accept women	☐	☐	☐
Insufficient number of detoxification services	☐	☐	☐
Insufficient family support services in the community	☐	☐	☐
Insufficient respite care facilities	☐	☐	☐
Insufficient transportation for clients to access services	☐	☐	☐
Insufficient low cost housing for families	☐	☐	☐
Lack of formalized interagency cooperation	☐	☐	☐
Lack of information about relevant resources in the community	☐	☐	☐
Parents fear of losing their children	☐	☐	☐
Negative attitudes of program staff toward individuals with AOD abuse problems	☐	☐	☐
Insufficient number of foster families willing to take children who were exposed to alcohol or other drugs in utero	☐	☐	☐
Resistance of parents to accept services	☐	☐	☐
Other (specify) _____	☐	☐	☐

F4 For each barrier that is a problem, please indicate how it might be addressed

F5 Compared with 5 years ago, how do you feel the abuse of specific drugs among your client population has changed?

	Increased	Decreased	No change	**Don't know**
Alcohol	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐
Crack	☐	☐	☐	☐
Opiates (heroin, methadone)	☐	☐	☐	☐
Amphetamines (speed, ice)	☐	☐	☐	☐
Sedatives (valium, downers)	☐	☐	☐	☐
Barbiturates	☐	☐	☐	☐
Psychedelics (LSD, mushrooms, peyote)	☐	☐	☐	☐
Inhalants (glue, gasoline)	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐

F6 Does the type of drug being abused affect the difficulty you (or your caseworkers) experience in working with families?
Yes ☐ No ☐ Don't know ☐

F7 If yes, please identify which type of AOD abuse is most difficult to work with and why.

SECTION G: GENERAL PERSPECTIVES

In this last section of the questionnaire, we are interested in determining how you view the problem of family AOD abuse in the context of other family problems that ongoing treatment caseworkers must contend with. Please answer all questions based on your personal experience.

G1 Do you feel that your agency has a role in combatting AOD abuse?

Yes cl No ☐ Don't know ☐

G2 If you answered yes to the above question, please describe how you see your agency's role. If you answered no, please explain why you feel your agency does not have a role.

_____

_____

_____

G3 Overall, given the many problems that clients served by your agency are facing, how important do you feel it is for your agency to confront the problem of family AOD abuse?

Number one priority of agency	☐
Extremely important	cl
Moderately important	☐
slightly important	❑
Not important	cl
Don't know	☐

Hospital Social Worker

RESEARCH QUESTION	ITEM(S)
1a - Concept of AOD abuse	NA
1b - State and local statutes	B1, B2, B3, B4
1c - Service costs	NA
1d - Change in services/demand for services	NA
2a - Number of clients with AOD abuse problems/change	C1 thru C10
2b - Characteristics	NA
3a - Foster Care	NA
3b - Adoption	NA
4a - Goals/effectiveness	NA
4b - Staffing	NA
4c - Juvenile court and hospital social workers perspectives	D1, D2, D3, D4
5a - Client needs	NA
5b - Staff effectiveness	NA
5c - Barriers	NA
5d - Roles	NA

Revised July 3 1, 1992

Hospital Social Worker

Please feel free to seek assistance in completing this questionnaire from other staff members, particularly with respect to those questions that require statistical information. However, we would appreciate it if you would complete the questions soliciting opinions or beliefs yourself.

Guidelines for completion of the form

Please restrict your responses to impressions that are directly based on your experience as a hospital social worker. Many of the questions require you to state opinions that are based on your personal experience. In general you should answer these questions **only if:**

1) You have had direct contact with children and/or their families.

2) You have discussed cases or client situations with staff members.

3) You have access to records and/or databases containing pertinent information.

Otherwise, you should respond “don’t know”.

SECTION A: RESPONDENT/PROGRAM INFORMATION

A1 Name: _____

A2 Contact telephone # (-____)_____ _____

A3 Job title: _____

A4 What are your primary responsibilities?_____

_____

_____

A5 How long have you been employed in this position? _____

A6 What was your previous position and how long were you employed in that position?

Position: _____

Length of time: _____

SECTION B: REPORTING REQUIREMENTS

In this section we are interested in the requirements of hospital staff who are mandated reporters of child abuse and neglect cases.

B1 Is your hospital required to report to the local child welfare agency or child abuse and neglect hotlines any of the following situations:

	Yes	No	Don't know
A pregnant woman who is known to be using substances	☐	cl	cl
A pregnant woman who is suspected of using substances	☐	cl	cl
A parent or primary caretaker who is known to be a AOD abuser	☐	cl	cl
A parent or primary caretaker who is suspected of using substances	cl	☐	cl
A parent who abuses substances to the extent that a reporter suspects the children are being maltreated (although there has been no actual observation of maltreatment)	☐	☐	☐
An infant who was exposed to AOD in utero	☐	☐	☐

B2 Have any reporting requirements changed over the past 5 years?
Yes ☐ No ☐ Don't know ☐

B2a If yes, indicate the reporting requirements that have changed.

_____

_____

_____

B3 Is your hospital required to conduct any tests to determine whether an infant has been alcohol or other drug exposed prenatally?
Yes ☐ No ☐ Don't know ☐

B4 If yes, what tests are they required to perform?

_____

_____

_____

_____

B5 What tests are routinely performed in your hospital to establish a diagnosis of suspected fetal alcohol effects?

_____

_____

_____

SECTION C: STATISTICAL INFORMATION

In this section of the questionnaire we are soliciting information about the number of infants and children who are identified or diagnosed as having physical problems resulting from maternal or family AOD abuse. Please use available hospital data to answer the questions. If no data are available, indicate this by putting an X in the box after each question.

We would like you to use data from the last fiscal year for which you have completed data.

Please indicate the fiscal year_____

During your last fiscal year:

C1 How many live births were there at your hospital?
Number of births _____ Data not available ☐

C2 How many of these infants were diagnosed as fetal alcohol syndrome?
Number of infants _____ Data not available ☐

c3 How many of these infants were diagnosed as alcohol exposed in utero?
Number of infants _____ Data not available ☐

c4 How many of these infants were diagnosed as addicted to drugs other than alcohol in utero?
Number of infants _____ Data not available ☐

C5 How many of these infants were diagnosed as exposed to drugs other than alcohol in utero?
Number of infants _____ Data not available ☐

C6 How many of these infants were left in the hospital by mothers who were known to have alcohol or illicit drug abuse problems?
Number of infants _____ Data not available ☐

c7 How many children served in the hospital emergency room were reported to child welfare as potential abuse or neglect victims?
Number of children _____ Data not available ☐

C8 What percent of these cases appear to be the result of a AOD abuse problem in the family?
Percent of cases _____ Data not available ☐

C9 How many children served by the hospital pediatric ward were reported to child welfare as potential abuse or neglect victims?
Number of children _____ Data not available ☐

C10 What percent of these cases appear to be the result of a AOD abuse problem in the family?
Percent of cases _____ Data not available ☐

SECTION D: PERSPECTIVE ON WELFARE AGENCY SERVICES

In this section of the questionnaire we are interested in your perceptions regarding the: capacity of your local child welfare agency to meet the needs of the children and families you report to them.

D1 In your experience with reporting families to child welfare authorities or to the child abuse and neglect hotline, how satisfied have you been with the way reports are handled?

- ☐ Very satisfied
- ☐ Somewhat satisfied
- ☐ Somewhat dissatisfied
- ☐ Very dissatisfied

D2 If dissatisfied, please indicate the reasons why (put an X in the box for all that apply)

- ☐ Confidentiality was not maintained
- ☐ Agency did not investigate the report
- ☐ Agency did not remove the child from the home
- ☐ Agency did remove the child from the home instead of providing services
- ☐ Agency did not provide services to the mother
- ☐ Agency did not follow up on information provided by the Hospital
- ☐ Other (specify)_____

D3 What kinds of barriers do you feel child welfare agency investigators confront in attempting to investigate a report of a child who is a potential abuse or neglect victim as a result of family AOD abuse.

- ☐ Insufficient training to deal with AOD abusers
- ☐ Insufficient placements for children
- Cl Insufficient treatment facilities to enroll parents in
- ☐ Insufficient time to devote to investigating the case
- ☐ Other (specify) _____

D4 How effective do you feel the child welfare protective services and foster care agencies are in meeting the needs of children from families with AOD abuse problems?

- ☐ Very effective
- Cl Somewhat effective
- ☐ Somewhat ineffective
- ☐ Very ineffective
- ☐ Don't know

D5 If ineffective, please explain why you feel this way.

_____

_____

_____

_____

_____

Juvenile and Family Court Judge

RESEARCH QUESTION	ITEM(S)
1a - Concept of AOD abuse	NA
lb - State and local statutes	NA
1c - Service costs	NA
1d - Change in services/demand for services	NA
2a - Number of clients with AOD abuse problems/change	Bi, B2
2b - Characteristics	NA
3a - Foster Care	NA
3b - Adoption	NA
4a - Goals/effectiveness	NA
4b - Staffing	NA
4c - Juvenile court and hospital social workers perspectives	C1 thru C7
5a - Client needs	NA
5b - Staff effectiveness	NA
5c - Barriers	NA
5d - Roles	NA

Revised July 3 1, 1992

Juvenile/Family Court Judges

This questionnaire is to be completed by a Judge of the Juvenile or Family Court

Please feel free to seek assistance in completing this questionnaire from other staff members, particularly with respect to those questions that require statistical information. However, we would appreciate it if you would complete the questions soliciting opinions or beliefs yourself.

Guidelines for completion of the form

Please restrict youe responses to impressions that are directly based on your experience as juvenile/family court judge. Many of the questions require you to state opinions that are based on your personal experience. In general you should answer these questions **only if:**

1) You have had direct contact with children and/or their families.

2) You have discussed cases or client situations with staff members.

3) You have access to records and/or databases containing pertinent information.

Otherwise, you should respond “don’t know”.

SECTION A: RESPONDENT DESCRIPTION

In this section of the questionnaire, we are interested in finding out about your activities as a judge and the kinds of cases that you hear.

A1 What is the name of your court? _____

A2 How many other judges are on the court? _____

A3 How long have you been a judge on this court? _____

SECTION B: CASE INFORMATION

This section requests information pertaining to cases that were petitioned in your court during the past fiscal year. If the court maintains data on these cases, please use this information in providing your responses. If the court does not maintain these data, please provide your best estimate. Indicate whether you are reporting from data or estimating your response in the appropriate box for each question. If you do not feel you can estimate the response, please put an X in the box labelled "don't know".

B1 How many of the following types of cases did your court preside over last year?

_____ Child abuse and neglect cases

_____ Status offender cases

_____ Adoption hearings

_____ Termination of parental rights cases

_____ Incorrigible children or children beyond control of parents cases (i.e., PINS, CHINS, etc.)

_____ Other types of child welfare-related cases (specify) _____

☐ Data not available

Reporting from data ☐

Estimating response ☐

Don't know ☐

B2 What percent of these cases involved parental AOD abuse?

_____% Child abuse and neglect cases

_____% Status offender cases

_____% Adoption hearings

_____% Termination of parental rights cases

_____% Incorrigible children or children beyond control of parents cases (i.e., PINS, CHINS, etc.)

_____% Other types of child welfare-related cases: _____

☐ Data not available

Reporting from data ☐

Estimating response ☐

Don't know ☐

SECTION C: PERCEPTIONS OF CHILD WELFARE AGENCY SERVICES

This section solicits your opinions regarding child welfare services provided by the local agency in your court's jurisdiction.

Cl In your experience with reporting families to child welfare authorities or to the child abuse and neglect hotline, how satisfied have you been with the way reports are handled when there is a problem of family AOD abuse?

- ❑ Very satisfied
- ❑ Somewhat satisfied
- ❑ Somewhat dissatisfied
- ❑ Very dissatisfied
- ❑ Not applicable, no experience

C2 If dissatisfied, please indicate the reasons why (put an X in the box for all that apply).

- ☐ Confidentiality was not maintained
- ☐ Agency did not investigate the report
- ❑ Agency did not remove the child from the home
- ☐ Agency did remove the child from the home instead of providing services
- ☐ Agency did not provide services to the mother
- ☐ Agency did not follow up on information provided by the Hospital
- Cl Other (specify)_____

c3 What kinds of barriers do you feel child welfare agency investigators confront in attempting to investigate a report of a child who is a potential abuse or neglect victim as a result of family AOD abuse?

- ☐ Insufficient training to deal with AOD abusers
- Cl Insufficient placements for children
- ❑ Insufficient tune to devote to investigating me case
- Cl Other (specify) _____

c4 How successful do you feel child welfare agencies are in meeting the needs of children and families with AOD abuse problems?

- Cl Very effective
- ❑ Somewhat effective
- Cl Somewhat ineffective
- Cl Very ineffective
- El Don't know

c5 How capable do you feel your local child welfare agency is in meeting the needs of **parents/caretakers** with AOD abuse problems (i.e. do they have adequate staff, do they have sufficient resources, etc.)?

- ☐ Very capable
- ❑ Somewhat capable
- ❑ Somewhat incapable
- ❑ Very incapable
- ❑ Don't know

C6 How capable do you feel the local child welfare agency is in meeting the needs of youth with AOD abuse problems (I.E. do they have adequate staff, do they have sufficient resources, etc.)?

- ☐ Very capable
- ☐ Somewhat capable
- ☐ Somewhat incapable
- ☐ Very incapable
- ☐ Don't know

c7 What do you feel are the barriers that child welfare agencies confront in attempting to serve families with AOD abuse problems?

	Major barrier	Moderate barrier	Slight barrier	Not a barrier	Don't know
Insufficient training of staff in working with families with AOD abuse problems	☐	☐	☐	☐	☐
Lack of funds for child welfare agencies to provide needed services	☐	☐	☐	☐	☐
Insufficient low cost or no-cost inpatient AOD abuse treatment facilities	☐	☐	☐	☐	☐
Insufficient low cost or no-cost outpatient AOD abuse treatment facilities	☐	0	☐	☐	☐
Resistance of families to receive services	☐	☐	☐	☐	☐
Resistance of family members to acknowledge AOD abuse problem	☐	☐	☐	☐	☐
Insufficient transportation for family members to access services	☐	☐	☐	☐	☐
Insufficient homebased services	☐	☐	☐	☐	☐
Insufficient high quality placements for children	☐	☐	☐	☐	☐
Lack of effective interagency relationships	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

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(3 of 4)

FINAL REPORT:
STUDY OF THE IMPACT ON SERVICE DELIVERY OF FAMILY SUBSTANCE ABUSE
(CONTRACT NO. 105-91-1811)

APPENDIX B:
REVIEW OF THE RESEARCH LITERATURE

THE IMPACT OF FAMILY SUBSTANCE ABUSE ON ACYF-FUNDED PROGRAMS: A REVIEW OF THE RESEARCH LITERATURE

November 1, 1994

Submitted To: *The* Adminstration on Children, Youth and Families
The Administration for Children and Families
U.S. Department of Health and Human Services
Contract No. 105-91-1811

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I. INTRODUCTION

In the past decade, substance abuse has emerged as a critical problem in the United States, The damaging effects of parental substance abuse on the lives of children and youth have generated considerable concern at the Administration on Children, Youth and Families (ACYF). It has affected many ACYF-funded programs, including Child Protective Services and Head Start. While the effects of parental substance abuse differ depending on the programs involved, one thing is certain: they dramatically impact the ability of these programs to deliver quality services to their client population.

Before one can fully understand how parental substance abuse alters the service delivery of ACYF-funded programs, one must understand the patterns of adult substance abuse. In the last ten years, the trends in adult substance use and abuse has strongly shifted. Unlike, the drug epidemic of the 1960's and 1970's that primarily involved men addicted to heroin, the current drug epidemic has affected many more women than in the 1960's and 70's (GAO, 1990). Experts attribute the increase in female drug uses to the existence, accessibility, and low cost of crack cocaine (GAO, 1990). Also, more women, especially those who live in the inner cities, are single parents with the dual responsibilities of being the sole breadwinner as well as the sole caregiver. This factor contributes to the increased daily stress these women are under, and in turn, escalates the likelihood that these parents will deal with the stress by drinking alcohol or using drugs (DHHS, 1992).

Parental substance abuse has created grave problems for children. At least 1 in 10 children in the United States is born into a chemically dependent family each year (CSR, 1992). Parental addiction has long-lasting detrimental effects on the health and safety of children. Children who have been exposed to drugs and/or alcohol while in the womb may evidence numerous problems, including delayed speech, mental retardation, and other types of developmental difficulties. Research conducted at the University of California at San Diego demonstrated that 25 percent of drug-exposed children had problems with the development of fine motor, language, and cognitive skills, as well as adaptive behavior. Forty percent of the same sample from this University of California study experienced neurologic abnormalities that might affect their ability to socialize and function within a school environment (GAO, 1990). Because of these difficulties, these children require special programs to meet their needs which in turn places increased demands on existing children's programs. Cocaine-exposed infants also often have a variety of medical complications that range from drug withdrawal, seizures, and strokes to rare urogenital birth defects.

Even if not exposed to alcohol or drugs during the prenatal period, children may experience extreme difficulties related to their parents substance abuse. Infants and children of substance abusers tend to live in chaotic and often dangerous home environments that are not conducive to their overall physical, social and psychological development (Feig, 1990). It is extremely difficult for parents who are abusing substances to fulfill their parenting roles and responsibilities, such as providing emotional and physical support for their children. Many of these parents put their own needs --- meaning their need to get high --- before their children's needs. This all-consuming need for drugs and/or alcohol usually takes precedence over providing foods and other necessities (Feig, 1990). Since the judgment of substance abusing parents is often clouded, they do not comprehend that their children are not being well-fed, clothed or getting enough sleep.

These factors also increase a child's risk of becoming a victim of physical abuse, sexual abuse or neglect because drugs such as alcohol, cocaine and crack tend to be associated with increased violent behavior. Substance use is also believed to reduce sexual inhibitions and may be responsible for much of the increase in child sexual abuse cases reported by staff at many child welfare agencies (CSR, undated). Some studies demonstrate a direct relationship between alcohol abuse and child abuse and between cocaine use and child neglect. A study conducted by the Massachusetts Department of Social Services found that illicit drug use or excessive alcohol use was a factor in 64 percent of child abuse/neglect case investigations (GAO, 1990). It has also been noted that cocaine and crack use is significantly related to parental neglect, particularly failure to provide adequate supervision, food, clothing, medical care, and other necessities for children (GAO, 1990; Besharov, 1990). Other social systems may fail to help insure the child's safety: for example, most of the friends maternal substance abusers have are also substance abusers (DHHS, 1992).

As a result, infants and children of substance abusing parents also are at an increased risk of out-of-home placement, either through foster care with strangers or formal or informal placement with relatives. In the neighborhood of Harlem in New York City, out of the 1,900 drug-exposed children born between 1986 and 1990, only 25 percent were receiving primary care from their biological mothers. In most cases a grandmother or a foster mother was the primary caregiver for the child. One study tracked 13 children who had been exposed to drugs *in utero* and found that these children had been in 35 foster homes, collectively, before the age of 6 (CSR, 1992). Finally, a survey in Illinois of 385 children placed in foster care in 1986 indicated that one-half of these children had come from families with substance abuse problems (Bays, 1990).

These statistics demonstrate that parental substance abuse has created tremendous problems for ACYF-funded programs in the last 10 years. Those factors which come with working with substance abusing families present a wide variety of problems for ACYF agencies. Assessment of the risks to a child is often more complex and difficult in a substance abusing family. For instance, a mother may deny substance use, or her

distrust of child welfare authorities may result in a lack of candor. Caseworkers also may spend days tracking down mothers who give false addresses to hospitals. Further, many of these parents lack the motivation, endurance and social support needed for recovery (DHHS, 1992).

The Administration for Children, Youth and Families through its four bureaus has funded State and local programs that deal with family or parental substance abuse, including comprehensive services programs and local community and Statewide impact projects. However, there is limited knowledge about how family substance abuse affects ACYF-funded programs and the response of ACYF programs to this challenge. This report attempts to synthesize the available salient research literature from 1986 to the present on the impact of family substance abuse on ACYF programs. Succeeding sections of the report address both the impact of family substance abuse and system responses for each of the main ACYF program areas: Child Protection, Foster Care, Adoption Services, Head Start, and Runaway and Homeless Youth. Alphabetized and topical lists of references are presented in Appendices A and B, respectively, and Appendix C constitutes an annotated bibliography of particularly relevant articles.

II. FAMILY SUBSTANCE ABUSE AND ACYF PROGRAMS

The problem of family substance abuse affects the management, administration, and operations of each and every ACYF program. The child from a substance abusing family, and the family as a whole, present very complex human service, child welfare, and educational challenges. Unfortunately there is little available information that ACYF programs can use to systematically plan ways to address the needs of substance abusing families and their children. There is even less information available regarding how the changing nature of AOD abuse within the families served by ACYF programs has impacted on the capacity of these programs to achieve their mandated goals and purposes. The same family or child may, in fact, present a problem to more that one of these systems: for example, an abused child who is placed in foster care may also be enrolled in Head Start. In this section we focus on the impacts of family substance abuse on service delivery and the response of ACYF-administered programs to these impacts as identified in the research literature.

A. FAMILY SUBSTANCE ABUSE AND CHILD PROTECTIVE SERVICES

The Child Protective Service (CPS) system incorporates the general child welfare activities of investigating reports of child abuse and neglect, conducting risk assessments, and providing services to families in cases of substantiated abuse and neglect. CPS agencies actively serve about 1.8 million children a year, or 27 of every 1,000 children under age 18 (DHHS, 1991). It is the responsibility of the CPS system to ensure the safety of these children while they remain in their homes. When a decision is made to remove a child from the home, it is usually the CPS division of child welfare that removes the child or that requests the court or law enforcement agency to remove the child, depending on State regulations.

The National Center on Child Abuse and Neglect (NCCAN) coordinates Federal efforts to combat child abuse and neglect and assists with national, state, and community efforts to prevent, identify, and treat child abuse and neglect. NCCAN administers four State grant programs: Two Basic State Grants programs which provide funds to States to improve the general quality of child protective services (CPS) at the State and local level and to specifically improve CPS response to medical neglect and related issues; the Community Prevention State Grants program which provides federal matching funds to encourage the development of State Children's Trust Funds which in turn fund local child abuse and neglect prevention programs; and, the Children's Justice Act State Grants

program which provides funds to States to improve law enforcement, prosecutorial, and judicial system responses to child abuse and neglect and to improve these systems' coordination with CPS. Under the Research and Demonstration Discretionary Grants program funds are given to public and private entities to support a variety of research, program evaluation, and model program development efforts. The Emergency Services discretionary grants program specifically targets family substance abuse prevention and intervention.

IMPACT OF FAMILY SUBSTANCE ABUSE ON CPS

The impact of substance abuse related maltreatment, neglect and abandonment cases on CPS systems is considerable. It is estimated that 675,000 children lived with their chemically dependent parents in 1990 (Bays, 1990). Children living in substance-abusing families are at increased risk for maltreatment. In Wyoming, where only 23 percent of CPS reports involve parental substance abuse, such cases account for over half of the states' child abuse fatalities; in Boston researchers found that 64 percent of substantiated child abuse and neglect involved parental alcohol abuse (McCullough, 1991).

In a 1990 national survey by the Child Welfare League of American (CWLA), nearly 50 percent of 200 caseworkers reported that the number of children affected by or using alcohol or drugs had increased in the past year. Of the respondents, 92 percent reported that parental substance abuse was a factor in reports of physical abuse and neglect; and 64 percent reported that referrals of abandoned infants have increased because of problems related to parental substance abuse (Curtis, 1993). Likewise, in a mailed survey of State child protective services agencies, conducted by the American Public Welfare Association, it was reported that the number of child abuse and neglect cases reported to CPS agencies has steadily increased In the four states on which detailed cases studies were presented, parental substance abuse was a primary contributor to child abuse and neglect (Tatara, 1990).

Nationally, it has been found that substance abuse has become the dominant characteristic in the child maltreatment and neglect caseloads of 22 States and the District of Columbia: Local estimates of the proportion of child welfare cases involving substance abuse are 50 percent in Illinois, 80 percent in Washington, DC., 76 percent in San Francisco, 64 percent in Boston, and 70 percent in Philadelphia (Feig, 1990). In many of these case, the children have suffered extreme neglect, and in some cases they have been completely abandoned.

The onset of the crack epidemic has also been associated with an increased number of reported abuse cases and referrals to CPS between 1986 and 1991. Neglect and caretaker absence or incapacity have been the primary reasons children were removed from their families in California and New York; most of these children (78 percent) also had been prenatally exposed to cocaine (GAO, 1994). In New York City in 1989, 59

percent of the child abuse and neglect fatalities involving children previously known to the authorities were drug-exposed babies (Virginia Child Protection Newsletter, 1991).

The dramatic rise in the use of highly addictive drugs such as crack cocaine has increased the caseloads of CPS workers who are struggling to respond to the needs of boarder babies and maltreated children. Crack poses more threats to children than any other drug because of the high percentage of women who are users, and because it adversely affects a woman's ability to serve as the family caretaker. In the 1990 survey by the CWLA of the impact of alcohol and other drugs on the delivery of child welfare services, 69.5 percent of responding member agencies said crack use was a serious problem among children and families they served. Eighty-eight percent said parental users of crack were more difficult to serve than other drug users; and 83.3 percent said crack users were more likely to behave unpredictably or violently toward their children (Curtis, 1993).

The impact of substance abuse on CPS systems is the result not only of the growth in absolute numbers of cases, but also of the increase in the difficulty of investigating and providing services to these cases. Officials interviewed during the OIG study (1990) reported that substance-exposed infant cases, especially crack baby cases, require extensive tracking and followup. It was noted that caseworkers can spend days tracking mothers who give false addresses to hospitals (OIG, 1990). Another study reported that 83 percent of the CPS service providers interviewed believed that alcohol and other drugs (AOD) related problems increased the time they spent investigating a case. In addition, 93% of respondents reported that AOD abuse was increasingly become a factor in initial investigations. Despite this, only 65.9 percent related that their agency provided training associated with the problem of family AOD abuse for CPS workers (Curtis, 1993).

Ensuring the safety of children who are exposed to parental alcohol or drug abuse in their homes often involves extensive monitoring and intensive in-home services. Unfortunately, many CPS systems do not have the staff or financial resources to meet the needs of these families. As a result, caseload sizes are increasing beyond what workers can be expected to handle. Generally, CPS workers carry caseloads of 20 to 30 children, but referrals of substance-abusing families have resulted in caseloads as high as 60 to 70 children (Walker, 1991). In one study, a child welfare agency official even reported an average caseload of 161 children for protective services workers (OIG, 1990). In contrast, Child Welfare League of America standards call for no more than 12 to 17 cases per worker (OIG, 1990; McCullough, 1991). The CWLA also reports that of all substantiated cases of child abuse and neglect, between 50 and 80 percent involve some degree of parental substance abuse (NCCAN, 1994).

While most people agree that substance abuse in families constitutes a cause for concern, substance abuse alone is not enough to require (or even to authorize) a report to CPS. Only if there is evidence of direct harm or imminent danger of harm to the child should a report be filed (NCCAN, 1994). Many children, therefore, may receive no

outside assistance or intervention despite the fact that their parents are abusing alcohol and/or drugs.

Although CPS is unable to assist some children of substance abusing parents, their job becomes more complicated in the case of prenatal exposure to drugs and alcohol. The process of aiding substance-exposed infants has been complicated by the fact that reports to CPS of positive drug-exposure test results in newborns generally are insufficient reason for placing a family under court jurisdiction or for criminal prosecution. Followup action in response to a positive drug-exposure report varies considerably according to State and local agency practice. The process for initiating a social services investigation may lead to a child abuse and neglect or abandonment petition, but may also result in the case being dismissed or in the family being placed under informed supervision (Ooms, 1990).

Because substance-exposed infants are generally not reported to CPS at birth, their impact may not be immediately felt by all CPS systems. However, as noted earlier, there is some indication that many of these children will enter the system at a later date as victims of abuse and neglect. Increases in the number of child maltreatment cases lend support to this supposition. The National Committee on Prevention of Child Abuse noted that in 1988 there were slightly more than one million reports of child maltreatment, whereas in 1989 there were 2.4 million reports.

Contrary to what might be expected, most of the substance-exposed infants and children who are victims of abuse and neglect do not go into foster care placements. According to one study, 50 to 75 percent of babies born substance-exposed go home with a mother or relative, rather than into foster care. In New York, only about one-third of substance-exposed infants go into foster care immediately, and only 1,200 of the 4,000 infants reported to be born substance-exposed went into foster care (GAO, 1990).

Family substance abuse affects CPS systems in other ways as well. In a 1994 study, Gregoire (1994) reported that in spite of the significance of the problem of parental substance abuse, many social workers know little about the impact of addictions. In fact., social workers failed to identify and respond to a client's alcohol problem in 83 percent of the cases they handled. The study concluded that most social workers receive little or no formal training in addiction and may avoid dealing with clients' drug problems. Another study asserted that child welfare workers have generally had limited training in alcohol and drug abuse treatment. This leaves them ill-equipped to assess the level of risk and to develop appropriate case plans for families with substance abuse problems (Tracy, 1994).

CPS Response to Family Substance Abuse

The role of CPS in the child welfare system is to ensure the safety of children. However, responding to the issues which surround family substance abuse is not an easy task.

States are increasingly relying on statutes to provide for the healthy development of the fetus by criminalizing the prenatal transmission of drugs. Laws incorporating either prenatal drug exposure or prenatal drug use into child abuse and neglect statutes have been passed in several states, including, Florida, Hawaii, Illinois, Massachusetts, Minnesota, Oklahoma, New York, Nevada, and Rhode Island (Feig, 1990). These laws vary in their particular requirements and intentions (DHHS, 1994). For example, California, New York, and Illinois require hospitals to report all cases in which infants are born exposed to drugs. Minnesota has gone even further, requiring all mandated reporters to notify local child welfare agencies of pregnant women suspected of, or known to be, using controlled substances (GAO, 1990).

In contrast, the States of Florida, Massachusetts, Oklahoma, Indiana, Utah and many others require hospitals to report substance exposure to child welfare agencies only when the infant is actually physically drug-dependent and must undergo withdrawal. In one State, hospitals have been instructed by child welfare agency personnel to report drug-exposed infant cases only when the mother cannot care for her child (GAO, 1990). Indeed, when the question of prosecuting pregnant women has reached the courts, judges have tended to view cases individually and women generally have not been prosecuted (Madden, 1993). Similar outcomes are reported by Hansen (1992) in his review of two State Supreme Court decisions which sided with the mother. In a Florida case, the original conviction, based on the drug trafficking law (in which the mother had been charged with illegally delivering cocaine to her child through the umbilical cord) was overturned. In a Connecticut case, the mother's act of injecting cocaine just before labor was deemed insufficient cause for terminating her parental right to custody (Hansen, 1992).

Those opposed to criminal prosecution of substance-abusing women argue that the data do not support incarceration as an effective impetus to accepting help for a drug problem (Hutchins, 1990). They further argue that even if criminalization were an effective approach, there are currently few drug treatment facilities that will accept pregnant women. Opponents also believe women fearing punitive actions against them will not seek medical attention during pregnancy, placing fetuses at increased risk of complications resulting from prenatal drug exposure (DHHS, 1992). In response, many states are treating the problem of substance-abusing mothers as a public health problem. Legislation which provides for priority access to treatment programs by pregnant women or which provides child care vouchers for those women undergoing treatment is currently in effect in 23 states (AHA, 1994).

On the other hand, proponents of criminal proceedings against pregnant addicts argue that prosecution will encourage women to take responsibility for their actions by seeking treatment and that the infant's interest should outweigh that of the mother. There

are no national data to assess the impact of criminalization on use of prenatal care services or prevention of fetal drug exposure. However, one study indicated that lower income and minority women with less access to drug treatment and prenatal care services may be disproportionately effected by criminalization. Researchers reported that although white, middle-class women were as likely as black poor women to abuse drugs during pregnancy, black women were more likely to be reported to child abuse authorities (Walker, 1991). A study in Pinnelas County, Florida reported that while drug use between whites and blacks was equal, blacks were reported to CPS 10 times as often as whites (Chasnoff, 1991). In order to truly prevent child abuse and neglect in these situations, Chasnoff (1991) proposes that professionals develop a way to involve mothers in preventive programs rather that initiating charges. He suggests prenatal education and training can improve the prognosis of children prenatally exposed to drugs.

One example of how women can be directed into prenatal care programs has been developed by National Association for Perinatal Addiction (NAPARE). NAPARE operates the Alcohol, Drugs and Pregnancy hotline (formerly the Cocaine Baby Hotline). Approximately one-third of the calls to the Hotline are from women seeking information about the effects of drug use on their pregnancy or on their unborn child. Services provided through the Helpline include dissemination of prevention materials, phone assessment and treatment referrals, access to community resources, and referral to professional teams at NAPARE (Perinatal Addiction Research and Education, 1993).

These different reporting requirements for substance-exposed infants suggest that the impact of this problem on CPS systems may be most immediate in those localities with the broadest reporting requirements. In fact, in three cities required by State law to refer all substance-exposed infants to child welfare authorities, the number of infants referred during recent years has increased dramatically. In New York City, for example, referrals increased by 268 percent during the four-year period from 1986 to 1989. For approximately the same period, referrals in Los Angeles increased by 342 percent and in Chicago the increase amounted to 1,735 percent (GAO, 1990).

CPS agencies have also been attempting to enhance workers' knowledge and skill through specialized training to meet the new demands on the child welfare system. For instance, the National Center on Child Abuse and Neglect, suggests that there are four obstacles which workers need to overcome in order to better serve chemically dependent families. These are:

- The lack of training on issues surrounding substance abuse, and the impact such abuse has on how a family functions;

- The inability of workers to comfortably discuss illicit substance use and other behaviors associated with substance use with parents due to moral and legal considerations;

- The lack of contact between professionals in the child abuse and neglect field and professionals in areas such as substance use, developmental disabilities, and mental and physical health problems; and

- The prevalence of stereotypes in attempting to assess possible substance abusers" (NCCAN, 1994).

In order to help serve families affected by substance abuse, NCCAN began funding the Emergency Child Abuse and Neglect Prevention Grant Program in 1991. This program makes funds competitively available to improve the delivery of services to children whose parents are substance abusers. Such services may include the hiring of additional personnel, training for personnel to improve their ability to provide emergency child abuse prevention services, expanding services to deal with family crisis created by substance abuse, and establishing or improving interagency coordination.

In FY 1991, $19.5 million was appropriated to implement the Emergency Child Abuse and Neglect Prevention Program. The appropriation levels for 1992 and 1993 were $19.5 million and $19 million, respectively. The following table shows how the funds were distributed in FY 1991:

Table 1: Emergency Child Abuse and Neglect Fund Distribution FY 1991

Priority Area	Maximum Grant Amount	Number of Projects
#1: Service Delivery	$400,000 per year	24
#2: Public Information	$100,000 per year	20
#3: Service Improvement	$200,000 per year	25
#4: Training	$100,000 per year	25

In particular, the National Center on Child Abuse and Neglect recommends initiating such projects as: programs for women with children, residential treatment programs, family preservation programs, specialized programs for foster care children, and even grandparent support groups (NCCAN, 1994).

Two examples of how the Emergency Child Abuse and Neglect Prevention funds have aided CPS agencies can be seen in the development of Project TEAMS in California and Project Futures in Chicago. Project TEAMS is a two-component training program administered by the UCLA Department of Pediatrics. The first component is a six-month

intensive training course for 40 public health nurses and protective service workers who serve drug-exposed children and their families. The course promotes a team approach to assessing the needs of this population. Participants learn about the medical, developmental, environmental, and physical care needs of drug-exposed infants and toddlers, and about the impact of substance abuse on family functioning.

The second component of TEAMS is a one-year professional training program with a major focus on drug-exposed children and drug-involved families. Participants attend a weekly seminar and are required to complete a field placement or research project on child abuse and neglect issues. Although TEAMS funding from NCCAN has expired, the program now receives funding from the Department of Children's Services and the Los Angeles Board of Supervisors (Ahart, 1991).

Project Futures is a cooperative venture between state-level agencies and local service providers in Chicago. The program was formed through an interagency cooperative agreement among the Illinois Departments of Children and Family Services, of Alcoholism and Substance Abuse, and of Public Health. Located on the west side of Chicago, the program is targeted to cocaine-affected infants and their mothers. Most of the families served are African American. CPS caseworkers refer drug-abusing parents to Project Futures as an alternative to placing their children in foster care. The program's fundamental goal is to ensure that no child dies from abuse or neglect as a result of a mother's drug abuse. Project Futures provides an array of services to clients, including outpatient drug treatment, temporary housing, counseling, and parenting classes. A drug treatment plan based on individual need is designed for each parent and clients receive weekly home visits to provide support during drug withdrawal. The program also provides residential options designed exclusively to accommodate women with children. This option is usually utilized by parents who are homeless or need to leave a home environment where other family members may also be substance abusers (Ahart, 1991).

In order to further assist substance-exposed children, the National Center on Child Abuse and Neglect also recommends that specialized child protective services units be established to work with chemically-dependent families. Programs of this type which have already been established address the needs of substance abusing families by keeping worker case loads low, providing intensive training on alcohol and drug related topics, and through "vertical case management." According to NCCAN, vertical case management allows a single case worker to handle emergencies, family maintenance, family reunification, and permanency planning services for one family (NCCAN, 1994).

B. Family Substance Abuse and Foster Care

Although maintaining families is the first priority of the child welfare system, when the safety of the child can not be ensured, the child must be removed from the

home. Finding appropriate out-of-home placements for children while working toward a permanent plan for the child (whether family reunification or termination of parental rights and adoption) is the primary responsibility of the Foster Care system. Because of the close relationship between child protective and foster care services, there is a clear "trickle down" effect of family substance abuse on the foster care system. Here we briefly address the impact of this trickle down effect on fostrer care and the response of foster care systems.

IMPACT OF PARENTAL SUBSTANCE ABUSE ON FOSTER CARE

At present, the foster care system appears to be in crisis. The Administration for Children and Families estimates that no part of the child welfare system is in more trouble than foster care. Between the years 1985 and 1991, the number of children requiring foster care placements rose from 245,000 to approximately 429,000. During the same period, the number of foster families decreased from 137,000 to 100,000 (U.S. Advisory Board on Child Abuse and Neglect, 1993). In addition, although foster care was initially conceived as a temporary response, children are now staying in foster care longer than they did 10 years ago. In New York City in 1986, 60 percent of the babies discharged from hospitals to foster care-mostly babies exposed to crack-were still in foster care three years later. Of those in foster care, 56 percent had been in two or more foster homes, and 20 percent had been in three or more homes. Several children under age five had been in more than five homes (Besharov, 1990).

Officials blame most of this increase in demand for foster care on the problem of substance abusing parents. Support for this contention can be found in many forms. For example, a GAO study compared and contrasted the population sizes and distinctive characteristics of 32,132 young children in foster-care programs in California, New York, and Pennsylvania, the states with the largest average foster-care population in 1986 and 1991. The investigators found that the number of children in foster care who had at least one parent who was abusing drugs or alcohol was 78 percent in 1991, compared with 52 percent in 1986. In both 1986 and 1991, cocaine was the most prevalent drug being abused by the parents of these children (GAO, 1994).

In another study, conducted by the Child Welfare League of America, 87.1 percent of those providing foster care services reported that children prenatally exposed to alcohol or other drugs were more likely to requite multiple foster care placements than other children. The same was true for children whose parents abuse substances. In addition, it was reported that these children remain in foster care for longer periods than do others (Curtis, 1993).

Additional support for the link between parental substance abuse and increases in foster care may be found in the fact that the States and cities hardest hit by crack addiction are those that have experienced the largest increases in their foster care

populations. Dramatic increases have been reported in Washington, D.C. and Baltimore, for example. Likewise, California's foster care population rose 41 percent between 1984 and 1988, and New York City's increased by 98 percent (Feig, 1990).

Another major trend resulting from the increase in parental drug abuse is the "boarder babies" syndrome. Boarder babies are babies who remain in the hospital, even through they are ready to be discharged, for reasons such as parental abandonment and lack of available and appropriate foster care placements. A GAO study that examined the medical records of newborns born at 10 hospital in 1986 found that 1,200 of the 4,000 infants born drug-exposed were in need of foster care (GAO, 1990).

As discussed previously, some States require hospitals to refer every infant with a positive toxicology to child welfare. The number of babies boarding in hospitals was found to be highest in areas where the law requires a CPS referral for all drug-exposed newborns. Shortly after such a law was passed in Florida, it was not uncommon to find 20 to 30 boarder babies in a Miami hospital at any one time in need of foster care (McCullough, 1991).

The effect of boarder babies on the foster care system is considerable. This is true not only because of the numerical increase in placements to be made, but because these boarder babies often require special medical and developmental services. Responding to this change in foster care needs means recruiting foster families who can provide care to very young children and meet the needs of developmentally, emotionally, or physically handicapped children. In the CWLA survey, 47.7 percent of the respondents reported that they have problems fmding foster parents for children prenatally exposed to substances (Curtis, 1993).

Further substantiation of the special care which substance-exposed children require from foster parents was reported in a study of the "Baby Moms" program (more formally named the Fragile Infant Special Care Program), run by the San Francisco Department of Social Services. The study reviewed three distinct categories of foster parents: current "Baby Moms," persons either directly or indirectly encouraged to leave the program, and rejected applicants. Despite a small sample size, significant differences between the groups were found, suggesting that foster parents who successfully care for severely ill infants possess measurable and important qualities (Cohon, 1992).

The care of the very young, medically fragile, and handicapped children also significantly increases the cost of foster care because families taking these children usually receive higher foster care payments and the children often require costly medical, educational, and psychological services. For example, 70.5% of the foster care workers surveyed by the Child Welfare League stated that foster parents of AOD abused children require more worker collaboration and help than do other parents (Curtis, 1993).

The basic per-capita foster care costs in New York, Los Angeles and Chicago ranges from $3,600 to $5,000 per year (GAO, 1990). Nationally, the average amount paid to foster care parents per child ranges from $1,000 to $4,000 (Besharov, 1990; McCullough, 1991). However, specialized foster care, such as that boarder babies and other substance-exposed children often require, may cost between $4,800 and $36,000 annually. Total expenditures for all drug-exposed children in need of foster care and adoption services totaled $1.375 billion in FY 1990 (Feig, 1990).

FOSTER CARE RESPONSE TO FAMILY SUBSTANCE ABUSE

When it is determined that a child of substance-abusing parents is living in an unsafe environment, the child's safety must be placed above the goal of keeping a family together. As has been discussed, the impact of AOD on the foster care system is dramatic. Such problems as personnel shortages and shortages of foster parents are all compounded when substance-abused children are involved (Curtis, 1993). In 1988, the U.S. Congress passed legislation to establish the Abandoned Infants Assistance Demonstration Grants Program to meet the needs of boarder babies. The intent of the program is to provide needed social services to families of abandoned infants; to recruit, train and retrain foster parents; and to operate residential programs for drug-exposed children and children with AIDS. In addition, respite care programs have been established, and health and social service personnel have been recruited and trained to work with families, foster families, and residential care staff. Program components include home visits, developmental child care, parenting education for mothers during and after pregnancy, and drug and alcohol treatment (Feig, 1990). The Children's Bureau funded 40 Abandoned Infants Assistance Programs in fiscal year 1990.

As this might suggest, the primary approach to addressing the impact of family substance abuse on foster care has been first to focus on services which make initial entry of the child into foster care less likely and second to promote family reunification through provision of supportive services to the family. The Bureau has funded programs that take an innovative approach to assisting families with substance abuse problems. Using of multidisciplinary teams to coordinate services to assist these families is a popular approach. In Chicago, the major hospitals use multidisciplinary teams to conduct health and safety needs assessments for drug-exposed infants. Workers use these assessments to determine the type of placement required for drug-exposed infants (Ahart, 1991).

In addition, the National Advisory Board on Child Abuse and Neglect, recommends a number of innovative approaches which could begin to stabilize the crisis in which the foster care system finds itself. The Board suggests, for instance, that foster care be made part of a constellation of neighborhood-based supports for children and families. Ensuring that children are protected would be embedded in local responses. This would mean developing such programs as:

- Open or partial foster care in which children would go to a second home after school, but still live with their parents. It might also mean a child remaining in 24 hour foster care only when their family finds itself under unusual stress;

- Whole family foster care in which the entire family participated in the foster care experience; and

- Kinship care (or foster care by relatives) (U.S. Advisory Board on Child Abuse and Neglect, 1993).

Finally, case management is beginning to be introduced into the foster care system. While, case management is an accepted technique for coordinating human services, it has not been used with high-risk children. At the Center for the Vulnerable Child at Children's Hospital, Oakland, California, case management has been introduced into multidisciplinary clinical programs for foster children, drug-exposed infants, etc. This allows health, social work and child welfare professionals to coordinate the aid which is provided to the children. Case management activities were altered for each group, depending on their characteristics and problems encountered (Halfon, 1993).

C. PARENTAL SUBSTANCE ABUSE AND ADOPTION SERVICES

As might be expected, the impact of family sustance abuse on, and therefore the system response of adoption services has been less than that for either CPS or foster care. Adoptions comes into play only when a decision is made to move for termination of parental rights in these cases. The Children's Bureau's entitlement and formula grant programs are the largest component of the Children's Bureau programs and budget -- Title IV-E (foster care and adoption Assistance) and Title IV-B. These programs disperse funds to the States who may use them to provide direct services or enter into agreements and contracts with other public and private agencies for provision of appropriate services. Of the nine programs in the Bureau, only one -- the Abandoned Infants Assistance Program -- specifically targets drug exposure of an infant or young child lacking a non-hospital housing alternative. The other programs do serve some children from substance abusing families, but only to the extent that these children meet other specific program requirements (e.g., age, need for care, etc.).

IMPACT OF FAMILY SUBSTANCE ABUSE ON ADOPTION SERVICES

When a child is abandoned or cannot be safely returned home, adoption services become the placement option of last resort. Family substance abuse impacts on adotive services primarily in two ways: First, by increasing the number of children (primarily drug-exposed infants) for whom adoptive homes need to be found, and second by

complicating the overall adoption process reflecting the special needs presented by many of these children.

Among all drug-exposed children declared court-dependent in 1989, the rate of foster care placement was 60 percent, and many of these children were expected to become candidates for adoption (Barth, 1991). The literature reports two barriers to providing children with permanent homes. One is the process for terminating parental rights, which in theory takes 18 months but in practice can take as long as three years if a parent contests the action. Second, the demand for adoption has outpaced the availability of adoptive homes, particularly in terms of special needs children.

The fundamental blueprint for the Nation's child welfare system is the Adoption Assistance and Child Welfare Act of 1980. Although it is based on the idea that families ought to be maintained, the new generation of substance-exposed children may not be suited to this system. In fact, working toward the goal of maintaining families has put many child welfare agencies in conflict with the public. State and local child welfare agencies are being charged with failing to sufficiently protect children (CSR, undated). In recent years, some States and local jurisdictions have moved toward expediting termination of parental rights based on abandonment by reducing the required time period.

Although broadening the conditions for terminating parental rights may release children for adoption at younger ages, there is still a question of whether there are adoptive homes for many of these children (Anderson, 1990). When children of substance abusing parents are made available for adoption, they often bring with them severe physical, developmental, and emotional problems. Many of these children need years of extensive services that prospective adoptive parents many be unable to afford or reluctant to assume. In fact, 83.5 percent of adoption workers who have placed prenatally-exposed children in adoptive homes claim it is more difficult to place these children than it is to place other children (Curtis, 1993).

Part of the reason for this stems from the potential for difficulties arising in the future. The detrimental affects of fetal alcohol syndrome and drug-exposure, such as learning disabilities, emotional problems, etc. may not show themselves until the children are of school age. Although the majority of families who adopt handicapped children (including drug-exposed infants) find the placement rewarding, there are still many problems which must be dealt with (Rosenthal, 1992). More and more adoptive families have been returning to their state agencies requesting additional funding to cope with the problems of substance-exposed children (Interstate Compact, 1992). Cases of adoptive parents suing agencies because they were not told that the child had been prenatally-exposed to alcohol or drugs are also becoming more frequent (Cass, 1992; Komissaroff, 1992).

ADOPTION SERVICES RESPONSE TO FAMILY SUBSTANCE ABUSE

One way in which adoption agencies are attempting to ensure permanency for children removed because their parents abuse alcohol and drugs is through a process known as "fast-tracking" adoptions. Children removed from particularly dangerous situations may be placed into "pre-adoptive" homes while they wait for the termination of parental rights process to be completed (DHHS, 1992). Many states are also moving to speed up the termination process in cases of abandonment, from an average of one to two years, to an average of six months (DHHS, 1992). Some experts, however, feel this response is insufficient and parental rights should be terminated when parents exhibit no real effort to cease their substance use (Besharov, 1990).

Another response which adoption agencies are using to aid children incorporates "Fost-Adopt" programs. These are programs in which foster parents plan to adopt the child they are caring for. More and more States are accepting these programs as legitimate avenues for ensuring permanent homes for children (DHHS, 1992).

Just as the foster care system is considering developing "open" or "partial" foster care options, open adoption is becoming a more common element in serving special needs infants. In cases where open adoption occurs, post-placement contact with the biological parents is maintained. In a survey of 1,268 adoptive parents in California, those parents involved with open adoption seemed fairly comfortable with the situation, with a few exceptions (Berry, 1993).

The problem which AOD exposed children can pose for adoptive parents, in terms of medical and psychological treatment are the same as those confronting foster parents addressed previously. IV-E Assistance is available to adoptive families with children who display special needs (due to substance exposure or genetic disorder). Two court orders have been handed down which should aid adoptive families in securing funds, even if they have been denied aid in the past or if they did not request aid at the time of finalization (Interstate Compact, 1992). In addition, adoption agencies are increasingly modifying their policies to be more forthcoming about the problems which drug-exposed children may face. Providing as much information and training to adoptive parents of these children may even increase that chance that the child will have fewer problems. Many studies are now showing that early intervention and treatment can be very effective with drug-exposed children (Chasnoff, 1992; Rinkel, 1992). Research has also not completely documented the long-term effects of exposure, or the effects of a loving, nurtming adoptive home (Jenista, 1992).

D. Family Substance Abuse and Head Start

Head Start is the comprehensive child development program that serves approximately 700,000 low-income pre-school-age children. Head Start programs provide a full range of services to children, including educational, medical and dental, nutritional,

social, and mental health services. During its 28-year history, the program has changed its approach to focus as much on the family as the preschool child, and to be attentive to the special needs of certain populations. In addition to administering local Head Start service systems, Head Start also administers the Comprehensive Child Development Program and Parent/Child Centers which are designed to address the needs of younger children and their families. Head Start staff recognize that substance abuse is a growing problem among the families they serve and Head Start has in place a comprehensive substance abuse strategy including education and services for substance abusing families (Head Start 1991).

IMPACT OF FAMILY SUBSTANCE ABUSE ON HEAD START

While the impact of parental substance use on Head Start is not as immediate or obvious as the impact on the child welfare system, these programs also experience negative consequences as drug-exposed infants and children from substance abusing families seek services from them. Although the perinatal complications of drug exposure are well known, studies are just now revealing the long-term effects of substance abuse, and in particular cocaine, on children's development past infancy. Children born with fetal alcohol syndrome (FAS) have been found to require special attention to meet their educational and developmental needs, which are often extreme (DHHS, 1990).

As these children become eligible for the Comprehensive Child Development Program, the Head Start Parent Child Centers, and Head Start programs, they will need services that extend beyond those currently offered to families and children. When 117 grantees were sampled for an OIG study on family dysfunction among Head Start families, grantees ranked substance abuse as the most common problem shared by dysfunctional families and mentioned alcohol and illicit drug use as common (OIG, 1989). Head Start directors estimate that 20 percent of the children enrolled in their programs live in substance abusing families (CSR, undated). Because the Bureau does not require Head Start programs to maintain records or to report on the number of parents who are known or suspected substance abusers, this is most likely an inaccurate, low estimate. The Bureau acknowledges that it is reasonable to assume adults associated with Head Start may be affected by substance abuse in the same proportion as adults in the general population (Collins, 1991).

Head Start staff have begun to document the effects on children of living in a family with substance abuse problems. In Chicago, for example, staff noted that parents came to the center intoxicated or high, children acted out drug scenes while playing, such as cutting lines through sugar as though it were cocaine and pretending bread sticks were cigarettes or marijuana; children talked about their parents' alcohol and other drug use; and parents removed their children from the Head Start program because of a confrontation with staff about their drug use (Perinatal Addiction Research and Education, 1993). A Parent/Child Services program serving 135 children in Multnomah County,

Oregon, estimated that 50 percent of the children served showed signs of the effects of prenatal drug-exposure (Ahart, 1991).

When a child enters Head Start, an Individualized Family Service Plan (IFSP) is developed by the staff in consultation with the child's parents. The purpose of the IFSP is to provide staff and teachers with information about a child's characteristics, abilities, and needs in order to understand each child, help children adapt to the classroom environment and provide any special assistance they may require. Yet parents who abuse substances seldom participate in their children's education and may delegate caregiving to others, creating a barrier for staff in their efforts to assess children's individual needs. Some parents may fear prosecution if they are asked to disclose information about their child's drug exposure. Issues such as these limit the Head Start staffs' ability to learn about a child's home environment, possible drug exposure, and other needs a child may have (CSR, undated).

Head Start Response to Family Substance Abuse

In general, Head Start believes it can play an important role in aiding families affected by substance abuse in a number of other ways. These include:

- Offering prevention activities for families and staff;
- Providing substance abuse information and education for families and staff;
- Developing formal ties with community agencies so that substance abuse resources and referrals will be available to families;
- Providing a warm and supportive environment for staff and families to discuss the problems associated with substance abuse;
- Adapting classroom curricula and resources to meet the needs of children demonstrating harmful affects of substance-exposure, whether prenatally or from current situations; and
- Working with other community-based programs to reduce the violence and family stress associated with drugs (Head Start, 1991).

None of these roles would require Head Start teachers and other personnel to become substance abuse experts. Rather, they need to be capable of understanding the basic needs presented to families by substance abuse, and be able to access other available

resources. In order to carry out the objectives listed above, staff must be trained to deal effectively with chemically-dependent parents and their children.

In 1989, a national work group was convened by the Head Start Bureau in Washington, D.C., to produce an action plan for grantees to address substance abuse. The goal of the meeting, attended by National Head Start Association members and Head Start administrators, was to discuss Head Start's role in assisting families with substance abuse problems and to understand how to effectively coordinate efforts for prevention, intervention, and treatment (National Head Start Association, 1990).

One result of the national work group was the decision to establish the Family Service Centers (FSC) demonstration projects. The purpose of these projects is to strengthen Head Start's capacity to build on existing program features and develop effective strategies for collaboration between Head Start programs and community agencies, in or&r to address the problems of substance abuse, illiteracy, and unemployment faced by many Head Start families.

Since 1990, the Bureau has provided funds to 66 Head Start agencies to develop and implement FSC demonstration projects to assist Head Start families with substance abuse and other problems that create family dysfunction. Since 1990 the average grant award has been approximately $245,000 a year for three years. Currently, 65 FSC projects are in operation in 36 states, serving approximately 4,700 families. A breakdown of how these funds were distributed throughout the Head Start programs' 10 regions is listed in the Head Start Family Service Center Demonstration Projects (ACYF, 1994).

As one example, Head Start and the Robert Wood Johnson Foundation have begun a collaborative program to help local Head Start programs develop and implement model substance-abuse prevention projects. The goal is to reduce children's vulnerability to a range of high-risk behaviors, particularly substance abuse, as they grow older. The program is administered by the Columbia University School of Public Health. Specific projects focusing on substance abuse prevention commenced at six Head Start sites in mid-1994. These projects will link families with human service and health organizations that can work with them well beyond a child's Head Start years. Project objectives include:

- Helping parents enter the labor force, obtain child care, and secure other needed services.
- Helping families involved with illegal drugs or alcohol.
- Supporting adults who assume the primary caregiver role.
- Creating safe places for young children and families in neighborhoods.

- Heightening awareness among local leaders of the concerted efforts among schools and community-based organizations to reduce demand for illegal substances.

Another cooperative Head Start project involves the National Association for Perinatal Addiction and Education (NAPARE) and is funded by the Administration for Children and Families, the City of Chicago, and the Chicago Department of Human Services. This project will develop a curriculum to address issues related to substance abuse that is designed to help Head Start staff appropriately intervene with families and children who are prenatally or environmentally exposed to alcohol. Training will be divided into modules that will focus on learning about the problem and the families involved, developing greater knowledge about addiction and recovery, learning about the effect of prenatal and environmental exposure to drugs, identifying appropriate interventions for children, discovering ways to facilitate positive parenting, and identifying and utilizing individual, organizational and community resources (Perinatal Addiction Research and Education Newsletter, 1993).

Local Head Start programs are also assisting families with substance abuse problems through prevention materials designed for children. The National Head Start Association and the Center for Substance Abuse Prevention have designed a series of substance abuse prevention materials for use by local Head Start programs, including a teacher's guide, an activity book, and a trainer's guide (National Head Start Association, 1993a).

E. Family Substance Abuse and RHY Services

The Family and Youth Services Bureau (FYSB) primarily supports programs meeting the needs of youth who are, or who are at high risk of becoming, runaway or homeless youth (RHY). These youth often have experienced abuse, neglect, or other problems in their own home, or they may have prior histories of delinquent behavior, particularly status offenses. Altogether, FYSB administers four funding programs:

- The Basic Center Grants program which provides ongoing funding, on a competitive basis, for runaway and homeless youth emergency shelters;

- The Transitional Living Program Grants program which funds demonstration projects for providing services to older youth to better prepare them for independent living as adults;

- The Youth Gangs Prevention Grants program which funds demonstration projects focusing on preventing youth involvement in gangs; and

- The Drug Abuse Prevention Program for Runaway and Homeless Youth which funds demonstration projects designed to prevent AOD abuse among RHY youth or youth at risk of becoming runaways or homeless.

The Runaway and Homeless Youth Program was developed to provide services to these youth and their families with the primary goal of reuniting the youth with their family. Family and Youth Services Bureau (FYSB) programs seek to provide positive alternatives for youth, ensure their safety, and maximize their ability to take advantage of available opportunities.

IMPACT OF FAMILY SUBSTANCE ABUSE ON RHY SERVICES

The available literature on the effects of parental substance abuse on adolescents is sparse. Studies on runaway and homeless youth have focused primarily on the psychosocial behavior of adolescents as the root cause of departure from their families. Parental substance abuse however often results in chaotic and dysfunctional family environments for adolescents as well as younger children. While younger children may come to the attention of child welfare agencies, to escape intolerable family lives many adolescents simply leave home and many others are pushed out or abandoned by their parents (GAO, 1989; Smollar, et al., 1985). A GAO study (1989) of runaway and homeless youth services indicated that 18 percent of the youth seen by federally funded shelters reported that their parents had substance abuse problems. The Southeastern Network (1989) of Runaway and Homeless Youth Services, in its review of the programs included in the network, reported 20 percent of youth indicated that their parents had substance abuse problems.

While limited data are available regarding the effects of parental substance abuse on adolescents, one study suggests that adolescents may run away from home and live on the street or in shelters for two primary reasons: a family history of alcoholism or other drug abuse and parental drug use or positive parental attitudes toward substance abuse (OSAP, 1992). In a 1990 survey by the Southeastern Network of Youth and Family Services, 12 percent of 253 youth respondents reported that their parents had used crack in their presence and 15 percent knew that their parents used crack. Over 54 percent of respondents reported that their parents consumed alcohol in their presence and 18 percent said their parents' substance abuse was a problem. More than 50 percent of those responding identified parental substance use as a motivator for their own use of substances (Jarvis, 1990).

A study conducted for the Administration on Youth and Families examined parental substance abuse and child maltreatment as causes of youth homelessness. The study reported that 26 percent of mothers (or mother figures) and 36 percent of fathers (or father figures) of homeless or runaway youth abused alcohol. The study's preliminary fmdings suggest a high correlation between maternal alcohol abuse and sexual abuse of

the child In addition, there was a high correlation between physical/sexual abuse and the current level of mental distress felt by the interviewed youth (van Houten, 1992). Other studies suggest that in order to escape intolerable family lives, many adolescents simple leave home, while others are pushed out or abandoned (GAO, 1990).

Just as the focus of foster care and adoption agencies is changing in light of substance use problems, runaway and homeless youth programs are finding that reunifying adolescents with their families may not be in their best interest. As the number of children with substance-abusing parents who seek shelter and services through the program has increased, the need for shifting priorities and alternative living arrangements for the children has also increased. This has created a serious problem for the federally funded program. The Basic Center grantees are limited to sheltering youth for no more that 2 weeks, although more extended stays are possible under special circumstances. However, because they were not created to be permanent residences, other arrangements are needed for youth of substance abusing parents or guardians. Although child welfare placements may serve as a resource for these youth, they are insufficient to meet the demand and, for those 16 and older, alternative long-term placements may be virtually nonexistent.

Children from families with at least one substance-abusing parent are at a higher risk of developing their own substance-abusing problems as adolescents and adults (Blau, 1994). Many runaway and homeless youth exhibit signs of alcohol use. One study, conducted by the national network of Runaway and Youth Services, reported that 46 percent of runaway, homeless and other youth in high-risk situations had a substance abuse problem; 14 percent of the youth were addicted to alcohol or drugs (National Network of Runaway and Youth Services, 1991). Other studies have found even higher levels of substance use and abuse among runaway and homeless youth. For example, a study in Los Angeles found that 85 percent of the runaway and homeless youth served at a free clinic used drugs, 57 percent were addicted to alcohol or other drugs, and 35 percent used IV drugs (National Network of Runaway and Youth Services, undated).

The limited information available suggests that the increased prevalence of substance abuse among both the parents of RHY youth and these youth themselves are fundamentally altering the nature of the RHY problem, and negatively impacting on the capacity of existing service models to meet the needs of these youth and their families.

RHY Programs Response to Family Substance Abuse

In FY 1990, FSYB awarded $12,098,197 for 80 new grants to conduct projects in three priority areas:

- **Comprehensive service projects** to encourage the development of community support and resources. Their purpose is to ensure the provision of high quality, coordinated drug-abuse prevention and

reduction efforts in rural areas and in communities with fragmented or minimal services for runaway and homeless youth. FSYB awarded $5,880,289 for 38 projects in this priority area.

- **Local community and statewide impact projects** to coordinate community-based drug abuse prevention services in rural areas and in communities with few services, and to develop statewide organizations supporting runaway and homeless youth. FSYB awarded $1240,508 for 10 Local Community Impact projects and $298,019 for 6 State Impact projects.

- **Demonstration projects for increased services to minority youth, services to older homeless youth in transition to independent living programs, and adolescent pregnancy projects** to support the development of model approaches for addressing the prevention and reduction of illicit drug use by the targeted populations. FSYB awarded $2,726,208 for 15 Minority Youth Projects, $998,932 for six Older Youth in Transition to Independent Living Projects, and $954,241 for five Adolescent Pregnancy Projects.

In FY 1991 FSYB awarded $14.8 million in continuation grants to 120 Drug Abuse Prevention Programs (DAPP) grantees to continue their drug abuse prevention and intervention activities to runaway and homeless youth and their families. These projects focused on:

- Continued improvement or expansion of existing services
- Further development of service networks in rural and other areas with scarce resources
- Continued development of innovative program models
- Provision of special services for Native American youth on or near Indian reservations and Alaskan Native villages
- Strengthening of service networks for local, as well as statewide coordination efforts

A breakdown of how these grants are distributed by state is listed in the Drug Abuse Prevention Program booklet for Runaway and Homeless Youth (DHHS, 1994).

In an ACYF funded study, researchers discovered that service providers need to take an aggressive role in reaching out to identify the youth and families affected by

substance-abuse. Additional services are also required by youth once they become homeless. The study recommended such things as: long-term shelter, education, employment, training, and related counseling (van Houten, 1992).

To further understand the reasons why adolescents abuse substances, FSYB has funded a national study of substance abuse by runaway and homeless youth. The study examines the extent of alcohol and other drug use among runaway and homeless youth, the role of alcohol use by family members in decisions by youth to run away from home, and the nature of services received by runaway and homeless youth with substance abuse problems. This study will elucidate the effects of parental substance abuse on adolescents. Its results will be released for publication in late 1994 (DHHS, 1994).

ZZZ. DISCUSSION

Substance abusing families present numerous problems for ACYF-administered programs. AOD (alcohol or drug) abuse is one of several forms of family dysfunction that cut across all populations served by ACYF programs. Recent studies have documented the pervasive ecological, economic, and system factors associated with families needing ACYF program services. These families are more likely to be low-income with single mothers as head of household, and disproportionately represent undereducated, minority populations. There also are strong indications that substance abusing families are a persistent and growing segment of the low-income families all ACYF programs serve.

The problem of family substance abuse affects the management, administration, and operations of each and every ACYF program. The child from a substance abusing family, and the family as a whole, present very complex human service, child welfare, and educational challenges. Unfortunately there is little available information that ACYF programs can use to systematically plan ways to address the needs of substance abusing families and their children. There is even less information available regarding how the changing nature of AOD abuse within the families served by ACYF programs has impacted on the capacity of these programs to achieve their mandated goals and purposes.

If ACYF is to respond effectively to the impact of substance abuse on families and the programs it administers, more concrete and comprehensive information on both the nature of the impact of family substance abuse and the efficacy of system responses must be collected and analyzed. A number of under-researched areas critical to understanding parental substance abuse and its impact on ACYF service delivery systems are apparent from the literature. First, there remains a paucity of concrete information regarding the substance abusing populations served by ACYF programs. Second, there has been little evaluation to date of either program or policy initiatives designed to specifically address family substance abuse in these service populations or the concomitant problems created by family substance abuse. Finally, despite recent program initiatives chronicled here, there persists a lack of specific information on emergent or exploratory strategies or approaches to addressing problems related to family substance abuse in these populations, including such factors as addressing chronic neglect, basic service providers training needs, and recruiting, training, and supporting foster and adoptive families.

Improved Descriptive Statistics on Substance-Abusing Client Populations

A persistent problem for ACYF is a lack of concrete information on the substance-abusing client populations of ACYP-funded programs. Systematically collected national data regarding the estimated percentages of families with AOD problems and how these families impact ACYF-funded service delivery programs are not available; similarly, comprehensive data on the service needs of substance abusing families and their children are simply not available. Such data may also facilitate system-wide program planning and management within ACYF, and at a minimum includes information on:

- the public policy and procedural context in which various ACYF-funded programs operate, particularly the child welfare programs of CPS, foster care, and adoptions operate in relationship to client AOD abuse;

- changes over time in AOD abuse prevalence among client populations, including changes in the nature, scope, and intensity of of the problem;

- descriptive data on the scope and pattern of current approaches and practices to addressing family substance abuse by ACYP-funded programs (e.g., service provision models, risk assessment and risk abatement approaches, levels of staff training, etc.)

- the relationship of family substance abuse to general and specific service level demands, including the service needs of children and families with suspected or known AOD abuse problems, and the similarities and differences of these needs across ACYF program areas; and,

- the number of children in foster care or available for adoption who have special service needs resulting from suspected or known parental AOD abuse.

In a study conducted by OIG (1990), only eight of the 12 cities visited could provide the number of crack babies reported to the child welfare system. Even fewer localities record information linking substance abuse to child abuse and neglect cases, foster care placements, and children entering early childhood education programs. Head Start, for example, currently states that approximately 20 percent of its clients nationwide are impacted by family substance abuse. Although this figure is widely quoted, it is based on supposition rather that statistical evidence (Head Start, 1991). Individual program surveys tend to quote figures three and four times higher than the 20 percent ceiling.

The incidence of alcohol use and abuse among the runaway and homeless youth population is equally uncertain. Studies report that anywhere between 20 percent (GAO,

1990) of the runaway and homeless youth population surveyed and 100% (National Network of Runaway and Youth Services, undated) abuse substances. Without clarifying the actual numbers of substances abusers in certain populations, ACYF cannot fully understand the needs of substance abusing families, the impact of family substance abuse on children, and what alternatives and support systems should be implemented to offset detrimental outcomes.

The literature also suggests that research should be supported to determine the prevalence of illegal drug use among women and the relationship between illegal drug use by pregnant women and birth and developmental outcomes. Recommendations also cover other areas that have implications for tracking the numbers of children and families affected by substance abuse, such as participation in national data collection and analysis programs. One example is currently supported by NCCAN. The National Child Abuse and Neglect Data System (NCANDS) Summary Data is a voluntary reporting program on child maltreatment reported to and investigated by State child protection agencies. States currently receive technical assistance to facilitate participation in this Federal information system that was designed to assist policy makers and practitioners. While all States do not participate, the literature suggest that such participation would greatly enhance coordination and service delivery.

Program Evaluation and Public Policy Assessment

There is a definite need to improve the assessment of current responses of service delivery systems to the needs of children and families involved with substance abuse. Although ACYF has recently funded initiatives in response to the growing problems associated with family substance abuse, little evaluation literature has been published documenting the successes and failures of these efforts, their strengths and deficiencies, and what factors contribute to positive and negative outcomes. In particular, little research has been conducted addressing the impact or effectiveness of changes in public policies, statutes, or regulations in addressing family substance abuse-related problems. Given the apparent scope of the problem, it is important that public policy assessment be directed at both broad new initiatives as well as specific targeted efforts in terms of their effectiveness in addressing the needs of this population.

For example, while there is a growing belief that social and family supports can be important deterrents to child abuse and neglect, few studies have assessed the kinds of supports which are most likely to prove beneficial to at-risk families with a substance abuse problem (U.S. Advisory Board on Child Abuse and Neglect, 1993). Some cities have organized high-risk drug baby units to provide intake and risk assessment for drug-exposed infants. The caseworkers assigned to these units are trained to deal with the needs of the substance-abusing mother and her child (OIG, 1990). In some cities, the child welfare agencies have decentralized services into zones and community services, and case workers are now physically located closer to the families they serve (OIG, 1990). No studies, however, have been conducted to determine whether these changes are

successful in improving outreach and intervention with substance abusing families. The lack of evaluation prevents ACYF from determining if these initiatives can and should be replicated in other settings.

Similarly, public policies mandating reporting and sometimes temporary removal of substance-exposed newborns, and accelerated termination of parental rights procedures for AOD-exposed infants remain for the most part unexamined in regard to their long term consequences for children and families. As addressed previously, criminalization of prenatal drug exposure has both its supporters and detractors, but little concrete research to support its efficacy as either a deterrent or intervention approach.

Specific program and public policy research initiatives are needed to evaluate and assess the efficacy of current service delivery models and approaches. Such research would address multiple topics including:

- the kinds of barriers agency staff confront in serving children and families with suspected or known AOD abuse problems and current program strategies for dealing with such barriers;

- the kinds of systems-wide practices, procedures, and/or staff training that are needed to most effectively meet the needs of AOD abusing families in ACYF programs; and,

- short-term and long-term research on outcomes of intervention efforts with AOD-abusing families and their children;

Research on Service Provider Needs and System Innovations

Research is also necessary to better understand the needs of service providers and strategies for meeting those needs. For example, in the substance abuse field it is widely accepted that it is not possible to change the general behaviors of substance abusers until the substance abuse behavior itself is changed (Besharov, 1990). It is important to note, however, that child welfare workers, early childhood program staff, and runaway and homeless youth program staff are not drug treatment professionals. Rather than treating substance abuse, it is essential that professionals who work with parents and children understand the indicators and dynamics of substance abuse, routinely look for it in the families they serve, and be prepared to intervene when substance abuse is suspected (NCCAN, 1994). In particular, research needs to be conducted which focuses on how to improve the capacity of service providers in these important roles.

The available literature also suggests that CPS service providers need new and more effective strategies for addressing chronic low-level neglect in substance-abusing families. Alternate intervention strategies with these families need to be developed, implemented, and assessed in terms of the efficacy. Research on the long-term effects of substance-abuse related chronic neglect on children, and system strategies for ameliorating these effects through special early childhood programs such as Head Start is also needed.

Finally, research is needed to assess the impact of changes in substance abuse on the recruitment and retention of foster care and adoptive parents. As noted previously, the increase in children requiring foster care placements seems to have resulted in a severe shortage of foster care families. There are several issues that need to be resolved with respect to this finding. First, studies should be conducted to determine whether the shortage of foster care families is due to a failure of agencies to recruit and retain quality foster care homes, or whether it is a result of the difficulty involved in finding foster parents to care for children suffering the effects of parental substance abuse. Second, additional work is required to better determine the needs of foster parents who do care for substance abused children. Experts have suggested that certain conditions must be met if foster parents are to be recruited. These include increased payments, extensive support services, and specialized training for foster parents (Anderson, 1990). Others have begun to look at the qualities of foster parents best suited to caring for special needs children (Cohon, 1992). However, further and more comprehensive information is necessary to truly understand how foster homes need to be supported with both training and services.

The major issues pertaining to adoptive families which need to be explored include whether the need for adoptive families has been affected by substance abuse and whether there are families available to adopt children from substance abusing homes. Some experts maintain that there are families willing to adopt these children as infants, but that *the* child welfare system and the courts are not making them available for adoption by terminating parental rights (Besharov, 1990). Others insist that adoptive homes for these children are not available, due to the problems associated with prenatal substance abuse. Furthermore, it is argued that terminating parental rights to early may prevent families from being reunited (Besharov, 1990). More information is needed regarding the degree to which the shortage of adoptive parents reflects difficulties in recruiting and/or retaining parents willing to adopt infants exposed *in utero* to alcohol or drugs or children coming from substance abusing families. Children of substance-abusing parents often have severe physical developmental, and emotional problems. Many of these children will need years of extensive services for which prospective adoptive parents may be unable or unwilling to assume responsibility. The Adoption Assistance Program provides financial assistance to some of these families; however, there is still a question concerning the added burden on these adoptive parents and the general willingness of potential adoptive parents to assume this burden. In addition, several new approaches to adoption have been

attempted, such as "open" adoption, but additional research is necessary to determine what the affects of such situations are on the children and both sets of parents.

Despite attempts to address issues such as parental abandonment of newborns, drug-exposed infants, and increased maltreatment of children, child welfare systems require additional information on the impact of substance abuse on families and programs designed to serve them. Issues such as those presented above must be closely explored if ACYF hopes to effectively deal with the increasing demand which substance abuse is placing on the child welfare system.

Finally, the various programs administered by ACYF often serve the same clientele, either concurrently (e.g., CPS and Head Start) or in a consecutive interrelated process model (e.g., CPS-foster care-adoptions). Basic additional research is needed to enhance understanding of the core similarities and differences among programs in addressing family substance abuse and consistency and integration of family approaches across ACYF-administered program areas.

Addressing family substance abuse across ACYF programs involves system problems that require coordinated and integrated approaches . To implement such approaches ACYF needs additional information regarding how its various programs define and perceive the changing problem of family substance abuse. ACYF also needs information on existing innovative approaches to substance abuse-related service delivery by the various ACYF component programs and on the perceived impact of substance abuse on program resources and functioning.

Studies are needed to identify economies of scale in developing and providing informational materials, training, and technical assistance services to ACYF programs regarding substance abuse. By identifying commonalities of need across ACYF program areas, coordinated and integrated responses could be effectively developed. For example, program's administered by NCCAN (e.g., CPS) and by the Children's Bureau (e.g., Foster Care) may benefit from development of similar training programs which teach case workers strategies to use with substance-abusing parents.

ACYF has initiated numerous efforts in response to the growing concern among experts in the human services field that service delivery systems were being severely taxed by increases in the number of families with AOD abuse problems among their client populations and by the difficulties encountered in serving these families. Additional research however remains the key to improved response. In the absence however of an adequate research base for these efforts, or research on the efficacy of the various service delivery modifications and public policy changes they entail, the road to improved systems response to substance abusing families will be long and arduous -- it may be replete with hazards and detours along the way. Worst of all, it may in fact ultimately prove to be the wrong route to our ultimate destination: Improved quality for all our nation's children and families.

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APPENDIX C: ANNOTATED BIBLIOGRAPHY, SELECTED ARTICLES

Barth, Richard P. 1991. "Adoption of Drug-Exposed Children." *Children and Youth Services Review*, (13): pp. 323-342.

This article presents the findings of a study examining adoptions of drug-affected children in the state of California, which closely mirrors national numbers. The study compared adoptive parents' characteristics and experiences with drug-exposed and non drug-exposed children.

California showed a combined 167 percent increase in referrals of drug-exposed babies to child welfare services between 1986 and 1989. Single adults adopted 6.2 percent of all children and 6.9 percent of drug-exposed children. Adoptions by relatives, who are more likely to adopt drug-exposed children, accounted for approximately 10 percent of all adoptions. In addition, 81 percent of children adopted in public agencies were first cared for as foster children by their adoptive parents. On the whole, parents of drug-exposed and non drug-exposed children had similar expectations. Only 26 percent of adoptive parents of drug-exposed children indicated that the social worker supported their ability to care for a drug-exposed child. Parents of drug-exposed children also indicated being better prepared than parents of non drug-exposed children. This is attributed to the greater likelihood of adopting a drug-exposed child after providing foster care to him or her.

The article concludes that caring for drug-exposed children is more similar to than different from caring for non drug-exposed children. Thus, it should be understood by adoption social workers that these parents' experiences are roughly equivalent. Furthermore, it underlines the belief that adopting drug-exposed children--while not without challenges--is characterized by challenges that usually can be met.

Bays, Jan. 1990. "Substance Abuse and Child Abuse." Child Abuse, 37(4): August, pp. 881-904.

This article describes the incidence of families with substance abuse problems and its impact on child maltreatment. There are approximately 10 million adult alcoholics, 500,000 heroin addicts, and between five and eight million regular cocaine users in the U.S.

Research shows that most women drug users are in their child-bearing years. More than 300,000 infants are born annually to women using crack cocaine, and 10,000 infants are born to women using 'opiates. Alcohol is the most abused substance in the U.S., and the major teratogen to developing fetuses. In addition, cocaine-exposed infants are more often intrauterine growth retarded, with small head circumferences.

Most drug involved parents suffer from side effects that can interfere with good parenting skills. Intoxicated adults can become violent, paranoid, and less constrained about injuring, molesting, or neglecting children. The spouses or partners of women who are chemically dependent are also more'likely to abuse drugs or alcohol. It is estimated that 30 to 50 percent of men who abuse women also abuse children. Although few studies have examined the direct correlation between parental chemical dependency and child sexual abuse, one study found that incest fathers were more likely to have been drinking during the abuse.

The article offers the following recommendations: 1) child welfare agencies should anticipate the possibility for child abuse or neglect in drug addicted families, and investigate or intervene accordingly; 2) recognition 'of substance abuse should occur as early as possible in pregnancy to prevent damage to infants in utero; 3) preventing drug and alcohol abuse should be of higher national priority; 4) parents must receive drug abuse treatment while their children receive protective services; and 5) intensive efforts should be made to provide services to families who are willing to be treated for substance abuse.

Besharov, Douglas J. 1990. "Crack Children in Foster Care." *Children Today,* July-August, 19(4): pp. 21-35.

This article reports the findings of several studies of children prenatally exposed to crack. Even at its peak in the late 1960s and early 1970s, heroin withdrawal affected only one tenth as many newborns and did much less damage to them than does fetal exposure to crack.

For the first time large numbers of women who use drugs--particularly crack--have children or are pregnant. Children with parents who use crack are often abused and neglected. In addition, there is a severe nationwide shortage of drug treatment programs, especially for women; most have long waiting lists, and many do not accept pregnant women or mothers.

Research revealed an unprecedented surge in the number of children removed from their parents who were placed in foster care. Foster care was designed to be a temporary remedy for use only until parents were able to care properly for their children. However, presently, more children are returning home to parents who often still abuse drugs, only to be replaced in foster care. Many judges and caseworkers would place more children in foster care, but they believe that the emotional limbo of foster care can be as harmful to these children as can living at home with their drug-using parents. Some drug-using parents are able to care for their children, with support from social service agencies, but most children are at great risk while they remain in the home.

The growing foster care population of crack children is forcing a fundamental reexamination of state adoption laws. Making it too easy to terminate parental rights would be as harmful as current policy and would face legitimate opposition.

In light of these foster care issues, the article suggests that the first priority is having the high-quality foster parents, and the second priority is giving long-term foster children a sense of constancy. A confounding problem is that payments to foster parents have not kept pace with inflation of the decade. Agencies must compete against the marketplace for the mothers who were once their prime source of foster parents and who are now in the paid labor force.

Bijur, Polly E.; Kurzon, Matthew Overpeck, Mary D; et al. 1992. "Parental Alcohol Use, Problem Drinking, and Children's Injuries." *Journal of the American Medical Association,* June *17,* 267:23, pp. *3166-3171.*

This article reports the findings of a study conducted to assess the problems of parental alcohol abuse and children's injuries. The study consisted of a survey of 12,360 children and parents from single- and two-parent households.

At least seven million children in the U.S. live with at least one alcoholic parent, and 18 percent of U.S. adults report having lived with an alcoholic or problem drinker when they were children. Children of mothers categorized as problem drinkers had 2.1 times the risk of serious injury as children of mothers who were nondrinkers. Children of women who were problem drinkers married to men rated as moderate to heavy drinkers are at a greater risk of serious injury compared with children of nondrinkers. Spouses without problem drinking can reduce the: risk for child injury by providing emotional support and assuming responsibilities for parenting. For single-parent families, frequent moves and proximity to health services may result in barriers to seeking medical care for child injuries. This can also lead to injuries not being reported.

These nationally represented data have strong implications. Physicians who treat both parents and children need to be cognizant of the potential role played by parental problem drinking. The data suggest that the primary prevention of injuries might be enhanced if physicians included questions about parental alcohol use in patients' social history records.

Boland, Paul. 1991. "Perspective of a Juvenile Court Judge." *The Future of Children*, Spring, pp. 101-104.

This article asserts that the problem of alcohol-and drug-exposed children usually has been viewed from a narrow perspective as primarily involving drug-exposed infants and drug-involved mothers. However, the problem should be more broadly defmed to include its impact on public health and juvenile justice systems. Any effective policy response must consider and meet the needs of these systems as well.

Juvenile court judges are faced with an expanding role as the needs of families with substance abuse problems increase. During 1990, 20,000 children entered the Los Angeles County juvenile justice system as a result of allegations of abuse and neglect. The majority of these cases involved poor families. In 80 percent of the petitions filed, parental drug or alcohol abuse represented a critical element in the case.

The juvenile court judge, like all other judges, must apply the law to resolve a dispute. Juvenile court judges handling abuse and neglect cases, however, must monitor whether child welfare agencies have provided services to individual children and families sufficient to comply with Federal and state requirements that reasonable efforts be made to keep the family together. In performing these duties, the juvenile court judge often confronts three problems: (1) the court caseload is so high that efficient and effective judicial decision making is extremely difficult; (2) the lack of legal representation for the child and severely overloaded child welfare caseworkers further hinder proper preparation and handling of these cases; and (3) although mandated by law, the resources to assist families are often simply not available in a given community. Additionally, results from poverty and drug abuse increase pressure on juvenile courts. The article identifies four initiatives Los Angeles County juvenile court judges have undertaken to address these problems: 1) judicial training, 2) representation of children, 3) decision-making protocols, and 4) court findings, orders, and progress which help judges understand the medical and psychological effects of substances on pregnant women and infants, and provide information on intervention and treatment programs. Representation for children provides each child with an attorney to ensure that essential services be provided to meet a child's needs. Decision making protocols provide judges with guidelines in making risk assessments and in formulating treatment. Court findings, orders, and progress requires that the case plan is written to articulate the action expected of parents, attorneys and case workers.

Fox, E. Fetal Alcohol Syndrome. 1992. South Dakota University Affiliated Programs.

This article presents evidence of the incidence and prevalence of fetal alcohol syndrome (FAS), fetal alcohol effects (FAE), and alcohol related birth defects (ARBD). In addition, several guides and strategies for educating children, adolescents, and adults with FAS are presented and recommended.

FAS is defined as a medical condition characterized by physical and behavioral disabilities resulting from heavy exposure to alcohol before birth. A child with a history of prenatal alcohol exposure, but not all the physical or behavioral symptoms of FAS, may be categorized as having FAE or ARBD. Although, a child with FAE does not have all the physical abnormalities of FAS, FAE is not the less severe form of FAS. The following physical characteristics are common in children with FAS, FAE, or ARBD: growth deficiency for height and weight below the 10th percentile, distinct pattern of irregular facial features and other physical abnormalities, and central nervous system dysfunction.

FAS is recognized as the leading known cause of mental retardation and the second most common birth defect, and is irreversible yet, 100 percent preventable. FAS is diagnosed in about one in 600-700 live births and FAE in about one in 300-350 live births. The nature and extent of damage to the unborn child depends on many factors, including when during pregnancy the woman drank, the pattern of alcohol abuse, whether other drugs were used, and other biological features of the fetus and mother. Alcohol exposure during the first trimester may be the most critical for physical deformities and mental retardation, as this is when the baby's organs, limbs, facial features, central nervous system, and brain are developing. This is also the period when most women do not yet realize they are pregnant Alcohol exposure during the third trimester promotes growth deficiencies for the fetus.

Infants with FAS are often neglected, abandoned, and abused by their mothers, who often continue to drink after delivering. Child physical and sexual abuse may occur during the child's preschool years, particularly among children who remain with mothers who continue to abuse alcohol and otlher drugs.

The article concludes by noting that alert preschool and Head Start teachers are an important part of the community screening, an they often are the first to recommend a diagnostic evaluation.

Gittler, J. and McPherson, M. 1990. "Prenatal Substance Abuse." *Children Today*, July-August, 3-7.

This article presents findings from several surveys, studies, and reports indicating that the incidence and prevalence of perinatal drug exposure is substantial and has risen since the mid-1980s. Research shows that there is an increasing number of children exposed to crack, heroin, methadone, cocaine, amphetamines, PCP, and marijuana during their mothers' pregnancies. Many women who give birth to drug-exposed infants are infected with HIV, the virus that causes AIDS. Thus, newborns who are drug-exposed may also be at risk of HIV infection. Also, many babies whose mothers used crack are abandoned, neglected, or abused.

The care of large numbers of drug-exposed newborns, primarily crack babies, is severely straining the resources of hospitals and social service agencies, juvenile and family courts, and public schools, in large urban areas serving the poor and minorities. A survey of hospitals in five large cities found that during June 1989,304 babies, the majority of whom had mothers who were drug abusers, were abandoned and became "boarder babies."

In New York City, the increase in child welfare caseloads in social service agencies attributable to parental drug abuse increased from 2,627 cases in 1986 to 8,521 cases in 1988. It is estimated that the proportion of new child welfare cases involving parental drug abuse in Boston and San Francisco were 64 percent and 76 percent, respectively.

It was estimated that 30 to 50 percent of identified crack-exposed babies are placed in foster care. In New York City, the number of children in foster care rose from 27,000 in 1987 to more than 50,000 in 1989, largely because of parental drug abuse. In Los Angeles County, there was a 500 percent increase in the number of children placed in foster care as a result of parental drug abuse between 1981 and 1987. Furthermore, juvenile and family courts in major cities are reporting increases in their caseloads due to parental drug abuse. Public schools are also having to provide special assistance to children who have experienced developmental delays as a result of exposure to drugs.

Recommendations to address these problems stress the importance of the allocation of substantial resources for early intervention programs targeting women of child-bearing age, and the need for family-centered community-based programs that provide services to drug-exposed infants and their families.

Grayson, J., Ed. 1991. "Substance Exposed Babies." *Virginia Child Protection Newsletter,* Spring, (33): pp. l-24.

This article presents am overview of the crack epidemic of the mid-1980s and how it affected children and families.

It has been estimated that during 1989, one in 10 pregnant women used crack cocaine at some point during their pregnancies. More children were born suffering from fetal alcohol syndrome, fetal alcohol effects, and neonatal withdrawal syndrome, and thus more were at risk for experiencing developmental delay due to maternal drug use.

Drug use among pregnant women is not just a problem of the poor and minorities; it is a problem that crosses all races and economic status. The costs of care for drug-exposed babies can be four times as much as for babies with no exposure. Experts predict that children affected by crack will cause an increasing impact on educational, medical, social welfare, and justice systems.

Children whose parents use crack are also at risk of maltreatment. Reports of child abuse increased nationally by 100,000 to 2.3 million in 1988, according to a survey conducted by the National Committee on the Prevention of Child Abuse. In New York City, reports of child abuse and neglect where parents were involved with drugs rose from 2,727 in 1986 to 8,521 in 1988. A review of the New York City cases of children who died as a result of neglect and abuse in 1987 showed that 73 percent of the deaths resulted from adult drug abuse, up from 11 percent in 1985.

Several states have attempted to use current drug or child protection statutes to criminally prosecute women who have given birth to drug-exposed children. One way to attempt to battle this problem is by taking a legal approach through the child welfare system. Experts agree that most drug addicts are dependent on social services and are from multigenerational welfare families.

As a result of parental crack use, families are in chaos, and large numbers of children are at risk of serious problems. It will take the coordinated efforts of medical services, mental health, and social service providers as well as major expenditures to develop a comprehensive, coordinated approach to the problem.

Hutchins, E. and Alexander, G. 1990. Substance Use During Pregnancy and Its Effect on the Infant: A Review of Issues. Department of Maternal and Child Health, School of Hygiene and Public Health, The Johns Hopkins University.

This report provides an assessment of substance abuse during pregnancy and its effects on the infant. The expanding popularity and highly addictive properties of crack cocaine have generated considerable concern at local and national levels. With potentially increasing numbers of women using illicit substances during pregnancy, state health and social services programs are struggling to define how best to address the growing problem of infants exposed to drugs. Compared to the relatively stable patterns of abuse of alcohol, marijuana, and heroin by women of childbearing age over the last decade, the use of crack cocaine in this population is viewed as responsible for startling increases in the number of infants damaged in utero.

Reports on the magnitude of the problem of drug-abuse during pregnancy are still considered preliminary. Drug abuse during pregnancy does not appear to be limited to only urban settings or to lower income women. Many drug-exposed infants have complications that make caring for them extremely difficult. Drug-exposed infants often require high-technology care, may encounter serious developmental problems, and are more likely to be born prematurely and to have a low birth weight. The multiple disabilities affecting these infants, many of which may be irreversible with even the best care, place stress on every system involved in their care, including hospitals, child protective services, foster care, and schools.

The cost of maintaining a drug-affected baby is increasing rapidly; such care may cost a total of $18,000 or more per child. Hospitalization cost estimates range from $4,200 to $6,000 per child for the care of drug-exposed infants who do not need intensive care but must be hospitalized due to withdrawal symptoms. It is imperative to find a. solution to the problem of substance abuse during pregnancy, which has far reaching effects on a variety of state and local programs, including the health care delivery system, foster care, protective services, and public school systems.

Collaboration between state and county health officials, state alcohol and drug abuse administrators, child protective services, and foster care agencies is required to establish a comprehensive intervention strategy. The challenge is to develop programs that are preventive in focus and comprehensive in design and provide prenatal care, drug treatment, and support for both parents and infants. While the public debate continues over mandatory screening and criminalization approaches, maternal and child health agencies are faced with the difficult task of planning for the service needs of both the pregnant substance abuser and the drug-exposed infant.

McCullough, Charlotte B. 1991. "The Child Welfare Response." *The Future of Children*, Spring, 1:1, pp. 61-71.

This article examines the impact of drug-exposed infants and drug-affected children on the child welfare system. Parental crack usage has dramatically increased the number of drug-exposed and drug-affected children and the number of children who need out-of-home care. The needs of families with substance abuse problems are difficult to meet because of a combination of obstacles that jeopardize the system's ability to respond Child welfare workers cannot wait for the system to study and absorb the impact of cases involving drug-exposed children because decisions regarding these children must be made as quickly as possible.

There are four possible ways of providing child welfare intervention: 1) in-home family support services, 2) out-of-home care for infants, 3) mother and child residential treatment, and 4) adoption. In-home services allow families to stay together while receiving a variety of services, such as treatment and counseling for parents and medical care and day care for children. This service is appropriate for families only if the program 1) correctly identifies "workable" families, 2) is realistic about the level of parental functioning, and 3) is able to work with all family members.

Options for placement in out-of-home care include foster care, kinship care, and residential care. The shortage of foster parents who accept drug-exposed infants, who often need special care, results in placing more children in each of the available homes, and in shifting children from one home to another. Kinship care, the placement of children with a relative, is receiving increasing attention. However, the financial toll, combined with the special care needed by these infants, often puts an insurmountable burden on relatives. Residential care, shelters designed for infants and children whose parents are unable to care for them, should involve the parent in planning and caring for their infant or child. The drug epidemic has not had a dramatic impact on adoption services, largely because adoption is rarely the option chosen for drug-exposed infants or for young children of drug-dependent parents. Barriers, such as termination of parental rights (which is usually contested) mean that the process usually lasts three years. In addition, potential adoptive parents are fearful of the long-term effects of drug exposure and the possible need for expensive medical, educational, and psychological care. Mother and child residential programs serve the drug-exposed infant and drug-dependent mother together and work toward attaining sobriety and preserving the family.

The article concludes that families with substance abuse problems have different, but equally critical, needs at various stages of their lives. Therefore, what is urgently needed is adequate funding for an array of services and objec'iive outcome data to determine which intervention is most appropriate for which population.

National Center on Child Abuse and Neglect, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services. 1991. "A Report on Child Maltreatment in Alcohol Abusing Families." pp. l-64.

This report presents findings based on data collected from 35 Child Protective Services (CPS) agencies statistically selected to be nationally representative.

The data revealed that the incidence of maltreatment (number of children maltreated annually per 1,000 children) among children in alcohol abusing families (65.3 per 1,000 children) was 3.6 times higher than the incidence of maltreatment for children in families without alcohol abuse (17.9 per 1,000 children). CPS reported that parental substance abuse directly led to or contributed to 78 percent of maltreated children. CPS agencies were more likely to keep cases open immediately after substantiation, and more likely to make a foster care placement for children in substance abusing families, compared to children not in substance abusing families. Among children whose maltreatment had been substantiated by a CPS agency, children in alcohol abusing families were more likely to be in families with annual incomes under $10,000, white, and under five years old, than were children in families without alcohol abuse. Children in alcohol abusing families were more likely to have been emotionally abused and neglected, but less likely to have been educationally neglected than were children in non-alcohol abusing families. Children in illicit drug abusing families were more likely to be in families with annual incomes under $10,000, black and under age one, than were children in families without illicit drug abuse. Families suspected of illicit drug abuse were more likely to have a child placed in foster care during the first three to four months after substantiation, than were families without suspected illicit drug abuse.

The report provides several recommendations: 1) risk assessment approaches used in CPS agencies should include familial alcohol abuse as a risk factor, 2) NCCAN should continue and intensify its efforts to inform CPS agencies and the agencies that come into contract with alcohol abusing families about the relationship between child maltreatment and familial alcohol abuse; 3) NCCAN should continue its efforts of Federal interagency coordination, and continue implementing its efforts aimed at training and coordinating State and local agencies in accordance with NCCAN's legislation; and 4) CPS agencies should continue to treat cases of maltreatment involving alcohol abusing families to prevent the recurrence of maltreatment.

United States General Accounting Office. 1994. Foster Care: Parental Drug Abuse Has Alarming Impact on Young Children. April, pp.l-29.

This GAO report compares and contrasts population sizes and distinctive characteristics of children ages five and younger in foster care in 1986 and 1991. The study reports on the findings about these young children of foster care programs in California, New York, and Pennsylvania, the states with the largest average foster care populations in 1991.

The populations of young foster children in 1986 and 1991 were notably different in a variety of ways. First, in 1991 the total foster care population in these states had increased by 66 percent, and the number of young foster children had increased by 110 percent. Neglectful or absent parents increased from approximately 47 to 68 percent of the removals from 1986 to 1991. However, child abuse of any type accounted for 11 percent of the young children removed from their homes in 1986 and fell to 7 percent in 1991.

It was estimated that the number of parents who abused drugs or had other children in foster care increased notably in 1991, as compared to 1986. The study found that 78 percent of young foster children had at least one parent who was abusing drugs or alcohol in 1991 compared with 52 percent in 1986. In addition, the study revealed that young children in foster care have or are at high risk for a wide range of health problems. The number of young foster care children with serious physical health problems increased significantly in 1991, to an estimated 58 percent; similarly, 62 percent of these children were at high risk for serious health problems due to prenatal drug exposure in 1991, compared to 43 percent in 1986. Cocaine was the most prevalent drug that young foster children were known to be prenatally exposed to in both years.

A number of recommendations are made. The first is to increase the availability of drug abuse treatment programs for biological mothers and pregnant women to reduce (1) the risks associated with prenatal drug exposure, and (2) the likelihood that children will be removed from their families. The second is to increase the availability of treatment services to address the health and developmental needs of drug-exposed children. Meeting both of these needs should increase the possibility that such families can be reunified and leave the foster care system.

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(4 of 4)

FINAL REPORT:
STUDY OF THE IMPACT ON SERVICE DELIVERY OF FAMILY SUBSTANCE ABUSE
(CONTRACT No. 105-91-1811)

APPENDIX C:
THE BALTIMORE AND MIAMI EXPERIENCE

THE IMPACT OF FAMILY SUBSTANCE ABUSE ON ACYF-FUNDED PROGRAMS IN BALTIMORE AND MIAMI: TWO CASE STUDIES

December 14, 1994

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CHAPTER 1: INTRODUCTION

1.1 INTRODUCTION

In the Fall of 1991 the Administration on Children, Youth, and Families (ACYF) initiated the *Study of the Impact on Service Delivery of Families with Substance Abuse Problems (Contract #105-91-1811).* The study represented a response to a growing concern among experts in the human services field that service delivery systems were being severely taxed by increases in the number of families with alcohol or drug (AOD) abuse problems among their client populations and by the difficulties encountered in serving these families. These increases in AOD abuse-related problems were of particular concern to ACYF since the programs it directly or indirectly funds -- including child abuse and neglect prevention, child protective services, foster care, adoptions, Head Start and other early childhood education programs, and runaway and homeless youth services -- are among those most directly responsible for serving abandoned or maltreated infants, children, youth, and their families.

Anecdotal information from ACYF-funded program administrators and staff indicated that children and families with AOD abuse problems were increasing both the demand for services in general and the need for specialized services. Programs operating within limited budgets and service capacities reported being hard pressed to meet the service needs of this population.

The problem of family substance abuse affects the management, administration, and operations of each and every program funded by ACYF. Substance abusing families are a persistent and growing segment of the low-income families ACYF programs serve, but there is little available information that the ACYF units can use to plan ways to address the needs of substance abusing families and their children. There is even less information available regarding how the changing nature of AOD abuse within the families served by ACYF programs has impacted on the capacity of these programs to achieve their mandated goals and purposes.

The various programs funded by ACYF often serve the same clientele, either concurrently (e.g., CPS and Head Start) or in a consecutive interrelated process model (e.g., CPS-foster care-adoptions). Hence, the primary purpose of the *Impact* study was to provide information to the Administration on Children, Youth and Families (ACYF) that would guide future policy and programmatic decisions and improve the overall quality and effectiveness of its many service delivery programs, including Head Start, Head Start

Parent Child Centers, the Comprehensive Child Development Program (CCDP), the Child Abuse and Neglect State Grant Program, the Federal Foster Care Program, the Adoption Assistance Program, and the Runaway and Homeless Youth Program.

Although these programs differ from one another with respect to services and service objectives, they were all implemented by Congress with the intent that they would improve the quality of the lives of the children and families served and enhance the potential of these children and families for personal growth, productivity, and self-sufficiency. A fundamental task of the *Impact* study was to determine whether the family substance abuse problem affects the ability of these service delivery programs to attain these intended goals, and if so, the ways in which these programs are affected.

Overall efforts and accomplishments of the *Impact* study are documented elsewhere in the *Final Report: Study of the Impact on Service Delivery of Family Substance Abuse (1994).* As part of this overall effort however, in 1994 research staff conducted intensive qualitative case studies of the ACYF-funded programs in two cities, Baltimore and Miami, the results of which are the subject of this report.

In the remainder of this chapter we present an overview of the literature on the impact of family substance abuse on AUF-funded programs and a brief discussion of the overall case study goals, objectives and research methods. Chapters 2 and 3 constitute self-contained case studies of the impact of family substance on ACYF-funded programs in Baltimore, Maryland and Miami, Florida, respectively. Finally, Chapter *4* presents a discussion of the case study findings in light of other research with specific recommendations for future efforts on the part of ACYF.

1.2 BACKGROUND OF THE PROBLEM

Before one can fully understand how parental substance abuse alters the service delivery of ACYF-funded programs, one must understand the patterns of adult substance abuse. In the last ten years, the trends in adult substance use and abuse have changed significantly. In comparison to the drug epidemic of the 1960's and 1970's, the current drug epidemic has affected many more women (GAO, 1990). Experts attribute the increase in female drug uses to the existence, accessibility, and low cost of crack cocaine (GAO, 1990). Also, more women are single parents with the dual responsibilities of being the sole breadwinner as well as the sole care-giver. This factor contributes to the increased daily stress these women are under, and in turn, escalates the likelihood that these parents will deal with the stress by drinking alcohol or using drugs (DHHS, 1992).

Parental substance abuse has created grave problems for children. At least 1 in 10 children in the United States is born into a chemically dependent family each year (CSR, 1992). From 1985 to 1990 substantial increases were reported in the incidence of infants exposed and addicted to alcohol and other drugs [Feig, 1990; General Accounting Office

(GAO), 1990; Office of the Inspector General (OIG), 1990], babies born HIV positive *(Pediatric AIDS Fact Sheet,* ACCH, 1990), substance abuse problems among runaway and homeless youth (Southeastern Network, 1989), substance abuse-related child maltreatment cases (Feig, 1990), and demand for substance abuse treatment [National Association of State Alcohol and Drug Abuse Directors (NASADAD), 1989].

Parental addiction has long-lasting detrimental effects on the health and safety of children. Children who have been exposed to drugs and/or alcohol while in the womb may evidence numerous problems, including delayed speech, mental retardation, and other types of developmental difficulties. Research conducted at the University of California at San Diego demonstrated that 25 percent of drug-exposed children had problems with the development of fine motor, language, and cognitive skills, as well as adaptive behavior. Forty percent of the same sample from this University of California study experienced neurologic abnormalities that might affect their ability to socialize and function within a school environment (GAO, 1990).

1.2.1 IMPACT ON THE CHILD WELFARE SYSTEM.

Even if not exposed to alcohol or drugs during the prenatal period, children may experience extreme difficulties related to their parents substance abuse. The frequency of substance abuse related maltreatment, neglect and abandonment of children and the concurrent impact of these cases on CPS systems is considerable. It is estimated that 675,000 children lived with their chemically dependent parents in 1990 (Bays, 1990). Children living in substance-abusing families are at increased risk for maltreatment. In Wyoming, where only 23 percent of CPS reports involve parental substance abuse, such cases account for over half of the states' child abuse fatalities; in Boston researchers found that 64 percent of substantiated child abuse and neglect involved parental alcohol abuse (McCullough, 1991). A study conducted by the Massachusetts Department of Social Services found that illicit drug use or excessive alcohol use was a factor in 64 percent of child abuse/neglect case investigations (GAO, 1990). Cocaine and crack cocaine use is significantly related to parental neglect, particularly failure to provide adequate supervision, food, clothing, medical care, and other necessities for children (GAO, 1990; Besharov, 1990).

Nationally, substance abuse has become the dominant characteristic in the child maltreatment and neglect caseloads of 22 States and the District of Columbia: Local estimates of the proportion of child welfare cases involving substance abuse are 50 percent in Illinois, 80 percent in Washington, D.C., 76 percent in San Francisco, 64 percent in Boston, and 70 percent in Philadelphia (Feig, 1990). In many of these case, the children have suffered extreme neglect, and in some cases they have been completely abandoned.

The onset of the crack epidemic has also been associated with an increased number of reported abuse cases and referrals to CPS between 1986 and 1991. Neglect and caretaker absence or incapacity have been the primary reasons children were removed from their families in California and New York; most of these children (78 percent) also had been prenatally exposed to cocaine (GAO, 1994). In New York City in 1989, 59 percent of the child abuse and neglect fatalities involving children previously known to the authorities were drug-exposed babies (Virginia Child Protection Newsletter, 1991).

Those factors which come with working with substance abusing families present a wide variety of problems for ACYF agencies. Assessment of the risks to a child is often more complex and difficult in a substance abusing family. For instance, a mother may deny substance use, or her distrust of child welfare authorities may result in a lack of candor. Caseworkers also may spend days tracking down mothers who give false addresses to hospitals. Further, many of these parents lack the motivation, endurance and social support needed for recovery (DHHS, 1992).

In a 1990 national survey by the Child Welfare League of American (CWLA), nearly 50 percent of 200 caseworkers reported that the number of children affected by or using alcohol or drugs had increased in the past year. Of the respondents, 92 percent reported that parental substance abuse was a factor in reports of physical abuse and neglect; and 64 percent reported that referrals of abandoned infants have increased because of problems related to parental substance abuse (Curtis, 1993). Likewise, in a mailed survey of State child protective services agencies, conducted by the American Public Welfare Association, it was reported that the number of child abuse and neglect cases reported to CPS agencies has steadily increased. In the four states on which detailed cases studies were presented, parental substance abuse was a primary contributor to child abuse and neglect (Tatara, 1990).

In the 1990 CWLA survey on the impact of alcohol and other drugs on the delivery of child welfare services, 69.5 percent of responding member agencies said crack use was a serious problem among children and families they served. Eighty-eight percent said parental users of crack were more difficult to serve than other drug users; and 83.3 percent said crack users were more likely to behave unpredictably or violently toward their children (Curtis, 1993). Another study reported that 83 percent of the CPS service providers interviewed believed that alcohol and other drugs (AOD) related problems increased the time they spent investigating a case. In addition, 93% of respondents reported that AOD abuse was increasingly become a factor in initial investigations. Despite this, only 65.9 percent related that their agency provided training associated with the problem of family AOD abuse for CPS workers (Curtis, 1993). The CWLA also reports that of all substantiated cases of child abuse and neglect, between 50 and 80 percent involve some degree of parental substance abuse (NCCAN, 1994).

The impact of this family substance abuse on CPS systems may be most immediate in those localities with the broadest requirements for reporting substance-exposed infants to

CPS. In fact, in three cities required by State law to refer all substance-exposed infants to child welfare authorities, the number of infants referred during recent years has increased dramatically. In New York City, for example, referrals increased by 268 percent during the four-year period from 1986 to 1989. For approximately the same period, referrals in Los Angeles increased by 342 percent and in Chicago the increase amounted to 1,735 percent (GAO, 1990).

Family substance abuse affects CPS systems in other ways as well. In a 1994 study, Gregoire (1994) reported that in spite of the significance of the problem of parental substance abuse, many social workers know little about the impact of addictions. In fact, social workers failed to identify and respond to a client's alcohol problem in 83 percent of the cases they handled. The study concluded that most social workers receive little or no formal training in addiction and may avoid dealing with clients' drug problems. Another study also found that child welfare workers have generally had limited training in alcohol and drug abuse treatment, leaving them ill-equipped to assess the level of risk and to develop appropriate case plans for families with substance abuse problems (Tracy, 1994).

As a result, infants and children of substance abusing parents also are at an increased risk of out-of-home placement, either through foster care with strangers or formal or informal placement with relatives. Although maintaining families is the first priority of the child welfare system, when the safety of the child can not be ensured, the child must be removed from the home. Finding appropriate out-of-home placements for children while working toward a permanent plan for the child (whether family reunification or termination of parental rights and adoption) is the primary responsibility of the Foster Care system. Because of the close relationship between child protective and foster care services, there is a clear "trickle down" effect of family substance abuse on the foster care system.

At present, the foster care system appears to be in crisis. The Administration for Children and Families estimates that no part of the child welfare system is in more trouble than foster care. Between the years 1985 and 1991, the number of children requiring foster care placements rose from 245,000 to approximately 429,000. During the same period, the number of foster families decreased from 137,000 to 100,000 (U.S. Advisory Board on Child Abuse and Neglect, 1993). In addition, although foster care was initially conceived as a temporary response, children are now staying in foster care longer than they did 10 years ago. In New York City in 1986, 60 percent of the babies discharged from hospitals to foster care-mostly babies exposed to crack-were still in foster care three years later. Of those in foster care, 56 percent had been in two or more foster homes, and 20 percent had been in three or more homes. Several children under age five had been in more than five homes (Besharov, 1990).

Officials blame most of this increase in demand for foster care on the problem of substance abusing parents. a study by the **GAO** compared and contrasted the population

sizes and distinctive characteristics of 32,132 young children in foster-care programs in California, New York, and Pennsylvania, the states with the largest average foster-care population in 1986 and 1991. The investigators found that the number of children in foster care who had at least one parent who was abusing drugs or alcohol was 78 percent in 1991, compared with 52 percent in 1986. In both 1986 and 1991, cocaine was the most prevalent drug being abused by the parents of these children (GAO, 1994).

In the neighborhood of Harlem in New York City, out of the 1,900 drug-exposed children born between 1986 and 1990, only 25 percent were receiving primary care from their biological mothers. In most cases a grandmother or a foster mother was the primary caregiver for the child. One study tracked 13 children who had been exposed to drugs *in utero* and found that these children had been in 35 foster homes, collectively, before the age of 6 (CSR, 1992). Finally, a survey in Illinois of 385 children placed in foster care in 1986 indicated that one-half of these children had come from families with substance abuse problems (Bays, 1990). However, contrary to what might be expected, most of the substance-exposed infants and children who are victims of abuse and neglect do not go into foster care placements. According to one study, 50 to 75 percent of babies born substance-exposed go home with a mother or relative, rather than into foster care. In New York, only about one-third of substance-exposed infants go into foster care immediately, and only 1,200 of the 4,000 infants reported to be born substance-exposed went into foster care (GAO, 1990).

In another study, conducted by the Child Welfare League of America, 87.1 percent of respondents providing foster care services reported that children prenatally exposed to alcohol or other drugs were more likely to require multiple foster care placements than other children. The same was true for children whose parents abuse substances. In addition, it was reported that these children remain in foster care for longer periods than do others (Curtis, 1993).

Additional support for the link between parental substance abuse and increases in foster care may be found in the fact that the States and cities hardest hit by crack addiction are those that have experienced the largest increases in their foster care populations. Dramatic increases have been reported in Washington, D.C. and Baltimore, for example. Likewise, California's foster care population rose 41 percent between 1984 and 1988, and New York City's increased by 98 percent (Feig, 1990).

Another major trend resulting from the increase in parental drug abuse which impacts on foster care programs is the growing number of "boarder babies": Babies who remain in the hospital, even through they are ready to be discharged, for reasons such as parental abandonment and lack of available and appropriate foster care placements. A GAO study that examined the medical records of newborns born at 10 hospital in 1986 found that 1,200 of the 4,000 infants born drug-exposed were in need of foster care (GAO, 1990). The number of babies boarding in hospitals was found to be highest in areas where the law requires a **CPS** referral for all drug-exposed newborns. Shortly after such a law was

passed in Florida, it was not uncommon to find 20 to 30 boarder babies in a Miami hospital at any one time in need of foster care (McCullough, 1991).

The effect of boarder babies on the foster care system is considerable. In the CWLA survey, 47.7 percent of the respondents reported that they have problems finding foster parents for children prenatally exposed to substances (Curtis, 1993). Slightly over 70% of these foster care workers stated that foster parents of AOD abused children require more worker collaboration and help than do other foster parents (Curds, 1993).
As might be expected, the impact of family substance abuse on, and therefore the system response of adoption services has been less than that for either CPS or foster care. When a child is abandoned or cannot be safely returned home, adoption services become the placement option of last resort. Family substance abuse impacts on adoptive services primarily in two ways: First, by increasing the number of children (primarily drug-exposed infants) for whom adoptive homes need to be found, and second by complicating the overall adoption process reflecting the special needs presented by many of these children.

Among all drug-exposed children declared court-dependent in 1989, the rate of foster care placement was 60 percent, and many of these children were expected to become candidates for adoption (Barth, 1991). The literature identifies two barriers to providing these children with permanent homes. One is delays in the process for terminating parental rights (TPR); in theory pursuing a TPR takes 18 months or less, but in practice it can take as long as three years if a parent contests the action. Second, the demand for adoption has outpaced the availability of adoptive homes, particularly in terms of homes willing to accept special needs children.

Part of the reason for this stems from the potential for difficulties arising in the future. The detrimental affects of fetal alcohol syndrome and drug-exposure, such as learning disabilities, emotional problems, etc. may not show themselves until the children are of school age. Although the majority of families who adopt handicapped children (including drug-exposed infants) find the placement rewarding, there are still many problems which must be dealt with (Rosenthal, 1992). More and more adoptive families have been returning to their state agencies requesting additional funding to cope with the problems of substance-exposed children (Interstate Compact, 1992). Cases of adoptive parents suing agencies because they were not told that the child had been prenatally-exposed to alcohol or drugs are also becoming more frequent (Cass, 1992; Komissaroff, 1992).

Providing as much information and training to adoptive parents of these children decrease the likelihood of problems with the placement. Many studies are now showing that early intervention and treatment can be very effective with drug-exposed children (Chasnoff, 1992; Rinkel, 1992). Research has also not completely documented the long-term effects of exposure, or the effects of a loving, nurturing adoptive home (Jenista, 1992).

1.2.2 Impact on Head Start and Early Childhood Education Programs.

While the impact of parental substance use on Head Start is not as immediate or obvious as the impact on the child welfare system, these programs also experience negative consequences as drug-exposed infants and children from substance abusing families seek services from them. Although the perinatal complications of drug exposure are well known, studies are just now revealing the long-term effects of substance abuse, and in particular of cocaine, on children's development past infancy. Children born with fetal alcohol syndrome (PAS) have been found to require special attention to meet their educational and developmental needs, which are often extreme (DHHS, 1990).

As these children become eligible for the Comprehensive Child Development Program, the Head Start Parent Child Centers, and Head Start programs, they will need services that extend beyond those currently offered to families and children. When 117 grantees were sampled for au OIG study on family dysfunction among Head Start families, grantees ranked substance abuse as the most common problem shared by dysfunctional families and mentioned alcohol and illicit drug use as common (OIG, 1989). Head Start directors estimate that 20 percent of the children enrolled in their programs live in substance abusing families (CSR, undated). Because the Bureau does not require Head Start programs to maintain records or to report on the number of parents who are known or suspected substance abusers, this is most likely an inaccurate, low estimate.

Head Start staff have begun to document the effects on children of living in a family with substance abuse problems. In Chicago, for example, staff noted that parents came to the center intoxicated or high; children acted out drug scenes while playing, such as cutting lines through sugar as though it were cocaine and pretending bread sticks were cigarettes or marijuana; children talked about their parents' alcohol and other drug use; and parents removed their children from the Head Start program because of a confrontation with staff about their drug use (Perinatal Addiction Research and Education, 1993). A Parent/Child Services program serving 135 children in Multnomah County, Oregon, estimated that 50 percent of the children served showed signs of the effects of prenatal drug-exposure (Ahart, 1991).

1.2.3 Impact on Runaway and Homeless Youth Programs.

The available literature on the effects of parental substance abuse on adolescents is sparse. Studies on runaway and homeless youth have focused primarily on the psychosocial behavior of adolescents as the root cause of departure from their families.
Parental substance abuse however often results in chaotic and dysfunctional family environments for adolescents as well as younger children. While younger children may come to the attention of child welfare agencies, to escape intolerable family lives many adolescents simply leave home and many others are pushed out or abandoned by their parents (GAO, 1989; Smollar, et al., 1985). A GAO study (1989) of runaway and

homeless youth services indicated that 18 percent of the youth seen by federally funded shelters reported that their parents had substance abuse problems. The Southeastern Network (1989) of Runaway and Homeless Youth Services, in its review of the programs included in the network, reported 20 percent of youth indicated that their parents had substance abuse problems.

While limited data are available regarding the effects of parental substance abuse on adolescents, one study suggests that adolescents may run away from home and live on the street or in shelters for two primary reasons: a family history of alcoholism or other drug abuse and parental drug use or positive parental attitudes toward substance abuse (OSAP, 1992). In a 1990 survey by the Southeastern Network of Youth and Family Services, 12 percent of 253 youth respondents reported that their parents had used crack in their presence and 15 percent knew that their parents used crack. Over 54 percent of respondents reported that their parents consumed alcohol in their presence and 18 percent said their parents' substance abuse was a problem. More than 50 percent of those responding identified parental substance use as a motivator for their own use of substances (Jarvis, 1990).

A study conducted for the Administration on Youth and Families examined parental substance abuse and child maltreatment as causes of youth homelessness. The study reported that 26 percent of mothers (or mother figures) and 36 percent of fathers (or father figures) of homeless or runaway youth abused alcohol. The study's preliminary findings suggest a high correlation between maternal alcohol abuse and sexual abuse of the child. In addition, there was a high correlation between physical/sexual abuse and the current level of mental distress felt by the interviewed youth (van Houten, 1992). Other studies suggest that in order to escape intolerable family lives, many adolescents simple leave home, while others are pushed out or abandoned (GAO, 1990).

Children from families with at least one substance-abusing parent are at a higher risk of developing their own substance-abusing problems as adolescents and adults (Blau, 1994). Many runaway and homeless youth exhibit signs of alcohol use. One study, conducted by the national network of Runaway and Youth Services, reported that 46 percent of runaway, homeless and other youth in high-risk situations had a substance abuse problem; 14 percent of the youth were addicted to alcohol or drugs (National Network of Runaway and Youth Services, 1991). Other studies have found even higher levels of substance use and abuse among runaway and homeless youth. For example, a study in Los Angeles found that 85 percent of the runaway and homeless youth served at a free clinic used drugs, 57 percent were addicted to alcohol or other drugs, and 35 percent used IV drugs (National Network of Runaway and Youth Services, undated).

The limited information available suggests that the increased prevalence of substance abuse among both the parents of RHY youth and these youth themselves are fundamentally altering the nature of the RHY problem, and negatively impacting on the capacity of existing service models to meet the needs of these youth and their families.

In an ACYF funded study, researchers discovered that service providers need to take an aggressive role in reaching out to identify the youth and families affected by substance-abuse. Additional services are also required by youth once they become homeless. The study recommended such things as: long-term shelter, education, employment, training, and related counseling (van Houten, 1992).

To further understand the reasons why adolescents abuse substances, FSYB has funded a national study of substance abuse by runaway and homeless youth. The study examines the extent of alcohol and other drug use among nmaway and homeless youth; the role of alcohol use by family members in decisions by youth to run away from home, and the nature of services received by runaway and homeless youth with substance abuse problems. This study will further clarify the impact of parental substance abuse on adolescents; results should be released for publication in late 1994 (DHHS, 1994).

1.3 OVERVIEW OF THE CASE STUDY METHODOLOGY

As the preceding section makes evident, family substance abuse is impacting on all programs funded by ACYF, although perhaps in different ways and to different degrees. Although empirical research studies and surveys are invaluable, as part of this broader effort we also wanted to develop insights into the actual day-to-day impacts on programs and staff, to allow programs to define the problem and discuss their response in their own terms using their own conceptual frameworks, and to better understand similarities and differences regarding the impact of family substance abuse on these programs at the community level. For these reasons, we elected to conduct two city-wide case studies of the impact of family substance abuse on ACYF-funded programs.

1.3.1 STUDY GOALS, OBJECTIVES, AND RESEARCH QUESTIONS

The information presented above suggests that parental and adolescent substance abuse may impact on ACYF-funded service delivery systems in a variety of ways. If these service systems are to respond appropriately, more concrete and comprehensive information is needed. While there was anecdotal information on this topic, systematically collected national data regarding the percentages of families with AOD problems and how these families impact AUF-funded service delivery programs were not available. The *Impact* project was designed to address this knowledge gap. The study focused on five specific objectives:

Objective 1: To assess the impact of substance abuse on current service delivery provided across the six programs that ACYF administers: Head Start, the Head Start Parent Child Centers, the Comprehensive Child Development Programs, the National Center on Child Abuse and Neglect, the Runaway and Homeless Youth Program, the Foster Care Program, and the Adoption Assistance Program.

Objective 2: To assess the number of children from families where substance abuse is present who are being served by the various programs and changes in the population served over the past 5 and 10 years.

Objective 3: To assess the impact of changes in substance abuse on the recruitment and retention of foster care and adoptive parents.

Objective 4: To assess the capability of service providers to change the behaviors of substance-abusing parents.

Objective 5: To assess the current responses of service delivery systems to the needs of children and families involved with substance abuse.

Taken together, these five objectives served as the framework for the original approach undertaken in the *Impact* study. Specific research questions were developed for each study objective, identifying variables to be operationally defined and addressed in the data collecting process. These questions, organized under study objective, are presented in Table 1 below.

These research questions provided the underlying conceptual framework for conduct of the case studies. The primary goal of the two case studies was to collect intensive and in depth qualitative, and to the extent possible pre-existing quantitative information regarding the impact of substance abuse on the service delivery systems of ACYF-funded programs in two selected cities. Specifically, this effort would focus on gathering information on the nature of problems related to family substance abuse encountered by service providers and the ways that they cope with these problems. Another goal of the case studies was to obtain a comprehensive portrait of how ACYF service delivery systems coordinate their services with one another and with other community service agencies that may come into contact with their substance-abusing clients.

TABLE 1
STUDY OBJECTIVES AND RESEARCH QUESTIONS

Objective 1:	*To assess the impact of substance abuse on current service delivery provided across the six programs that ACYF administers.*
Q. 1-a:	*How do various service delivery systems define or conceptualize substance abuse? What kind of substance use is considered a "problem" as opposed to use that is not a "problem?"*
Q. 1-b:	*What are the State and local statutes or policies regarding assessing and reporting children and families with substance abuse problems?*
Q. 1-c:	*What has been the impact of children and families with substance abuse problems on overall service costs and on service costs per family?*
Q. 1-d:	*What changes have children and families with substance abuse problems occasioned over the past 10 years in the nature, scope, and intensity of the services provided by these programs? Has the demand for services increased?*
Objective 2:	*Assess the number of children from families in which substance abuse is present who are being served by the various programs and changes in the population served over the past 10 years and over the past 5 years.*
Q. 2-a:	*What is the current number of children and families with substance abuse problems served by ACYF-funded programs? How have the numbers changed over the past 10 years and over the past 5 years? Do the percentages of children and families with substance abuse problems vary as a function of geographic and demographic differences in the locations of ACYF-administered programs?*
Q. 2-b:	*What are the characteristics of the children and families served who have substance abuse problems? What are their racial/ethnic backgrounds, ages, socioeconomic status, and family structures? In these families, which family members are likely to be the substance abusers?*
Objective 3:	*Assess the impact of changes in substance abuse on the recruitment and retention of foster care and adoptive parents.*
Q. 3-a:	*What is the current ratio between the demand for foster care and the availability of foster care placements? How has this ratio changed over the past 5 and 10 years? Does this ratio vary as a function of geographic and demographic differences?*
Q. 3-b:	*What are the characteristics of children needing placements and how have these changed over the past 5 and 10 years? Do these characteristics vary as a function of demographic or geographic differences?*
Q. 3-c:	*How many children who entered the foster care system in Fiscal Year 1990 have families with substance abuse problems or have substance abuse problems themselves? How has this changed over the past 5 and 10 years?*
Q. 3-d:	*How do the characteristics of children in foster care placements who have family substance abuse problems differ from those of other children in foster care placements? What types of difficulties have been encountered in placing these children and in retaining placements for these children?*

Q. 3-e: How many children are currently available for adoption? What percentage of these children are from families with substance abuse problems and how has this percentage changed over the past 5 and 10 years? Has the problem of children from substance-abusing families resulted in changes in State statutes regarding termination of parental rights?
Q. 3-f: How many of the children available for adoption have special medical and/or educational needs resulting from prenatal or later parental substance abuse? What are the difficulties experienced in placing children from families with substance abuse problems in adoptive homes? How are these difficulties being addressed?
Objective 4: Assess the capability of service providers to change the behaviors of the substance-abusing parents.
Q. 4-a: What do various service delivery systems perceive as their primary role in serving children and families with substance abuse problems?
Q. 4-b: What are the goals of various service systems with respect to changing parental behaviors? What types of parental behaviors do various service systems feel it is their responsibility to address?
Q. 4-c: What has been the impact of substance abuse on staffing of these programs? Have there been changes in "staffing mix" associated with the substance abuse problem? Has there been an impact on staff recruitment, retention, or need for training? Does the impact of substance abuse on staffing vary as a function of demographic and geographic differences?
Q. 4-d: What are the perceptions of community service providers outside of the ACYF-funded programs (e.g., courts, police, hospitals, community mental health centers} concerning the capacity of the programs to meet the needs of the populations served by these programs? How have relationships between ACYF-funded programs and other service providers been affected by children and families with substance abuse-related problems?
Q. 4-e: What is the relationship between the service systems and community substance abuse treatment programs? How have these relationships affected the capability of service providers to meet the needs of children and families with substance abuse problems?
Objective 5: Assess the current responses of service delivery systems to the needs of children and families involved with substance abuse.
Q. 5-a: What are the needs of children and families involved with substance abuse?
Q. 5-b: Are programs able to meet the needs of children and families with substance abuse problems? What are the perceptions of program staff? What practices do program staff members believe they need to change?
Q. 5-c: Are the services offered and provided suitable to the needs of substance-abusing families?
Q. 5-d: What barriers have been encountered in providing services to children and families with substance abuse problems? Which of these barriers have been overcome? What is needed to effectively address these barriers?
Q. 5-e: What are helpful and appropriate roles that each ACYF-administered program can perform in combatting substance abuse?

1.3.2 City Selection

This onsite study constituted an extension and elaboration of prior efforts: As part of the *Impact* study in the Fall and Winter of 1992 research staff had conducted exploratory discussions and interviews with service agency staff in six cities selected on the basis of the magnitude of community substance abuse (based on DAWN surveillance data for emergency room drug abuse episodes), the density of female headed households, geographic region, and the presence of a P-CC or a CCDP program in the community. These interviews had been conducted as a supplemental effort to provide qualitative information and individual insights regarding the impact of family substance abuse on ACYF-funded programs. Table 2, below provides descriptive information on each of the six cities visited previously.

Table 2
Cities Selected for the 1992 Interviews

REGION	CITY	DRUG ABUSE EPISODES PER 1000 PEOPLE	DENSITY OF FEMALE HEADED HOUSEHOLDS	PRESENCE OF CCDP OR P-CC PROGRAMS
WEST	San Francisco	7.55	715	P-CC only
MIDWEST	St. Louis	1.55	526	P-CC Only
MIDWEST	Minneapolis	1.47	67	Neither
NORTH	Brooklyn	3.15	*2459*	CCDP Only
SOUTH	Baltimore	2.61	763	Both
SOUTH	Miami	1.52	40	CCDP Only

For the current case studies we elected to revisit two of these cities: Baltnnore and Miami. These cities were chosen in part for their proximity to the research team and in part to provide diversity of population characteristics.

1.3.3 Case Study Methods

Onsite interviews were to be conducted in the selected sites with direct service providers and administrators from the CPS systems, foster care and adoption systems, Head Start programs, P-CC or CCDP projects, runaway and homeless youth programs, substance abuse intervention or treatment programs, hospitals, and the juvenile or family courts. If model programs addressing the issue of interagency coordination existed in any of the

sites, individuals involved with implementing or providing services in these programs would also be interviewed.

Although the plan called for relatively unstructured free-flowing discussions with staff of ACYF funded programs, topical discussion guides were prepared to serve as reminders to site visitors of key issues and topics to be addressed. In general, the discussion guides address most of the same general topics as those covered in the mail survey instruments, but are designed primarily to generate discussion on the topic, allowing those interviewed in large measure to set the tone, content, and depth of the discussion. We also, however, wanted these discussions to provide more in depth perceptions concerning service barriers, problems, and needs and the levels and effectiveness of interagency coordination and services integration. In addition, a key element of the Phase II effort included selective discussions with staff in ancillary programs or agencies who could provide an external perspective on the impact of family AOD abuse on ACYF-funded program areas. These ancillary agencies included hospitals, schools, juvenile justice facilities, mental health services, and the juvenile or family court.

A total of 21 discussion guides -- one for each class of site visit participant-- and corresponding discussion protocols were developed. These were:

- County or City Child Welfare Agency
  - -- Child welfare agency director
  - -- CPS unit supervisors
  - -- CPS caseworkers
  - -- Foster care supervisor
  - -- Foster care caseworker
  - -- Adoption supervisor
  - -- Adoption caseworker

- Head Start Program
  - -- Head Start program director
  - -- Head Start education coordinator
  - -- Head Start social services coordinator

- CCDP/P-CC Programs
  - -- CCDP/P-CC director
  - -- CCDP/P-CC child development coordinator
  - -- CCDP/P-CC family services coordinator

- Runaway and Homeless Youth Program
  - -- Runaway and homeless youth program director
  - -- Runaway and homeless youth program service provider
  - -- Runaway and homeless youth focus group

- Juvenile/Family Court Judge

- Substance Abuse Intervention/Treatment Agency
  -- Substance abuse treatment agency director
  -- Substance abuse treatment agency service provider

- Hospital
  -- Hospital social worker
  -- Hospital staff pediatrician

Each discussion or interview was anticipated, based on prior experience, to take from between one hour and one and one-half hours to conduct. It should be stressed that these were discussion guides, not structured interviews. The goal was to ensure that all basic topics of interest were addressed in the discussion while at the same time allowing for maximum generativity and spontaneity on the part of the discussant. Stated simply, we wanted discussants to provide their own conceptual framework for describing the impact of family substance abuse on their program in their own words. Copies of the discussion guides may be found in Appendix C.

Two site visit teams - one for Baltimore and one for Miami - consisting of three and four professional-level staff, respectively, were constituted to conduct the agency visits. An orientation and training meeting for all staff participating in the site visits was conducted in late July. Following completion of the training, agency site visits were conducted in August and early September of 1994. Joint interviews were routinely conducted with the Director of Child Welfare and with the person identified as being in charge of city-wide AOD abuse data collection or response strategies. Other interviews were occasionally conducted by only one of the team members to allow for double-scheduling of interviews. In Baltimore, more interviews were conducted jointly by two or more interviewers, with one of the two assuming a leading role.

Summary notes were prepared on each individual interview with the primary focus on identifying particularly insightful or succinct observations on the part of the interviewees. As part of the effort, in each agency visited we requested copies of written agency policies, procedures, statistical reports, program evaluation reports, and similar documentation which might be available regarding the impact of family substance abuse on program operations or which would enhance our overall understanding of the agency and its programs.

CHAPTER 2:
THE BALTIMORE EXPERIENCE

2.1 INTRODUCTION

In August and early September of 1994 we conducted extensive discussions with over 20 agency staff as part of a case study designed to document the impact of family substance abuse on programs in the City of Baltimore, Maryland, that are funded or administered by the four major components of the Administration on Children, Youth and Families (ACYP). These include the National Center on Child Abuse and Neglect, the Children's Bureau, the Head Start Bureau, and the Family and Youth Services Bureau. The ACYF-supported programs include Child Protective Services, Foster Care, Adoptions, Head Start, Parent/Child Centers, and Runaway and Homeless Youth Programs.

The information gathered in the interviews focuses on the prevalence of substance abuse in the population served by the various programs over the last two years, the impact of this abuse on the ability of the service providers to perform their mandated functions, and suggested strategies for responding effectively to present circumstances created by the increase in substance abuse. Information gathered in prior interviews with agency staff conducted in 1992 has also been integrated into this report to the extent practicable for comparative purposes.

The remainder of this chapter provides an brief overview of Baltimore City and its substance abuse problem status, staff perceptions of the impact of family substance abuse on their programs, recent and current agency responses to the problem of family substance abuse, and agency needs and recommendations for improved response as identified by program staff. The chapter concludes with a discussion of similarities and differences in perception and need related to family substance abuse across the ACYF-funded program areas in Baltimore.

2.2 SUBSTANCE ABUSE IN THE CITY OF BALTIMORE

2.2.1 INTRODUCTION TO BALTIMORE

The City of Baltimore is the largest Primary Statistical Metropolitan Area in the State of Maryland, with an estimated population of 736,014. Baltimore experienced a 6.4 percent decrease in population between 1980 and 1990. According to 1990 Census data, males represent 46.7 percent of the population. Children under the age of 18 account for 24.4 percent of the population, and 13.7 percent are 65 years of age or older. The city is racially and ethnically diverse, with people of color representing 62 percent of the population; Blacks account for 59.6 percent, Pacific/Asian Americans for 1.1 percent, Hispanics for 1.0 percent, and Native Americans for 0.3 percent.

Of the total of 175,032 family households in 1990, 44.8 percent had children under the age of 18; 53.8 percent had a female head of household. In 1989, the total number of families below the poverty level was 3 1,174; 2 1.9 percent of all Baltimore children under the age of 18 lived in poverty. Approximately 20.7 percent of the total population was under the age of 14. The second largest population group (18 percent) fell between the ages of 15 and 24. In 1989, people of color represented 82.1 percent of the Baltimore City Public Schools population; 86.2 percent of school-age children in the city attended public school.

The per capita income in Baltimore rose from $12,893 to $17,263 between 1980 and 1990. The number of violent crimes reported totaled 15,618 in 1990, and 56,403 nonviolent crimes were reported. The city continues to be affected by the economic difficulties that most urban areas have experienced. Unemployment, business downsizing and closures, substance abuse, and homelessness adversely affect services offered by the two largest social service agencies in the city - the Department of Social Services (DSS) and the Department of Housing and Community Development.

2.2.2 COMMUNITY SUBSTANCE ABUSE

For the Baltimore metropolitan area, 261 drug abuse episodes for every 1,000 people were reported in the May 1991 issue of the Drug Abuse Warning Network (DAWN). By comparison, 1.49 episodes for every 1,000 people were reported for the United States. In 1993, the Alcohol and Drug Abuse Administration (ADAA) estimated that there were 33,000 injecting drug users in Baltimore City. During the same period, ADAA funded substance abuse treatment for 16,195 clients and an additional 5,864 clients received treatment in non-ADAA-funded programs, although an estimated 62,829 individuals were in need of treatment. Baltimore City funds 40 substance abuse treatment programs, and an additional 25 non-ADAA funded programs are available in the city.

Of the total number of clients treated in ADAA-funded programs, 63 percent were males and 77 percent were Black. Treatment services range from three-day outpatient services to more lengthy inpatient services. A wide variety of treatment options are available, including:

- Outpatient treatment
- Methadone maintenance
- Methadone detoxification
- Intermediate care
- Residential treatment
- Halfway houses
- Long-term care facilities
- Non-hospital detoxification
- Intensive outpatient programs
- Group homes

The FY 1993 success rate in discharges from ADAA-funded facilities was 32 percent. Of substances reported by clients admitted to treatment, cocaine/crack was most often identified (63 percent), followed by heroin and alcohol, with 55 and 49 percent, respectively. ADAA emphasizes that most clients reported multiple substance use.

2.3 SUBSTANCE ABUSE AND ACYF-FUNDED PROGRAMS

2.3.1. CHILD WELFARE PROGRAMS

2.3.1.1 Overview and Background

The Baltimore City Department of Social Services is the largest public social service agency in the State of Maryland. DSS operates under the direction of the Maryland Department of Human Resources, whose mission is to maximize the personal independence of Maryland's citizens in matters of economic and social concern. DSS provides the following services to Baltimore City residents:

- Aid to Families with Dependent Children
- Adult protective services
- Child day care
- Disability assistance and loan programs
- Medical assistance
- Social services to adults

The services listed above are partially funded by the Administration for Children and Families. In addition, DSS administers the Division of Child and Family Services (DCFS) which directs the programs listed below and which are funded by the ACYF and are the focus of this case study. The following list also includes Baltimore's FY 1993 caseloads, which reflect the extent of service delivery:

- Child Protective Services - These include investigating and providing continuing services in reported cases of child abuse and neglect. DCFS administered 10,649 cases in FY 1993.

- Intensive Family Services - These include a variety of intensive, short term services (usually over 6 weeks to three month period) designed to prevent out of home placements of at-risk children. DSS managed 3,556 cases per month in FY 1993.

- Services to Extended Families with Children - These include preventing formal foster care placements by maintaining children with relatives. In FY 1993, DSS processed 2,566 cases.

- Foster Care Services - These include emergency placement, long-term foster care, and permanency planning (including termination of parental rights) services for children removed from the home.

- **Adoption Services -** These include recruiting adoptive parents, conducting home studies of adoptive homes, placing of children needing adoption, and providing post-adoption services. In FY 1993, 107 children were adopted, and 98 homes were approved.

The Juvenile Division of the Circuit Court for Baltimore also interacts with many of the agencies that provide social services to the residents of Baltimore and provides a different window into the problems of substance abuse. Before 1992, only one judge and several referees were assigned to the Juvenile Division. Two years ago, two judges were assigned, and responsibilities were divided so that one judge handled delinquency cases and the other handled abuse and neglect cases. Although the judges rotate, all abuse and neglect cases and reviews of all children in placement have been under the same judge for the last 18 months.

Each year DSS serves 400,000-450,000 families. Baltimore City provides nearly half of the social services of the State of Maryland. The Division of Family and Children Services handles approximately 100,000 cases annually. An estimated breakdown of cases by program area is 70 percent CPS, 5 percent Family Services, and 5 percent Adoptions, with the remaining 20 percent divided between Foster Care and Kinship Care.

2.3.1.2 Impact of Family Substance Abuse

This section discusses the impact of substance abuse on the Division's service delivery, the Division's response, and recommendations to address the issue of family substance abuse. This discussion is based on information gleaned from seven interviews including a judge in the Juvenile/Family Court and six staff from the City of Baltimore Department of Social Services, Division of Family and Children Services, Office of the Director, Adoption Unit, Child Protective Services (CPS) Intake and Treatment Units. Repeated efforts to schedule discussions with foster care staff proved unsuccessful, and as a result, no contemporary discussion of foster care is provided here.

> *With drug-addicted parents, children stay in care longer: No treatment is available even when we have funds available to pay for it, or we aren't successful in getting the parents into treatment.*

In order of severity, agency personnel have seen a rise in the use of crack/cocaine and heroin, and in alcohol abuse. The typical substance-abusing family served by **the Division is African-American, has**

> *These cases are tough. In one of my cases mom has one child in foster care who had been exposed to crack before birth. The child is now two, but mom refuses treatment and refuses to relinquish the child. Now mom is HIV+ and pregnant again. She says she just wanted another child.*

a single parent (the mother) who is between 20 and 30 years old, and with an average of 2.3 children. Usually the family has little or no furniture and little or no food in the house; the children are unkempt and often stay out in the streets at all hours. Sometimes there are instances of physical abuse, although in substance abuse cases neglect is more prevalent than physical abuse. The family tends to be transient.

From the perspective of the Director's Office, one of the biggest problems faced by the agency is confidentiality. The confidentiality rule makes serving clients more difficult because it prevents agency personnel from sharing client information with service providers outside DSS, even when the intent is to provide the best possible services. Tracking cases is also problematic. Baltimore is, however, moving to an automated tracking system, rather than relying on manual methods. A third problem is that services are provided based on ability to pay, rather than on need.

> New *legislation has tightened confidentiality requirements and has made it even more difficult for agencies to share information about clients -- this often serves as a barrier to effective referral for needed services.*

The Intake Unit of Child Protective Services conducts initial investigations of child abuse and neglect reports, provides services to reduce the risk of maltreatment, and works to reunify families. A typical investigation takes about 30 days, with 10 to 20 hours spent on a case over the course of a month. If substance abuse is involved, more time is required to call agencies and secure services for clients.

> *The drug problem has gotten worse over the past jive years and more families are affected. Fathers are often incarcerated and mothers are turning to drugs. Young kids are getting themselves and their younger brothers and sisters off to school.*

Division staff estimated that the increase in substance abuse has contributed to a 65 percent increase in CPS reports of child abuse and neglect. The agency can confii that problems related to substance abuse occur in 40 percent of their total 100,000 cases. An additional 20 percent of cases is suspected to have problems related to substance abuse.

Comparing CPS Intake Unit caseloads from two years ago and today, there has been an increase from about 12 petitions per day to about 15 to 20 petitions per day. In FY 1993, CPS received 9,594 new reports of child abuse or neglect for investigation; approximately 35 percent of these reports involved substance abuse. Table 3 below presents a breakdown of these cases by type of case and drug involved.

> Our *agency needs help. We simply were not prepared for what has happened. The drug abuse problem has overwhelmed our agency.*

TABLE 3
SUBSTANCE ABUSE STATUS OF FY 1993 CPS CASES

Type of Case	Alcohol	Drugs	Both	None	Total
Indicated Abuse	77	153	29	718	977
Unsubstantiated Abuse	90	234	28	1,873	2,225
Indicated Neglect	110	1,247	117	823	2,297
Unsubstantiated Neglect	70	961	41	1,907	2,979
Indicated Sex Abuse	24	106	13	488	631
Unsubstantiated Sex Abuse	14	52	7	359	432
Total Reports	**385**	**2,753**	**235**	**6,168**	**9,541**

CPS also receives cases through the hospitals when mothers test positive for drugs at delivery because the law now requires that hospitals report these cases. Two years ago, some 15 to 20 children per day were placed; today, about 25 to 30 are placed. Today, the intake unit works primarily with women between the ages of 29 and 45 who have three to four children and usually have had three or four prior CPS reports.

> *Mothers won't go into drug rehab because the wonder-1 feeling of being on drugs far outweighs anything else -- even getting their kids back. Their need for drugs exceeds their love for their kids.*

Hospitals, schools psychologists, lawyers, and counselors are now mandated to report cases of abuse and neglect; the largest number of cases is reported by schools and hospitals. The Juvenile/Family Court also sends Child In Need of Assistance (CINA) cases to CPS. Most days there are 8-15 families in court on an emergency. In these cases, CPS obtains court orders to remove children from their homes. Ninety to 95 percent of the dependency and neglect cases seen in the Juvenile Division of the Circuit Court for Baltimore City have substance abuse as a factor.

Reports also have drastically changed over the past few years. Two years ago, reports were relatively simple, so investigations were relatively uncomplicated. Today, increased delinquency, greater drug use (which seems to be the biggest problem), and more parents with psychological problems are the norm.

Substance abuse has a strong impact on the community at large and makes it more difficult to work with parents in the CPS caseload. Substance-abusing parents tend to be uncooperative and to deny using, thus making it difficult to provide the services they

need. By the time the case reaches Intake, the family may be homeless, without utilities, and the children in need of food and clothes. CPS personnel have witnessed more child removals because of heroin and cocaine than because of alcohol. Heroin users are more difficult to influence and relapse more quickly. Few want methadone because they see it as just another drug; many want inpatient treatment, but CPS cannot access it. Sometimes treatment is available through the family's HMO, but the services are often inadequate and short-term (three days).

The number of incarcerations resulting from substance abuse separates children from parents and creates a greater need for temporary care facilities for children. Also, although substance abuse is a growing problem for women, services to women have not increased. The city has battered women's shelters where children can accompany their mothers, but there are no such facilities for women with substance-abuse problems.

> *By the time these cases reach CPS Intake, the family may be without utilities or may be homeless, and the children are in need of food and clothes. Everyone in the social service system is overwhelmed: Providers lack the resources and staff necessary to do what is needed for the family.*

Substance abuse has seriously affected the delivery of CPS services. Seldom do CPS personnel have the resources needed. The availability of services and the type of insurance coverage are major barriers to treatment, and there are too few programs available for uninsured people. Many programs have closed, and getting clients into counseling or detoxification programs is virtually impossible because long waiting lists force a delay of one to two months to secure a treatment slot. Some clients must switch insurance to qualify for enrollment in a program - another time-consuming process. The level of success is one or two enrollees per month. Five years ago, CPS closed more cases than it can close now. Today, it struggles to close cases in three months, but delays associated with resolving substance abuse issues (including resistance and denial) prevent resolution within that time. Dangerous neighborhoods and fear of trafficking-related violence raise personal safety concerns for team members who spend a great deal of time in clients' homes. Multiple problem families, and the inability to connect with families in a timely manner are also difficulties. The demands of brokering increasingly meager resources, the lack of power to change the behavior of substance abusers, and lowered expectations resulting from the low success rate across the range of social service delivery efforts prompt caseworker frustration.

Contradictions in the system pose problems for service agencies. CPS is mandated to preserve families and is allowed to use public funds to do it, but the social service system does not allow its clinicians to determine the kind of substance abuse treatment needed. Inpatient treatment is not an allowable social service expenditure; outpatient treatment is allowable but widely ineffective.

Because 90 to 95 percent of adoption cases involve substance abuse problems, it is difficult to compare cases that involve such abuse with ones that do not. Although certainly not the only reason children enter the adoption system, substance abuse does result in neglect and abuse that can lead to the need for adoption services. The pace at the Adoption Unit has changed in the past few years, with staff trying to do more permanency planning. The agency administers about 100 finalized adoptions per year. The need for foster care is also swelling, and foster care is becoming more expensive.

Every addicted newborn can become a part of the child welfare system. Medical assistance doesn't cover the baby after the mothers discharge, even if the hospital won't release the baby because of drug exposure. So the hospital wants us to take the baby right away even though DSS has five days to investigate for possible neglect. The cost of these babies hospital care is becoming a major problem.

There is a distinct correlation between the rising number of CPS cases and the increase in foster care and adoption cases. In the case of a drug-abusing mother, the newborn may be drug addicted, have emotional or physical problems, or be HIV-positive. These conditions make adoption quite difficult. Substance abuse is a major concern of adoptive parents. Few want to take drug-exposed children, and most children in the system are drug-exposed. Adoptive parents are always told what to expect -- learning problems, hyperactivity, and the difficulties of drug withdrawal -- and many are also concerned about adolescence and how drugs will affect their children later in-life.

Since 1989, every child who is removed from the home receives a physical and mental health screening. I'm concerned about the diagnoses being placed on children. Children get labeled "multiple personality disorder" -- DSS is paying for the tests so children always get labels which follow them wherever they go. But there's no treatment available, so what's the point of labeling the kids?

Placing children is never easy, and the presence of outward signs of drug exposure affects infants' chances of being placed. For older children, who may be on medication and have pronounced drug-related behavioral and physical problems, the chances of adoption are slim.

We talk honestly about the children we place. There are more children now with special needs. Children now are much more damaged emotionally...A lot of people are not willing to assume the risk with kids from drug-abusing families, even though studies have shown that those kids can be normal with the proper nurturing and care.

The types of services required by children of substance-abusing families

are not necessarily different from those for other abused or neglected children; instead, they are more intensive and long-term. These children frequently need therapy to handle emotional deprivation, abandonment, and other forms of neglect and abuse. Once children are placed in a home, their adoptive families often need therapy to adjust to a totally new lifestyle. For example, adoptive children coming from a home dominated by drugs tend to lie as a self-preservation mechanism, to horde food, and to display other behaviors necessary for survival.

2.3.1.3 **Response to Family Substance Abuse**

> *What works? Really committed caseworkers. They do the kind of case management that's needed -- they know their kids really well -- they have the knowledge base -- they work overtime when needed.*

In the Division of Family and Children Services, the rise in cases related to substance abuse has increased the need to hire staff. Both recruitment and retention have been difficult because of budgetary considerations. Baltimore City has begun using contract staff, rather than hiring permanent employees. For example, an independent contractor provides intensive family preservation services, including a family preservation program and higher-intensity foster care and family services. The intensive family services program is a three-month program in which workers provide up to 20 hours of service a week and are available 24 hours a day. The caseload is three families per worker. The higher-intensity foster care service strives for reunification; the caseload is six families per caseworker. This initiative has not been as cost-effective as the State had hoped and it has adversely affected the level of services that the agency can provide. Staff hired by the contractor tend to stay only 6-12 months as a result of the contractual status of employment and the nature of the work.

> *Having flexible finds available to pay for whatever is needed when its needed has made a big difference. We just wish they were more available and even more flexible.*

Baltimore has increased the level of its Flexfund, which is now close to $2 million. These funds can be used in a variety of ways to prevent the separation of children and families or to facilitate family reunification. They can be used to pay for outpatient drug treatment, emergency family needs such as food, clothing, security deposits, etc., that may be necessary if the child is to be maintained in the home.

To manage the rising numbers of substance abuse cases, the agency has introduced more intensive training, and made efforts to increase the ability of staff to detect substance abuse and to identify the effects of different drugs and their appropriate treatments.

Staff perceive collaborative efforts among providers to pool resources and information as an effective existing strategy for promoting optimal outcomes for substance-abusing families. In response to both the need and to the state mandate to promote interagency collaboration, the agency is developing a program with the Greater Baltimore Medical Center for the creation of two new outpatient treatment centers. The agency is also collaborating with Turk House to provide seven beds for inpatient treatment and referrals for outpatient services. An agency staff person will work in Turk House as a liaison to facilitate continuity of services. Some State funds are used for both projects. In addition to staff training, the agency has created an internal HIV unit and is developing a Maternal Substance Abuse Program (MSAP) in collaboration with the Health Department, the University of Maryland, and Drug Strategies in Washington, DC. On an outpatient basis, MSAP will offer intensive counseling, urinalysis, support groups with Narcotics Anonymous, child care, and a resource center. The program also will include an acupuncture component for postpartum mothers to reduce the costs of foster care and family services.

Two years ago the Intake Unit had only six units with three to four workers per unit; today there are seven units with four workers per unit. The reason for the increase in staff is the increased volume of reports directly related to substance abuse. Although caseloads are not supposed to exceed 19, the impact of substance abuse and homelessness means that this limit is sometimes exceeded. Furthermore, families enter the system with more problems, and this requires more per-case staff time from investigation through resolution.

In response to the increased prevalence of substance abuse among clients, most CPS staff participated in a two-day training program sponsored by the University of Maryland. The training focused on the variety of abusable substances and on techniques for working with substance abusers.

Families Now!--a team approach to treatment --has been established to help families more effectively and quickly. The goals of Families Now! are to:

- Work with families at high risk of out-of-home placement resulting from child physical abuse or neglect

- Prevent the placement of children in foster care

- Empower families and help them become self-sufficient

- Build on family strength to help families achieve and maintain stability and self-sufficiency.

Families Now! offers two types of specialized substance abuse treatment programs. Intensive Family Services (IFS) works with six families for three months, although some families continue in the program beyond three months to facilitate case resolution. The second program, the Level III Family Preservation Program, works with 12 families for up to nine months. Approximately 25% of the IFS cases involve confirmed (i.e. corroborated) family substance abuse problems; staff estimate that the true figure is much higher -- perhaps as high as 75% of all cases.

Both programs use caseworker/associate teams to provide home-based, personalized services; the caseworker is a professional social worker, and the associate is a paraprofessional, often a parent aide. In IFS, the team spends 5 to 20 hours per week with each family. In the Level III Family Preservation Program, the team visits families 3 to 4 times a month. The Families Now! teams assist families with housing, education, employment, home and money management, health, alcohol and other drug problems, HIV/AIDS concerns, development of parenting skills, and family relationships. Much of the counseling provided by Families Now! involves breaking through denial, understanding the damage caused by substance abuse, and focusing on reality. Staff also may provide counseling on relationships with children, spouses, and boyfriends, and advise on basic child care, parenting, and budgeting. Case managers do such hands-on work as setting up a schedule, going into the home, and cleaning with their assigned family. Case managers also assist parents in managing their children's problem behavior.

About 70 percent of all Families Now! cases are closed, with no further services indicated. In the IFS program, about 35 percent of the cases are closed in three months, and 60 to 70 percent in four to six months.

2.3.1.4 **Program Needs and Recommendations**

It is the view of service providers working in child welfare programs that the following strategies would aid in combatting the problem of substance abuse and its effects on family services:

- Expand inpatient treatment facilities, particularly those based on need rather than ability to pay.

- Expand access to 45-day AOD treatment programs.

- Provide accessible well child care programs for dependent children of parents undergoing treatment in inpatient facilities.

- Expand daily outpatient AOD treatment programs with child care facilities.

- Expand the availability of residential facilities for family stays of 12 to 18 months, with counseling for children and support for substance-abusing parents.

- Develop an intense, comprehensive approach to working with substance abusers modeled on the Intensive Family Services model;

- Continue collaborative efforts because the same client population is being served by many medical and social service organizations and agencies.

- Provide additional training for staff on:
  - effective intervention with limited time and resources;
  - the impact of substance abuse on children, including AOD exposure and child attention deficit disorders (ADD) and hyperactivity.

- Involve the local communities and the churches in taking greater responsibility for children of substance-abusing parents.

- Let the dollar follow the child's no matter what the problem, rather than categorizing services and thereby limiting the system's ability to help families and the families' ability to receive proper care.

- Adoption workers should gather more information about substance-abusing parents and learn more about their children's histories.

- Put more emphasis on placing siblings together in adoption and foster care settings.

- Give more attention to matching each child's needs with what a foster home has to offer.

- Take a holistic approach to fostering successful families, in the belief that improved housing, good educational systems, and supportive communities will lead to fewer families with substance abuse problems entering the sys tern.

2.3.2 HEAD START PROGRAMS

2.3.2.1 Overview and Background

Information included in this section was gathered from interviews with 14 staff members from two Head Start programs funded by ACYF through the City of Baltimore Department of Housing and Community Development. Baltimore City's 15 Head Start delegate agencies annually serve 2,700 to 3,000 children. Staff from two agencies supplied the information for this section.

St. Francis Xavier Head Start Program serves 216 children each year. All classes there are held Monday through Friday from September to June; in the summer of 1994, they tested a pilot summer program for 18 children. This center does not see many abused children, but the staff noted that families may cover up signs of abuse. Staff interact with the children to detect possible abuse or neglect. For substance-abusing families with children served by this Head Start program, heroin is the drug of choice. Test day (when dealers give out free hits) occurs around the winter holidays. In this center's neighborhood, hits of heroin cost about $2.

Coldsprings Family Development Head Start Center serves 195 children, with 65-90 percent believed to be directly affected by substance abuse, and the remainder exposed to it in their neighborhoods. Crack/cocaine is the preferred substance for the population served by the center.

2.3.2.2 Impact of Family Substance Abuse

> *Safety has become a big issue. We've had to curtail home visits and community outreach. We worry about placing children at risk when we go on walks. We have difficulty deciding whether or when to let a child go off with a parent who is obviously under the influence.*

Over the past three to four years, the use of illicit drugs has become more noticeable throughout the service area. Crime has also increased in the neighborhood, and residents of the community have established block watches. More children are neglected, and more are exposed to drive-by shootings, street violence, drug trafficking, and drug use. These changes have led to an increase in the number of families in crisis, and to a greater need for staff to develop relationships with parents, find out more about each family's past, and develop a strong parent involvement component to the programs.

The Head Start programs are seeing increasing numbers of children with problems that staff have received *little* formal training to handle, and an increase in the incidence of child neglect. On most Mondays, children from substance-abusing families are less likely to attend and more likely to be late. About 25 percent of the families served by one center are known to be substance-abusing, and approximately 55 percent of these children live with extended family members. The major problems cited by Head Start staff in serving children from substance-abusing families are not knowing how children are affected by substance abuse in the home; who is the child's primary caregiver; how to handle the increased incidence of abuse; and what additional needs parents, children, and staff may develop.

> *We are seeing more HIV+ cases and currently have three or four HIV+ children enrolled; last year we experienced our first death of a preschooler from AIDS.*

Children affected by substance abuse in the home tend be withdrawn, to display aggressive behavior, and to have mood swings, low self-esteem, undeveloped fine motor skills, and more health problems than other children. They use more street language and are generally more knowledgeable about the drug business. Some children from families with substance-abuse problems do not talk. In the past five years, one family services coordinator has seen an increase in the number of children with behavioral problems directly attributable to ADD.

> *Our Center is seeing increased numbers of these children with unfamiliar problems that the staff are ill-equipped to handle.*

At one program, staff members report having also seen more HIV cases. Last year that center experienced its first death of a preschooler from HIV; *three* or four children this year have been diagnosed as HIV positive.

> *If a kid is HIV+ but the mom isn't using, the family is much easier to reach. If active drug abuse is going on, the families are more difficult to get to and engage. It requires constant outreach and constant contact.*

The average age of a parent from one program is 22, and about 95 percent of families are headed by single mothers. Single-parent households are more likely to include a substance abuser. If the mother has a boyfriend, she is usually abused, and grandparents, aunts, and foster families are most often the primary caregivers. Parents who are abusing narcotics (rather than alcohol) are more challenging because they place their children in greater danger. Unemployment and lack of education are major barriers for these parents. Staff has noted an increase in the number of women being incarcerated for sale and possession of drugs and an increase in adult deaths resulting from substance use and HIV infection.

One big problem is the lack of a good curriculum for teaching substance-abuse prevention to three- and four-year-old children, although good materials are available on issues such as nutrition and fire safety. In addition, the materials are too wordy for parents who are illiterate. Staff often improvise, using bits and pieces of materials. A further problem is limited resources available outside the centers.

Staff also cite the need for 24-hour services to answer crisis situations, and the long waiting lists when referring a parent to another organization (frequently 30-day delays). Staff turnover in outside social service agencies has created a barrier to the kind of effective networking that centers have determined is needed to connect families in need with the available resources.

2.3.2.3 Response to Family Substance Abuse

Both centers have had a substance abuse specialist on staff. For several years, one center assigned a substance abuse coordinator to provide technical assistance to the staff. Because turnover in the position was high, however, the center staff never felt comfortable with any single person. Funding for the pilot program ended, and the center no longer has a substance abuse coordinator. The other center has focused on hiring a people-oriented substance abuse coordinator, supported by a Federal grant, and on providing staff and clients with someone to listen to their problems. The substance abuse coordinator's primary goal is to integrate a substance abuse prevention component into the Head Start program to help staff detect substance abuse and facilitate treatment referral services for children and parents.

One center has contacts at Johns Hopkins, Francis Scott Key, and Mercy hospitals, and at a neighborhood detoxification center. Narcotics Anonymous (NA) meets in the church next door on Sunday nights. The center networks with a wide range of substance-abuse treatment and prevention programs, including:

- Olive Center, a before- and after-school program for older children
- Descimus House, a halfway house for male ex-offenders
- Neighborhood churches
- The Baltimore public school special education program, which helps with children's speech and other needs
- Baltimore City Community College, which provides classes in skills development, automotive repair, and GED preparation
- New Visions, a coed treatment program

- Healthy Start Centers for pregnant women

- Bright Hope House, a residential treatment/housing project where people can stay for as long as one year. The project provides job training, NA meetings, and counseling. Residents are not allowed to have visitors for the first 60 days, and clients are not encouraged to work until they have been in the program for six months.

The center has a parent-involvement program that provides opportunities for parents to volunteer at the center and participate in parent policy and event-planning committees. During this school year, the center is focusing each month on a particular theme or topic proposed by parents, and offering germane programs and discussion groups for parents (e.g., October is Employment Skills and Career Training month).

The center has added a doctor to the staff. The staff also evaluates and refers children of substance-abusing parents to a mental health evaluation, education, and speech/language center for screening of mental capacities, education capabilities, and speech and language development. Parents have begun trusting the center's staff, who are then able to assess their needs and help them.

Training in areas of substance abuse is provided at Head Start centers. Staff members want to know what is the drug of choice for people in their area, how to handle the child of a substance abuser, and how to be more sensitive to their clients' needs. The Central Office Substance Abuse Division also sponsors monthly training sessions on issues surrounding substance abuse and some staff members attend each session. These sessions have focused on building healthy attitudes in families and increasing the self-esteem of substance abusers. Other training in the past have focused on identifying, approaching, and handling substance abusers; and domestic violence laws and programs.

Head Start centers are concerned about children in abusive situations and maintain positive relationships with CPS. In a recent case, an abused child told center staff about her mother's drug use. The police came to the center for the mother and the child was taken to a hospital. The child was eventually reunited with her mother.

CFD's staff believes the center's role is to serve as a support system for substance-abusing families and as a referral agency for families in need. Trying to fulfill this role, they have:

- Established a working relationship with nearby Sinai Hospital and they refer clients to its drug center outpatient clinic

- Initiated ties with Park West Medical Center and Greenspring Pediatrics Center (part of the Sinai complex)

- Established a Health Advisory Committee

Although Baltimore has no strong substance abuse treatment and prevention network, CFD has developed its own. A team of family service coordinators makes the private network function. The team is constantly looking for new resources and making use of those already at hand. This work is hampered, however, when staff turnover is high because effective networks require consistent contacts and these are hard to maintain with repeated shifts in personnel. In addition, excessive caseloads inhibit full use of existing coordination mechanisms; staff may not have the time to look for additional sources of aid. The lack of 24-hour services hampers the ability to provide a quick response in crisis situations.

The education coordinator at one center is planning to implement Head Start's substance abuse curriculum designed for children during this school year.

2.3.2.4 **Program Needs and Recommendations**

Staff of these two Baltimore Head Start programs identified program needs that for the most part involve either improved staffing and staff training or provision of more supportive preventive services to families. Their major recommendations include to:

- Offer prevention activities and more information on substance abuse, participate in community networks, and provide a supportive environment in which families and staff can acknowledge substance-abuse problems.

- Conduct additional staff training on substance abuse.

- Establish a home or resource center where families can receive help 24 hours a day.

- Expand the therapeutic nursery program at one of the two CFD sites. The program includes three licensed counselors and a social worker for 40 hours per week and has access to a child psychologist. It is funded for 15 children, but serves 25-30.

- Make listening/talking support services available to parents 24 hours a day.

- Offer parents education about the effects of substance abuse on children, and about how to access community resources for themselves or for others.

- Increase intervention training for the staff.

2.3.3 PARENT-CHILD CENTERS

2.3.3.1 Overview and Background

Staff from two Parent/Child Centers, all funded by ACYF through the City of Baltimore Department of Housing and Community Development were interviewed. The Parent/Child Centers are funded to serve families with children under the age three although in rare cases children four years old are enrolled. The goals of the centers are to encourage optimal development of children and to assist parents in their role as primary caregivers. The Martin Luther King, Jr. Parent/Child Center, one of the participating sites, is the only center under the auspices of the Department of Housing and Community Development that only serves families with children aged 0 to 3 years. The child development program at The Family Place, the second parent/child center where staff participated in interviews, serves mostly children up to the age of three, and some four-year-old children. It is a drop-in center, and children seldom return after the initial visit. Workers serve at least 20 children a week and about 50 families a month.

2.3.3.2 Impact of Family Substance Abuse

Most of the children we serve from substance-abusing families have poor hygiene, lack proper health care, and are malnourished, . They are overly responsible for their age and protective of their siblings, but most have developmental delays.

Nearly 50 percent of the families at one center have someone in the home with a substance abuse problem, while 90 to 95 percent of families receiving services have alcohol or other drug problems in their immediate or extended families. Although less willing to estimate percentages, staff at the other center feel that substance abuse is a major problem among the families they serve.

Staff members interviewed at both centers identify as major problems the lack of financial and service resources for the families they serve. They cite specifically the de-funding of women's programs in 1991 and 1992, and the de-funding of inpatient and outpatient detoxification programs. They note that the Maryland Medicaid HMO will pay for only 3 days of detoxification treatment rather than the 30 days people usually need, and that the program will not pay the costs of drug-affected newborns. Because of these shortcomings, substance-abuse counselors end up referring people to ineffective programs.

The increase in demand and decrease in the availability of services in Baltimore is a significant problem. Service providers are concerned that services which survived funding cuts have done so with reduced resources. The City Health Department is trying to bring services back to the hospital, but African American males, especially, are not hospitals' favorite clientele, and they will be less likely to receive services if programs are moved to hospitals.

Substance abuse has devastated families financially; most of them receive Aid to Families with Dependent Children, which barely covers their needs. The substance-abusing parents tend to be younger than other parents (17 to 25 years old), have more than one child, and lack a high school diploma or marketable skills. They also have very low self-esteem, a defeatist attitude, and little capacity or inclination to meet their families' basic needs. Families run out of food, and the children are not clothed. Grandparents are often the primary caregivers because a child's mother is abusing substances, and in some cases the grandparents are also substance abusers.

> *The primary needs of these families are for substance abuse treatment and aftercare, jobs, and housing that is affordable and away from drugs.*

Working with children from substance-abusing families requires increased energy and time. Attention span is a real problem among both parents and children. Because many parents are illiterate or are poor readers, one center relies on verbal communication and interactive training. Children may have trouble staying awake and are unable to participate in infant stimulation classes. Substance-abusing parents have drugs, not children, as their primary concern, and their children do not thrive and develop as they should because they have been physically and emotionally neglected.

The children served at one P-CC are said to be malnourished, protective of their siblings, overly responsible for their age, have poor hygiene, and lack proper health care. Typical of children from substance-abusing families, they lack social and communication skills; are emotionally deprived, delayed, and detached, have difficulty forming relationships; and lack preparation for school. They have poor hygiene and manifest attention-getting behavior. They are isolated, having been shunted from family to family. Their parents fail to take them to doctors, school, or any other available service. The primary needs of these families are substance abuse treatment and aftercare, jobs, and housing that is affordable and away from drugs. Many children witness violence and experience the stigma attached to having parents who use drugs. There is also the issue of conflicting messages and moral standards: children see their parents using drugs but are told not to do it themselves.

One program's participant recruitment costs are said to have risen considerably because of drug-related security concerns. Most recruiting is conducted in the streets; now one person never recruits alone and no recruiting is done in some neighborhoods. Female

staff never go alone to housing projects. Although 400 people were recruited for one program last year, only 50 completed the enrollment process. Motivating parents to initiate enrollment requires excessive staff energy and time.

Staff and child safety is also a concern. Children cannot use the playground adjacent to that center because staff cannot keep the area free from needles. Neighborhood violence endangers people inside and outside the center, and compromises the level of service the center can offer. Staff had to -hit the floors during a recent training session because of gunshots. The center provides a van service for some families, and on three or four occasions the van would not pick up families on certain blocks because of activity at the drug houses on freebies days. In the home-based program, if teachers do not feel comfortable going to a home because of safety or drugs, they return to the center.

Workers at one center are worried about getting shot in a drive-by shooting or in the cross-fire between rival drug-dealing gangs. They would like to provide services in the evening, but they don't feel safe. There is a sense of frustration at not being able to improve their working conditions or their clients' living conditions. Staff help children while they are at the center, but then have to send them back to the same troubled environments. There is a real air of hopelessness, and workers have to focus on small successes.

Staff members at one center say that ten years ago, the drugs of choice were marijuana, alcohol, and glue. Cocaine use started out on the west side of Baltimore because it was considered a rich man's drug and moved in from the western suburbs; then, when the price dropped, it moved into the east side. Cocaine, heroin, and crack now are the drugs of choice. Crack/cocaine is the most devastating; it takes the greatest toll on children because parents who use crack seem to lose their maternal and paternal instincts. Staff are also finding increased use of "speedball", a mixture of heroin and cocaine that is injected.

2.3.3.3 **Response to Family Substance Abuse**

One goal of the Parent/Child Centers is to increase positive interactions between parents and children, Staff members try to establish closer relationships with parents and to develop rapport so they can better assess the level of need. In cases of substance-abusing families, the centers put abusers in touch with appropriate agencies. One center has such a good working relationship with CPS that DSS refers some families to the program as a condition for keeping their children or having them returned.

To meet the food and clothing needs that result when substance-abusing parents lack funds for these necessities, one center enlists the help of other families served by the center. It has started a clothing closet, and keeps canned and dry goods on hand for

families in need. A city-sponsored substance abuse project has provided training to staff on the signs and symptoms and the legal aspects of substance abuse, and on confidentiality.

A clinical social worker at one center has arranged for speakers to make presentations on substance-abuse issues for parents and teachers next year. She has also identified other workshop presenters who will address people's needs; the program will begin in November.

The other center provides two forms of substance-abuse services: referrals and drug-education groups. All participants in youth programs also take part in the drug-education groups. Other services include support for women in recovery, because women need to receive services separately from men. About 85 percent of participants receive one or both substance abuse interventions. Transportation, flexible hours, and support in relationship building are offered. The center encourages participation and retention and offers woman-specific programs.

The center provides its staff with training on new drugs, the effects of *drugs on the* community, how to identify and how to respond to people on drugs. The program's substance-abuse counselor gives *training* through the in-house staff development program. Friends of the Family does a two-day retreat each year that looks at these issues on a global scale. A center founded substance abuse treatment provider network in east Baltimore operates effectively. Verbal agreements specify the level and type of support and services.

> *Substance abuse by parents does not disqualify them from the program. There are two kinds of users: those who acknowledge and those who are suspected of, but deny, substance abuse. Those who acknowledge their abuse are receptive to referrals for counseling or other treatment. If we only suspect substance abuse, there's not a lot the counselors can do and confronting the parent usually raises a lot of barriers to providing services.*

Teens and preteens are referred to programs dealing with their age group; for younger children, a child development specialist is available. These strategies are effective. A small percentage of children has been professionally diagnosed as prenatally exposed or addicted to drugs and alcohol.

Following is an example of a family with substance-abuse problems who benefited from services provided by one program: The family comprised a young woman in her early twenties, her four children, and her addicted mother with whom they shared a house. Her father, also an addict, moved in for a while. The bills were not being paid. The grandmother helped out with childcare but would steal and beg money from her daughter. The daughter did not want to put her parents out of the house. Program staff pointed out

to her the problems associated with leaving her children with her mother. City Homes, a women's support program, found the woman a better home in a better neighborhood and also found her a mentor, a slightly older woman who also had been addicted Now this woman is getting her General Equivalency Diploma.

The second example is of a family who did not benefit from these services. A woman, also in her late twenties, who lived with her boyfriend but could not take good care of her five children. With low self-esteem and in an emotionally abusive relationship, she was evicted from her house and went into hotel housing, but the grant ran out. Family Preservation found her a house and furniture, but because she was giving her checks to her boyfriend, they eventually became homeless. Now they are in a shelter, and both she and her boyfriend use drugs. Her children are still with her.

In the second family, the man totally controlled the woman and led her into drugs. It is difficult to successfully help people who go back to bad situations after receiving treatment. The woman in the second family needs to realize that she can help herself out of her difficult situation. She needs to surround herself with positive influences and increase her self-esteem.

2.3.3.4 **Program Needs and Recommendations**

Staff from these two Parent-Child Centers perceive most of their problems relating to coping with substance-abusing families as reflecting a lack of staff skill and training in relevant areas. Many of their primary recommendations reflect this perception, as well as a strong belief in the value of providing supportive services to families. Specifically, they recommend that we need to:

- Provide more in-depth staff training on how to handle situations involving substance abuse. The ideal model would give training at the centers over a six-week period. A second model would include onsite inpatient and outpatient family treatment services;

- Educate the staff on ways to identify and handle children who were drug-exposed or addicted at birth. Staff find it difficult to determine if behavior problems or delays result from drug exposure or environmental factors;

- Offer the staff more basic education on street names and slang for drugs and drug activities, drug and paraphernalia prices, how drugs are made, how people inject or ingest drugs, and how to recognize drug use; on AIDS issues; on compassion for and acceptance of drug users; and on counseling methods;

- Fund a full-time position to provide individual counseling or linkages to counseling programs;

- Generate innovative ways to overcome the obstacles of scheduling and transportation;

- Fund and offer such additional services as residential programming for families (including detoxification, support services, education, job training, employment, and housing);

- In lieu of foster care, provide long-term treatment centers and childcare for children whose mothers go into treatment. Parents need to get their children back as soon as they complete treatment;

- Offer 24-hour childcare centers and supervised housing linked with family-support services; and

- Identify and attack the root causes that lead to substance abuse--homelessness and unemployment.

2.3.4 RUNAWAY AND HOMELESS YOUTH SHELTER

2.3.4.1 Overview and Background

The Harris House is an emergency runaway and homeless youth shelter operated by the Fellowship of Light. It serves male and female youth between the ages of 12 and 17. Youths stay 1 to 30 days, depending on the referral source. They are self-referred (walk-ins), or referred by parents, community mental health facilities, schools, police, hospitals, or agencies such as the DSS. The shelter can house nine, and it serves an average of seven. Last year it served 153 youth, but that number has decreased in 1994 because the agency decided to extend the stay of DSS-referred youth from 10 to 30 days (a change not predicated on substance-abuse issues but on a desire to give shelter staff more time to involve workers, develop a plan, and advocate for more appropriate placements). The Fellowship of Light also operates Peggy's Place, a residential facility for girls. The Fellowship of Light receives funds directly from the ACYF Bureau of Family and Youth Services (FYSB).

On the REMIS database (the FYSB MIS), the shelter records reasons why each youth run away, substance abuse issues, prior placements, runaway episodes, and school. Information on the youths' health and any suicide episodes is maintained separately.

2.3.4.2 Impact of Family Substance Abuse

Many DSS referrals who enter the shelter do so because of their parents' substance abuse. In most of these cases, the young people do not use drugs, although they have been exposed to drugs in their home situations. Walk-ins or self-referrals often have run away because of conflict with their parents, not because of their parents' substance abuse.

Over the past five years, there has been a gradual increase in both the number of young people who present at Harris House and the number whose families have substance-abuse problems. Sometimes their parents are abusing alcohol or crack, or one or both parents have died from AIDS. Five years ago, these problems were rarely seen. About 50 percent of the families abuse alcohol either alone or in combination with other drugs.

The shelter's screening process enables the team to screen out youth with severe alcohol and other drug problems and refer them to a detoxification program. About 80 percent of the young people probably have experimented with alcohol or other drugs. Although many of the

> *Few of the youth coming to our program abuse drugs themselves -- drug users do not call the shelter to stay here. Many of these youth however are or have been involved in selling drugs.*

youth smoke cigarettes, few if any are active substance abusers. Those who are active abusers usually began using substances at age 10 or 11.

2.3.4.3 Response to Family Substance Abuse

In recognition of the growing impact of parental substance abuse on youth, shelter staff try to respond by being creative. Staff attend training and share information with other staff. The team has worked with other organizations in the community to develop a curriculum on substance abuse. The shelter team is part of a coalition with other shelters across the State, and they collaborate on training, convening conferences, and identifying grants to secure additional resources and other training. These strategies generally are effective.

In May, the shelter team completed an eight-month substance abuse curriculum in collaboration with other agencies. They will continue in the fall and will also look at other alternatives. They also plan to redesign the training program as a result of the substance-abuse curriculum.

The aftercare and outreach components of the program are being redesigned. In the past, turf fighting has prevented service coordination, but shrinking funds have motivated agencies to begin building coalitions. The youths' extended families do not intercede as they have in the past.

> *There are few treatment resources available for youth. The shelter does not directly provide treatment and the shelter does not accept drug-involved kids -- they are screened out.*

The shelter team works with DSS every day, and would like to see DSS do more. They have frequent but not daily contact with the police.

2.3.4.4 Program Needs and Recommendations

In dealing with the impact of family substance abuse, Harris House staff see the most salient or urgent needs to be in the areas of staff training and in providing more comprehensive prevention, intervention, and treatment services to these youth and families. Specifically, they would recommend approaches or initiatives that would:

- Provide comprehensive staff training, including training in:
  - signs and symptoms of substance abuse and withdrawal;
  - different types of drugs and their effects;
  - characteristics of the drug lifestyle and culture;
  - effective approaches in counseling;

- treatment resources for adolescents; and,
- approaches to youth conflict, violence, and crime reduction;

- Expand counseling services to help youth handle the realities of substance abuse, HIV/AIDS, physical and emotional abuse, and neglect;

- Fund employment opportunities, recreational activities, mentoring programs, community-building education, day care, and adolescent treatment programs (particularly detoxification programs);

- Provide long-term support for families after detoxification;

- Establish an aftercare manager position to track youths referred to other services;

- Improve pre-screening procedures to make certain young people are stable enough to enter the shelter;

- Identify ways to handle youth with AOD problems but no insurance, whose parents will not assume responsibility;

- Train people to differentiate between using and selling drugs, to avoid labeling youth “users” when they in fact are sellers; and,

- Establish follow-up procedures to cut the risk of the youths continuing/returning to behaviors learned at home.

2.4 DISCUSSION AND OBSERVATIONS

It is clear from the perspectives of all people interviewed for this study that substance abuse has increased over the past two years in the City of Baltimore, and that it continues to be pervasive in its impact on ACYF-funded programs. Although alcohol and other drug abuse are not the only reasons families need relief and assistance from ACYF-funded agencies, the interviewees agree that it is the single-most significant contributing factor.

2.4.1 IMPACT OF FAMILY SUBSTANCE ABUSE

When asked to describe the impact substance abuse has had on their specific agencies and the way services are delivered there, the study participants most frequently cited the following:

- Caseload Management Issues--These included increased caseloads and lengthened case-closure times.

- Staff Problems--Frustration, feelings of hopelessness, and turnover were mentioned, as was lack of knowledge about and understanding of substance abuse and its effects on the part of staff.

- Poor Home Circumstances--Children are said to increasingly present as unfed, unclothed, uncared for, and emotionally and physically damaged. These conditions occasion more intense and longer-term counseling and foster care services.

- Resource Gaps--There is a paucity of financial, medical, and social service resources to which substance-abusing parents and families can be referred.

- Culture Of Danger And Violence--Surrounding the families in need and the service providers working to help them is an atmosphere where drive-by shootings and stray gunshots threaten the safety of children, families, and staff both inside and outside the agencies.

2.4.2 ACYF-FUNDED AGENCY RESPONSES TO FAMILY SUBSTANCE ABUSE

In response to the growing problem created by substance abuse, agency personnel have sought additional funding from the State, the city, and ACYF, as well as alternative funding from a variety of foundations and federal agencies. A number of the agencies have enlarged their staffs, filling either new positions with people whose expertise is

substance abuse, or adding to the staff of standard service providers in response to the enlarged caseloads.

Responding to a citywide reduction of funding, service providers have begun more collaborative efforts. They have sought support from their colleagues, and have cultivated coalitions to address the personal stresses and programmatic strains that are created by an increased demand from a population in need and engulfed by substance abuse. They are collaborating and forming networks with medical and human services facilities to create treatment options, maternal substance-abuse programs, and counseling opportunities for parents, children, and staff. They are identifying additional community resources to which they can direct the people they serve so that other of their enormous needs may be met. These coalitions are also providing training for staff members. Education about drugs and their effects, drug abusers, intervention skills, treatment modes, and legal issues are being shared.

Although coalitions have improved staff morale and agency response, service delivery staff need additional financial and programmatic resources to fully address the problems deriving from the increase in substance abuse. In each case where a professional was asked about referrals to other agencies, the interviewees said that treatment services are not accessible or readily available. As indicated in Section II of this case study, the estimated number of people in need of treatment (62,829) is nearly three times the number of treatment slots available through the Alcohol and Drug Abuse Administration (ADAA) and non-ADAA sources (i.e., 16,195 and 5,864, respectively).

2.4.3 Recommendations

When asked to recommend strategies for addressing the profusion of new and intensified problems their agencies are encountering as a result of substance abuse, those interviewed presented a wide range of ideas, from the tightly focused and agency-specific to the global. Most often recommended were the following:

- Provide residential treatment programs for women and their children (87 percent of interviewees urged a 45-day program).
- Devise outpatient treatment strategies that work, unlike the ineffective outpatient programs presently available.
- Take a comprehensive approach to treatment, addressing not only the substance addiction, but also the basic needs of adequate housing, food, and clothing; emotional support and physical safety; and skills development and job training.
- Provide accessible and affordable childcare when parents are in treatment so that children can be returned to them as soon as treatment is completed.

- Develop more collaborative networks to share knowledge and skills, and free the money consumed by duplicate resources to fund scarce resources.

- Create staff development and training programs that equip service providers to confront the problems of substance abuse in their agencies and to counter the burnout and staff turnovers that result from frustration, fear, and lack of knowledge.

Across the range of staff members interviewed at the agencies participating in this case study, there was significant agreement about the problems of substance abuse in the community at large and on their agencies' territories. Responses to the problems were quite alike, as were the strategies proposed. Circumstances and solutions may be seen to differ in the details, but they are strikingly similar in sum.

CHAPTER 3:
THE MIAMI EXPERIENCE

3.1 INTRODUCTION

Miami was selected for inclusion into the study because it is one of the most ethnically diverse cities in the nation. The population mix of Hispanics, African Americans, and Anglos requires that effective service delivery satisfy the cultural characteristics of many different groups. In addition, Miami's geographical disposition for drug trafficking increases access to illicit drugs making the population susceptible to drug abuse.

This case study captures and portrays the prevalence of family substance abuse in Miami/Dade County and its impact on each of the program areas funded by the Administration on Children, Youth, and Families (ACYF) of the U.S. Department of Health and Human Services as experienced by program staff delivering services in this area. These include the National Center on Child Abuse and Neglect, the Children's Bureau, the Head Start Bureau, and the Family and Youth Services Bureau. The ACYF-supported programs include Child Protective Services, Adoption, Head Start, Parent/Child Centers, and Runaway and Homeless Youth Programs. Specifically, the case-study on Miami attempts to assess:

- Trends in community alcohol and substance abuse in recent years;
- The influence of family alcohol and substance abuse on delivery of services to the respective client populations;
- The impact of substance abuse on program staff in carrying out their functions; and,
- Strategies undertaken by each agency to respond to the impact of substance abuse.

Background descriptive data on the population of Miami and the prevalence of alcohol and substance abuse was obtained from a number of sources, including:

- 1990 Census Data;
- *Florida Kids Count, 1993;*

- The Metro Dade Substance Abuse Control Unit; and,
- The Up Front Drug Information Center.

Determining the influence of substance abuse on each of the programs under the direction of the four ACYF funded areas was derived from open-ended discussions with program staff from various administrative supervisory, and direct service levels held during the period from August 15 through August 24, 1994. Most staff were interviewed by two to three site visit team members, with the majority of interviews lasting approximately one hour. For each ACYF-administered program area the following staff were interviewed:

Child Welfare Programs: Sixteen people working in a variety of roles and programs were interviewed, including: the District Program Manager for Children, Youth and Families; seven Child Protective Services program staff; four staff working in Adoptions; and one staff member from Foster Care and one from the Termination of Parental Rights (TPR) program. In addition, discussions were held with Master from the juvenile and family court and with the Director of the Maternal Addiction Program.

Head Start Program: Eight people from different areas of the Head Start program were interviewed. Two center Directors, an Assistant Center Director, a Parent Involvement Coordinator, a Mental Health Coordinator, a Disabilities Coordinator, a Health Coordinator; and a Social Services Coordinator.

Runaway and Homeless Youth Shelter: One RHY program was accessible for the case study, in which the Coordinator of Residential Programs, the Director of the Transitional Living program, and the Assistant Shelter Director were interviewed.

3.2 SUBSTANCE ABUSE IN MIAMI/DADE COUNTY

3.2.1 INTRODUCTIONTO MIAMI/ DADE COUNTY

Dade County, Florida with a population of 1,937,094 covers a total area of 2,408 square miles, 354 which is water. The greater Miami/Dade area consists of 27 independent municipalities and unincorporated areas (Census Bureau, 1990). These include, among others, North Miami Beach, North Miami, Miami Shores, Hialeah, Miami Springs, Coral Gables, South Miami, Homestead, Surfside, Key Biscayne, and Bal Harbor. However, most social services and other government functions, including CPS, foster care, adoption services , etc., are provided on a county-wide basis.

Children under the age of 18 account for 24.2% of Dade County's population and 14.0% of the population is over 64. The population distribution by ethnicity is, 72.9% (1,413,015) white and 20.5% (397,993) black. In essence Miami is a very Latin community. Of the white and black population, 49.2% (953,407) is of Hispanic origin. However, the actual Hispanic population may be much larger for several reasons, among these: the under enumeration of Hispanics by the Census Bureau, and the migration of Latin American refugees to the Miami area. Immigrants from Cuba, South and Central American, Mexico and more recently Haiti congregate in South Florida.

The median income of families in Dade County in 1989 was $17,963 with an unemployment rate of 6.4%; 25.7% of these families lived under the poverty level. In 1990, 24.3% of all children under the age of 18 lived in poverty, with minority children more likely to be living in poverty than white children (17.5%). For children under the age of 18, 58.7% live in a two-parent family, 20.9% live with a single female parent, and 12.7% live with other relatives; only 7.7% living with a single father or other outside family member. For children living with a single mother, over half (5 1.4%) lived below the poverty level.

Infant mortality rates for non-whites are nearly double (15.5 per 1,000) those of the white population (6.8 per 1,000) in 1990. For teens in 1990, violent deaths occurred at a rate of 6.8 per 10,000, nearly a two point decrease from 1980. In 1991, Dade County recorded 16,073 closed cases of "verified and some indication" of child maltreatment. Of the closed cases, 35% were maltreatment, 47% were listed as neglect, and 18% recorded as threatened harm.

3.2.2 COMMUNITY SUBSTANCE ABUSE

The geographical location of Dade County with its extensive coastline, numerous air and sea vessels, and proximity to Latin American and the Caribbean creates an easy port of entry and distribution of illicit drugs. As a result Miami's population is at an increased

risk to the dangers and consequences of the drug trafficking world. Television shows such as "Miami Vice" in the 1980's portrayed Miami as a glitzy nightlife cocaine town, and in the 1990's the availability of drugs such as cocaine is still very high. The 1993 Florida Drug Enforcement Survey reported crack cocaine and cocaine hydrochloride to be very available with ratings of 4.8 and 4.7 on a 5-point scale of availability.

Information obtained from Metro Dade Substance Abuse Control Unit and the Up Front Drug Information Center reveal that while Miami's reputation as a large cocaine distribution site remains unchallenged, it is also increasingly becoming a major center for other drugs. Within the last three years heroin has entered the pipeline. While most of the heroin entering Miami is destined for northern cities some "spillage" occurs into the local community. The heroin reaching the streets of Miami is extremely potent. The high quality of heroin is causing polydrug users to experience adverse effects as they mix higher purity heroin with alcohol and other drugs. As a result the mortality rates attributed to heroin have increased as have the number of heroin-related hospital emergency room admissions.

In addition, the popular "Club Drugs" of the 1970's have been reintroduced to Miami's rapidly growing dance club scene. Club drugs with street names such as, Grievous Bodily Harm (GHB), Ecstasy, Rophies, and Special K, are produced domestically in clandestine labs (Information for Action Vol 1., No. 6). Club drugs, attracting young consumers, are especially harmful when mixed with alcohol.

Hurricane Andrew, which destroyed much of southern Miami/Dade County in 1992 and was the costliest natural disaster in U.S. history, exacerbated AOD abuse problems in the Miami area. Attempting to cope with the post-disaster trauma of the storm placed many Dade County residents at greater risk for abuse of alcohol and other drugs. The general disorganization of normal services in Miami contributed to a relapse among many substance abusers receiving treatment. Drug treatment centers that were not destroyed were diverted from their normal functions and turned into temporary shelters for those who had lost their homes to the hurricane.

Nevertheless, overall drug use in Dade County has decreased 40% between 1991 and 1993 (Dade County Prevention Network). The decline, however is primarily among new aperiodic users; chronic hard-core drug usage has remained relatively stable, and these users remain the greatest challenge for social service, law enforcement, and medical and mental health agencies. The rate of cocaine-related emergencies in Miami is more than double that of the national rate, with a 5.5% increase from 1991 to 1992 in hospital emergency room admissions (Dade County Prevention Network Vol 1., No. 4).

A distinct pattern of drug and alcohol use exists among the different ethnic groups of Miami. Among Hispanics, the pattern is closely associated with the level of acculturation, and to a certain degree specific country of origin. For example, among Latin males prior to immigrating their alcohol consumption tends to be low in frequency but high in

quantity. Following immigration this drinking pattern changes to both high frequency and high quantity (Cervantes et al. 1990a). Among immigrant females from Latin America abstention from alcohol is greatest among Central and South Americans followed by Mexican, Cuban, and Puerto Rican women (Caetano, 1988). U.S.-born Hispanic females have lower abstention rates, especially second generation females. Similarly, the most recent immigrant arrivals are less likely to become involved in other drug use, although. this may be reflective of the neighborhood where a family locates. Residents of the more stable communities, such as those established by the early Cuban arrivals who are now second and third generation Americans, are more likely to be engaged in drug culture than are recently arrived Nicaraguans, for example, who live in a neighborhood comprised of other recent Nicaraguan immigrants. Among African-Americans substance abusers, crack and cocaine are the most prominent drugs used.

Unfortunately, alcohol and substance abuse in the community affects much of the client population of ACYF programs in Miami. Child welfare programs have experienced increasing case loads as a direct result of family substance abuse. Other programs, such as Head Start, are responding to the developmental consequence for children who have experienced prenatal AOD exposure or who come from homes were substance abuse is a factor. As will be seen in the following section, for each of the ACYF-funded programs in Miami, family substance abuse has presented a fundamental challenge to their service delivery system and each has struggled to devise better and more effective response strategies for dealing with the community AOD abuse problem..

3.3 SUBSTANCE ABUSE AND ACYF-FUNDED PROGRAMS

3.3.1 CHILD WELFARE PROGRAMS

In this section we address the ACYF-funded program areas of Child Protective Services (CPS), Foster Care, and Adoptions. These three program areas increasingly are serving the same populations, or subsets of the same population along a continuum of care, and increasingly agencies such as Miami/Dade Children and Family Services are reorganizing their service delivery systems to reflect this continuum.

3.3.1.1 Overview and Background

Miami/Dade County Child and Family Services, as part of the overall Florida Department of Health and Rehabilitative Services (HRS), includes the following components: the abuse registry, child protective investigations, early intervention services, protective services, the substance abuse newborn unit, the termination parental rights unit, foster care, and adoption related services. The HRS Florida Abuse Hotline located in Tallahassee is the abuse registry for the State. Anywhere from 900 to 1,200 electronically transmitted reports are received monthly by the Dade County district screening office for further investigation. It is upon receipt of reports to the screening office from the abuse registry that Dade County's Child Welfare system differs from others.

Dade County is in the midst of a plan to reintegrate all aspects of the child welfare system. The move is toward a "Family Focused Response System" (FFRS) which is a family and community-based approach to service delivery. The first phase of the FFRS took place November 15, 1993, with the implementation of the "Triage Intake System."

The Triage Intake System has converted 36 of the 91 Protective Investigation positions into Triage Units. Under the new system, the Triage Unit is responsible for commencing cases, assessing the immediate risk, and handling crisis stabilization. Triage workers are assisted by "screeners" from the District office to obtain detailed information on each case before it is assigned. Within 3-5 days, cases are forwarded by the Triage Unit to either a Follow-Up Unit or to a Voluntary Protective Service Unit for further service delivery, or closed if the case is unfounded.

The main goal of Child and Family Services is family reunification. Protective Service Units are teamed with Follow-Up Units so that Early

> *You're not really helping -- just putting band-aids on the problem*

Services Intervention, such as voluntary family services, court ordered protective services, and foster care can be provided as soon as possible. This allows the Protective Service and Protective Investigation workers to merge and assume case management from the time that Triage passes the case for Follow-Up. Table 4 1 provides a statistical summary of the case load of the Protective Investigation Unit and Protective Service Unit.

TABLE 4
OVERVIEW OF DADE COUNTY PROTECTIVE SERVICES

PROTECTIVE INVESTIGATIONS		
	Subtotals	Totals
Number of Investigative Staff:		91
Triage:	36	
Protective Investigations:	55	
Number of Suspected Child Abuse/Neglect Reports:		900-1200 per month
Average Caseload Per Protective Investigator:		15
Case Dispositions		
Unfounded		53%
Proposed Confirmed		11%
Without Classification[1]		36%
PROTECTIVE SERVICES		
Number of Counseling Staff		50
Number of Open Cases		2,382
Families	2,382	
Children	5,798	
Average Caseload		50
Families	50	
Children	112	

[1] "Without Classification" includes cases where the perpetrator is unknown but abuse is believed to have occurred as well as cases where insufficient information is available to confirm abuse/neglect

HRS, District 11, Dade County. *Children and Families Protective Investigations and Protective Services*, April 1994.

The Substance Abuse Newborn Unit works independently from the Triage Response Unit. The Substance Abuse Newborn Unit of Miami/Dade County investigates reports of a mother's admitted drug/alcohol abuse during pregnancy, a positive toxicology screens of mothers or infants at delivery, and newborn abuse/neglect/abandonment cases reported by hospitals or physicians. Usually, the public hospitals have higher reporting rates than private hospitals and physicians. Most of the cases (approximately 99%) in this unit are "crack babies," cocaine/crack exposed infants. The remaining cases are babies with medically complex conditions due to neglect and/or abuse.

Termination of Parental Rights, Foster Care, and Adoptions have been integrated into one unit. The integration of the three programs allows staff to perform multiple roles which provides a reciprocal understanding of the challenges to each program and has resulted in strong team spirit. When parental rights have been taken away, the child is placed in a temporary foster care living situation while a qualified relative is found to take on guardianship of the child. If placement with a relative is not possible then adoption procedures commence. Children in their late teens are placed in independent living centers.

As of February 1994, the number of children in Foster Care for Dade County, was 2,719. This number represents a case to staff ratio of 26: 1. This is higher than the Child Welfare League's recommended ratio of 15: 1. With case loads of this size, the emphasis is on crisis management. Two years ago the average length of stay for a child in foster care was over 20 months, however this number has declined due to accelerated TPR petitions and an increased effort by the unit to find prospective adoptive parents. Recently a special program was initiated -- Project Smile - to recruit and train foster parents for HIV positive children.

There is also a Special Needs Adoption program for children who are hard to place due to their age or due to physical, mental, or emotional infirmity. As of February, 1994,114 children had been placed through this program, representing a 68% placement rate. Of the 152 children who have been freed for adoption through TPR and are awaiting placement, 102 were black.

3.3.1.2 Impact of Family Substance Abuse

Child Protective Services

Both the Protective Investigation Unit and the Protective Service Unit have been overwhelmed with cases of alleged child abuse or neglect where parental substance abuse is a factor. Most investigated cases involving parental substance abuse deal with child neglect, particularly negligent supervision cases where the parent's leave the child unattended while they pursue their next high.

In general staff report a lack of appropriate treatment centers to deal with the problems of family substance abuse. Specifically, there are no inpatient or detoxification treatment programs willing to accept pregnant women or inpatient programs which provide special services for women with children. Also, staff related the "Catch 22" nature of accessing treatment for many poor women with children. Unless a mother can make alternate informal arrangements through her family to provide care for her children, in order to enter a residential treatment program she must agree to temporarily place her children in foster care. However, once the children are placed in foster care, benefits including AFDC and Medicaid are cut-off to the mother, making it impossible for her to get inpatient treatment due to a lack of ability to pay.

A major problem is that while hospitals are required to report AOD exposed infants, they are not required to screen mothers or newborns.

Since 1988, the number of cases in Substance Abuse Newborn (SAN) unit has decreased. In 1989 there were *851* open cases; in 1993, 575-590 cases were reported. This unit deals exclusively with referrals of AOD-exposed neonates. By law, all identified AOD-exposed infants must be referred to CPS. Infants born HIV+ however are not routinely reported even when the mother's HIV infection has been acquired through IV drug use. Most of the cases in this unit are related to cocaine use on the part of the mother during the prenatal period; perhaps 10 cases a year are linked to heroin. Usually the heroin cases are among women visiting Miami -- usually from New York -- rather than permanent residents.

Respondents felt that the decrease in reports to the SAN is an artifact reflecting the impact of changed policies and procedures rather than a true decrease in incidence. Although required to report cases of AOD exposed newborns, hospitals and physicians are not required to screen for AOD exposure. Recent changes in Medicaid reimbursement have led to a number of private hospitals now accepting Medicaid obstetric patients; these hospitals do not routinely screen expectant mothers or newborns for AOD-exposure. Previously, almost all Medicaid obstetric patients were treated at Jackson Memorial Hospital which routinely conducts screening for AOD abuse.

While there is a decrease in cases reported to the Substance Abuse Newborn unit, the number of repeat cases has increased. Approximately 55% of the reported case are among hard core users who previously have given birth to substance exposed infants. Preventive efforts are difficult. We were told of one case where the delivery of a mother's eleventh child was her sixth substance exposed infant. Fortunately, there are more case of substance abused infants detected then cases that slip through the cracks.

HIV infection is also a growing problem in substance-exposed newborns, and constitutes the largest single category of medically challenged children in the SAN unit.. It is estimated that of the medically complex cases in the SAN unit, *80%* of these medical

complications are directly attributable with maternal substance abuse during the prenatal period. One medically complex case can cost the state one million dollars while the child remains in the care of the hospital. Once out of the hospital, ongoing care costs can easily reach one and a half million dollars for each of these children.

These cases are emotionally taxing on the staff in the unit. Staff are frustrated when confronted by the same mother coming through the system for the second, third, or fourth time. In addition, the increase in violence in the communities where staff must investigate cases poses additional stress on front-line workers in the unit.

Termination of Parental Rights

Approximately 60-75% of all cases referred for TPR involve cocaine abuse by the parents. Many of these children are cocaine-exposed newborns who will be freed for adoption. The trend in substance abuse by parents and legal guardian among the TPR cases has experienced little change within the last few years. Dealing with substance abusers is a challenge for TPR workers. Front-line counselors have found substance abusing parents to be extremely manipulative, with parents routinely lying about enrollment in drug treatment programs and classes, employment status, etc. Very few of the substance abusing cases reaching TPR result in family reunification. Some staff see the role of children as that of "levers" to be used against parents; either the parent cleans-up or the children will be taken away.

TPR staff receive no specialized training in strategies to effectively engage alcohol and substance abusing parents in treatment. Current training is limited to the legal procedures of dealing with substance abuse, familiarity with AOD treatment referral outlets, and recommended staff health precautions when working with possibly HIV positive intravenous drug users and their children.

Foster Care and Adoptions

The impact of substance abuse on the programming operations of Foster Care and Adoptions has been tremendous. Of 75 cases recently reviewed, 95% of the cases were the direct result of some level of substance abuse by one or both of the parents. Most of the cases that front-line counselors come into contact with involve crack cocaine.

The average length of stay of a child in foster care is three and half years, although as noted previously, staff report that the integration of TPR, foster care, and adoptions into one unit has recently led to improved permanency planning and more rapid case resolution. Moving children out

> *We're seeing cases where we just have more and more children entering care from the same family -- its increasingly difficult to keep siblings together in part because they may be sequentially removed over a period of years.*

of foster care is however a slow process. There is a feeling among foster care staff that the family courts do not understand the dynamics of the cycle of substance abuse recovery. The system is based more on parent performance then on a parent's capacity to take care of their children. Complying with a substance abuse program does not necessarily mean that the child can be safely returned to the parent. Often the court returns children to parents who have gone through substance abuse treatment program without looking at the events that occurred in the parent-child relationship. Most of the substance abusing mothers that come through the Child Protective services are AFDC recipient. Interestingly, when a child is taken away from a mother on AFDC, the mother loses the AFDC and Medicaid benefits which make it difficult for a her to comply with a drug treatment program.

Social workers who deal with the court system acts feel that court intervention efforts are frequently futile: The court is too concerned with providing mothers of newborns multiple opportunities to complete a substance abuse treatment program, resulting in extensive delays before children are finally freed for adoption. These efforts are seen by some staff as counterproductive in terms of ensuring permanency for the child given that crack babies, while still infants, are easy to place with adoptive parents, but as the child gets older the difficulties of finding an adoptive placement commensurately increase.

> *We need a system for expediting TPR when parents continue to violate performance agreements. In one of my cases the mother has been in court three times now, each time promising to complete the same treatment regimen, but she never follows through.*

Adoptive parents are made aware of the medical history of the child and of the potential developmental delays that the baby may experience as it matures. However, the possibility of amorphous future problems developing generally does not appear to deter these parents from adopting a particular child. These cases however are more likely to result in failed pre-adoptive placements as the potential adoptive parents identify cognitive, behavioral, or emotional problems on the part of the child. Sometimes, while the adoption placement appears initially successful, when the child later is enrolled in school or preschool, problems in the child's motor or speech skills, or overall psychosocial development when compared to other children of the same age may be identified by school personnel. At this point the parents may seek agency assistance in providing care and remedial services for the child or, more rarely, they may seek to dissolve the adoption itself. Staff feel that recent efforts to provide more direct supportive services to these families in the pre-adoption and post-adoption phases have helped to significantly reduce the frequency of failed adoptions for these children. Provision of these services has however led to increases in the overall cost of adoption operations.

3.3.1.3 Child Welfare System Response to Family Substance Abuse

> *We have a desperate need for follow-up services, particularly in-home follow-up services.*

Many of the changes that HRS is adopting were designed to improve overall systems response to cases involving substance abuse and to alleviate some of the strain associated with these cases. The agency's move to a Family Focused Response System is designed to more effectively provide services to families in cases of neglect; it also is designed to reduce the time that children spend in foster care before being freed for adoption and hopefully placed with adoptive parents. Increasingly, foster placements are being made with prospective adoptive parents, allowing these parents to become better-acquainted with the child prior to finalizing an adoption.

In addition, other strategies have been implemented to inform adoptive parents of the possible developmental and behavioral consequences of *in utero* AOD exposure of infants, and to provide additional supportive services to these parents. All potential adoptive and foster parents now receive copies of the child's complete medical history and participate in a 70 hour training and peer support group program.

The development of the SAN unit was also the direct result of the Child Protective Service's reaction to the escalating problem of substance abuse in the community. Since the formation of the SAN unit, adjustments with in the unit have been required to manage the complexity of the investigation and delivery of services. For example, the database that HRS utilizes to track SAN cases is very limiting and these cases are much more complex and detailed then what the computer can handle. Therefore, in July 1989 an in-house tracking system was implemented to monitor the status of the cases. Since the introduction of the in-house tracking system over 4,000 cases have been entered in the system and staff are now able to rapidly detect repeat cases.

> *The biggest issue is how to motivate these parents. You can have all the programs and all the money in the world, but unless the mother is motivated to use the services which are available, it just won't work.*

Staff from CPS, foster care, and adoptions also participated in a city-wide Cocaine Baby Task Force to develop city guidelines for handling substance abusing families. Some of the recommendations of the task force were to:

- include alcohol in the definition of "substance";
- change the term "physical dependency" used for newborns of substance abusers since it is medically inaccurate and obsolete;

- require hospitals, through state licensure, to develop screening and reporting protocols which examine multiple risk factors for children including pre-birth screening;

- classify caretakers who expose multiple children to dangerous substances as “neglectful”, and,

- develop more readily accessible, family-friendly, long term residential treatment programs providing prenatal and post-natal care.

33.1.4 Program Needs and Recommendations

Our overall impression in Miami was that staff in general are optimistic about, and supportive of, agency efforts to deal more effectively with AOD abusing families. In particular, staff relate improved handling of AOD-exposed infants and increased proficiency in expeditiously placing children in permanent homes. Despite these improvements, specific problems and significant needs remain -- particularly for CPS, but also for Foster Care and Adoptions. These include needs for:

- Better and more reliable information and training regarding the efficacy of different AOD treatment programs and approaches;

- Increased funding for adoption subsidies;

- Improved training of all staff on AOD issues and particularly on effective approaches to motivating and engaging substance-abusing parents in the treatment process;

- Increased departmental discretionary funding to pay for drug treatment and for ancillary services to support adoption placements;

- Improved training of juvenile court judges and masters; and,

- Expedited policies and procedures for TPR in cases involving newborns.

3.3.2 HEAD START

3.3.2.1 Overview and Background

The Head Start program is designed for preschoolers from low-income families to develop mentally, socially, emotionally, and physically. In Dade County the Head Start program consists of 61 centers with a total enrollment of 4,855 children. During our site visits we had the opportunity to learn the impact of substance abuse on six of the seven Head Start program areas: Health, education, mental health, disabilities, parent involvement and social services.

Head Start emphasizes the importance of early identification of health problems. Since many preschool children of low-income families have never seen a doctor or dentist, Head Start arranges for every child to receive comprehensive health care.

Head Start's educational program is designed to meet each child's individual needs. It also aims to meet the needs of the community and its ethnic cultural characteristics. For example, in Miami where half of the population is Hispanic, bi-lingual staff are important in program delivery. Therefore, at least one teacher or aide must speak the native language of the children in the program. Finding Spanish speaking staff is not a problem but with the increase in Haitian children it has been difficult finding qualified Creole speaking staff to meet this need. Every child receives a variety of learning experience to foster intellectual, social, and emotional growth. There is a low child to staff ratio. Staff members receive training in child development and early childhood education. They also receive special training to learn how to work the with disabled children in their class.

Mental Health services are provided to Head Start children in order to encourage their emotional and social development. A mental health professional is available to every Head Start center to provide mental health training to staff and parents and to make them aware of the need for early attention to the special problems of their children. One of the responsibilities of the mental health component is to conduct a developmental screening on each child applying to a Head Start center. If the child fails the initial developmental screening, a second screening is done. Two developmental performance areas that are looked at closely are speech and language. Often children that are not native English speakers fail the developmental screening. This is especially true among Haitian children who are shy and socialized to be less vocal.

Head Start is required by Congress to assure that at least ten percent of its enrollment slots are filled with children who have disabilities. Children with disabilities receive the same services, attend the same centers and classrooms, and participate (as much as possible) in the same activities as the other Head Start children. The most common disabilities seen among the Dade County Head Start children are speech and language delays, which are not attributed to cultural characteristics. Many of these disabilities,

such as delayed fine motor skills and language development, are strongly associated with environmental factors in the child's life, including *in utero* AOD exposure and physical or emotional neglect.

With in the last few years Head Start has experienced an increase in the number of HIV infected children. Due to issues of confidentiality, trying to protect the rights and privacy of both the parent and child, the medical condition of the child is shared with Head Start staff on only a "need to know basis."

The objectives of the parent involvement component of Head Start are to provide programs which:

- Support and enhance the parental role as the principle influence in their child's education and development;
- Recognize the parent as a responsible guardian of their child's welfare and contributing to Head Start in their community;
- Provide opportunities for parent participation through direct involvement in decision making, participating in classroom activities, and in activities which will lead to self-sufficiency.

The social service component of Head Start represents an organized method of assisting families to assess their needs, and then providing those services that will build upon the individual strengths of families to meet their own needs. Some of the activities that the social services staff use to assist families to meet their needs are: Community outreach, referral, family need assessments, providing information about available community resources and how to obtain and use them, recruitment and enrollment of children, and emergency assistance and/or crisis intervention. Usually, the social service unit is the first to identify cases of substance abuse and to recommend treatment and support services

3.3.2.2 Impact of Family Substance Abuse

> *The staff [teachers] aren't aggressive in reporting substance abuse problems. They are reluctant to get involved in other people's "personal business".*

The detection of substance abuse among Head Start parents is low due to poor screening. Typically, family members do not disclose substance abuse problems during initial screening into the program. In the initial needs assessment undertaken by the Social Service unit, information on parental or family substance is obtained only if the parent is open and willing to provide the information. When cases of family substance abuse are uncovered, it is generally because the problem has resulted into a

crisis disrupting the child's attendance, or through observations made on home visits. If a family member is receptive to assistance for their substance abuse problem, then a Family Service worker will refer the parent to a substance abuse treatment center. It is the responsibility of the parent to initiate treatment, the case load of the Family Service worker is too large to allow follow-up on the outcome of referrals made.

> *We don't have a system for detecting substance abuse. Problems are indirectly discovered through learning the parent is in jail or if the parent is drunk when they pick up the child.*

Detecting and referring parents to drug treatment programs is an issue for some Head Start employees. While *they are* concerned with the appropriate development of the child, referring parents to treatment programs is not their primary concern and therefore they are not always aggressive in their outreach to parents. In addition, staff relate uncertainty regarding the best approaches for intervening into this sensitive area without alienating families from the program: The general perspective appears to be one of extreme caution, preferring to err on the side of ensuring continued program participation on the part of the child even if this means not confronting a parental substance abuse problem. Staff also note the lack of supportive treatment resources -- particularly inpatient detoxification programs -- for mothers with children.

> *One big problem is that we're now seeing families with multiple generations with a pattern of substance abuse -- its getting harder to identify a functioning parent figure.*

Family substance abuse has also negatively impacted on levels of parental program involvement. Unaddressed AOD abuse problems result in lower participation in other parent support service areas. Also, increasing numbers of children are being enrolled by non-parental caretakers -- typically grandparents -- whose service needs differ substantially from those of the parents. Reflecting this trend, there are an increasing number of children enrolled where there is no meaningful contact with the parents themselves, but only with related caretakers.

> *If the parents are using drugs, it's hard to keep the child in the program. Sometimes these kids just sleep a lot and don't participate -- other times their hyperactive.*

Generally the consequences of family substance abuse for Head Start children are manifested in increased behavioral problems in the classroom, such as acting out, unresponsiveness, limited attention span, and poor attendance. These disruptive emotional and behavioral problems pose a challenge in managing the classroom and requires that the teacher use creative strategies to engage all children. In addition, a

diversity in drug awareness exists among Head **Start** children according to the "drug culture" in their community. One Head Start center, serving primarily the Central American Hispanic community, noted that substance abuse was not as problematic in their area as drug trafficking. This Head Start center is located near the river which is one of the avenues for drug trade. As a consequence, the children in this Head Start center have a good comprehension of drug jargon.

Escalating family drug abuse has also negatively impacted on the Head Start program's home visitation. Ideally, Head Start teachers conduct three home visits for each child per year. Fear of crime and violence has made staff reluctant to go into dangerous neighborhoods to conduct home visits. Increasingly, staff are only willing to performing home visits if allowed to conduct them in pairs. Staff stress that a significant number of families appear to be directly involved in drug trafficking, increasing staff perceptions of risk in conducting home visits. As a result, home visitation is occurring less frequently than was formerly the case.

3.3.2.3 **Response to Family Substance Abuse**

Head Start in Miami has begun to address the program impacts of family substance primarily through a number of special projects and initiatives. Staff training in recent years has included general information on family substance abuse issues and training in universal precautions in handling children to avoid possible HIV exposure.

The Social Service unit has recently begun working with the University of Miami's Substance Exposed Infant Program. The goals of this collaborative effort are to identify and recruit into the Head Start program those children prenatally exposed to drugs or alcohol who may later encounter behavioral or development difficulties as a result of this exposure.

> *We're coping, but its still not enough. There's a long waiting list for treatment and you can't get it for people when they're ready to accept it.*

The Miami Head Start Parent Involvement component will be piloting a family drug prevention and education program this year. The program known as "Getting a Head Start Against Drugs" has a curriculum for parents as well as for children. For both parent and children the curriculum is highly participatory and attempts to build a sense of family and self esteem while addressing common issues found among substance abusers.

3.3.2.4 Program Needs and Recommendations

Head Start staff identified numerous program needs and recommended strategies for improving Head Start response to family substance abuse. Many of these recommendation either directly -- or indirectly -- reflect staff training needs. These include needs for:

- More effective approaches to initial screening for substance abuse problems and improved training of all social service staff on AOD issues and particularly on effective approaches to motivating and engaging substance-abusing parents in the treatment process;

- Improved capacities to monitor referral outcomes, particularly for substance abuse treatment referrals;

- Changes in confidentiality rules to allow sharing of information with Head Start teachers regarding the possible AOD-related factors which may have a bearing on the child's classroom performance or behavior;

- Creative changes in the parent involvement component to make it more responsive to the needs and concerns of non-parental child caretakers.

3.3.3. RUNAWAY AND HOMELESS YOUTH

3.3.3.1 Overview and Background

The only federally funded Runaway and Homeless Youth program in Dade County is Miami Bridge with two locations, one in Homestead and the other in Central Miami. Miami Bridge is a nonprofit youth serving agency, committed to reuniting and preserving families. The program focuses on children between the ages of 10-21 who are runaways, "throw-aways" or otherwise "at risk" for homelessness.

Miami Bridge provides many services to the community including: youth outreach and runaway prevention programs; public education and awareness efforts; youth activities geared to delinquency prevention; parent, youth and family counseling to address conflict family conflicts; centralized intake and shelter for youths in crisis; a non-residential program for families; and a transitional living program for homeless youth.

The centralized intake program, First Stop for Families, screens all referrals for services to families. Referrals are received from the police, HRS, parents, teens, schools, etc. Once screened, the accepted family works with a Social Worker to resolve the family conflict before the situation is such that the teen runs away.

The shelter program is the core of Miami Bridge. Services provided in the shelter include: individual and family counseling; room, board, and clothing; full-time school program; and recreational activities. Each shelter has 24 beds and accepts teens between the ages of 10-17, female and male. Of the 24 beds, half are contracted with HRS to provide emergency shelter for teens in the HRS system (generally adjudicated foster care children), the remaining beds are for "crisis teens." The crisis beds are available for a maximum of 10 days. Crisis teens are generally runaways picked up by the police and brought to Miami Bridge. Table 5 below provides a statistical summary of demographic information on First Step for Families and Miami Bridge Shelter.

Other programs provided by Miami Bridge, which are not a part of the shelter, include Bridge Home-Based Services which is a continuation of First Stop for Families. In this program families are provided with extended support. The Social Worker will continue to work with the at risk family until they reach their goals. A more recent program to Miami Bridge, is Bridge Tomorrow, an independent transitional living program for homeless youth ages 16-21. In this program, older teens live in a community house and under the guidance of staff they are trained to become self-sufficient.

3.3.3.2 Impact of Substance Abuse

> *The problem is getting worse in terms of both youth and family substance abuse. Probably 75% to 80% of the youth we serve come from families where there is some level of a substance abuse problem.*

Approximately half of the youth that make contact with Miami Bridge have a prior or current history of alcohol or drug abuse; perhaps three-fourths come from families where substance abuse exists at some level. Miami Bridge does not accept youths into the shelter or in the transitional living program who are current substance abusers. Nevertheless, shelter staff suspect that half of their clients have prior alcohol or substance abuse problems. Identified drug use is occasional and usually involves marijuana and cocaine. If during a teen's stay in the shelter it is learned that they are either abusing or dealing drugs, then they are referred to another agency which is qualified to handle the situation. Unfortunately, the Village is the only residential drug treatment center for youths in Dade County and it is private and accepts only a few indigent patients.

> *We're just beginning to encounter the problem of youth who are orphaned due to parental AIDS -- we think this will be a bigger and bigger problem in coming years.*

The problems associated with substance abuse are perceived by staff to be getting worse. An increase in AIDs- related deaths of parents due to substance abuse, has impacted on staff and programming. More intensive counseling is necessary for a child

TABLE 5
MIAMI BRIDGE STATISTICAL SUMMARY
July 1993June 1994

Case Characteristics*	First Step for Families Central Intake %	(N)	Miami Bridge - Shelter %	(N)
Source of Referral				
Parent/Guardian	60%	(338)	7%	(80)
Police	12%	(68)	62%	(675)
HRS	8%	(45)	1%	(173)
School	4%	(23)	16%	(16)
Reason Given at Intake				
Family Crisis	43%	(248)	18%	(202)
Chronic Runner	18%	(I 07)	21%	(237)
Emotional Conflict in Home	9%	(50)	11%	(117)
Delinquency Involvement	8%	(44)	39%	(427)
Educational Level				
Grade 6-8	50%	(171)	52%	(464)
Grade 9	21%	(71)	21%	(187)
Grade 10	19%	(67)	15%	(136)
Grade 11	6%	(22)	5%	(46)
Grade 12	1%	(4)	2%	(14)
Sex				
Female	51%	(297)	39%	(434)
Male	48%	(286)	61%	(676)
Age				
Under 10	<1%	(I)	6%	(71)
1 0-1 1	3%	(18)	2%	(28)
12-13	22%	(128)	15%	(178)
14-15	46%	(269)	35%	(414)
Over 15	29%	(169)	41%	(488)
Ethnic Background				
Black	46%	(257)	50%	(553)
Hispanic (white and black)	37%	(204)	30%	(337)
White	16%	(86)	18%	(197)
Family Disposition				
Parent/Guardian	77%	(243)	50%	(390)
Relative's Home	5%	(15)	13%	(100)
On the Run/Street	1%	(4)	20%	(160)

* Most frequent categories only; percent totals do not equal 100%.

who has lost a parent to AIDS. They have also had several HIV positive youths and it is expected that the number will increase and heavily influence programming efforts.

The heavy influx of illegal immigrants poses another problem to Miami Bridge and to the community. While Miami Bridge will accept illegal youths with no relatives in the US into their crisis beds, once the youths leave the shelter there is really no where for them to go. HRS will not provide services to illegal immigrants and will refer them to Immigration and Naturalization Services (INS), which ends up in deportation. This policy discourage illegal youths from seeking help when in crisis. Yet because of their precarious situation these individuals are often the population at greatest risk for alcohol and drug use and abuse problems.

Children who are "throwaways"or "lock-outs" pose an increasing problem for the shelter program. According to staff, Florida law allows parents to "lock-out" youth older than ten years of age without legal repercussions. Staff suspect that these youth disproportionately come from families with substance abuse problems or they have a substance abuse problem of their own.

3.3.3.3 Miami Bridge Response to Family Substance Abuse

Keeping staff current on the trends in the illicit drug market is a big concern of Miami Bridge. A recently submitted proposal to ACYF to develop a local Drug Abuse Prevention Program (DAPP) to provide outreach to street youths in part will provide funding for more extensive and frequent training of staff.

Program staff have informally worked to strengthen their networks with AOD treatment resources, particularly the Village (which only serves youth), and various treatment programs for parents. As noted previously, however, accessing AOD treatment for youth remains a major problem. Staff training in the substance abuse area also has been expanded and strengthened, and the program continues to pursue possible sources of funding for increased program efforts addressing substance abuse issues -- particularly efforts directed toward these youth themselves.

3.3.3.4 Program Needs and Recommendations

Most staff expressed frustration regarding the general lack of availablity of meaningful treatment programs for AOD abusing youth, and over their failure to-date to secure additional funding for AOD-prevention related efforts. Specific needs identified included:

- A residential AOD treatment program for indigent youths (ages 14-W) and also one willing to accept pregnant adolescents;

- After-care programs and group homes for adolescents coming out of inpatient detoxification programs;
- Counseling staff with expertise in both youth and family substance abuse diagnostic and treatment issues;
- Self-help groups for adolescent substance abusers and parent education in AOD prevention and identification; and,
- Support groups for family members not abusing substances to help them cope and provide appropriate support to the substance abusing member.

3.4 DISCUSSION AND OBSERVATIONS

Family substance abuse remains a major problem for ACYF-funded agencies in Miami/Dade county. The overall impression is that although overall community levels of substance abuse have declined, their remains a persistent "hard-core" cocaine abusing population which disproportionately comprises the client population of ACYF programs. It is too early to ascertain how the changing patterns of substance abuse in the Miami areas, particularly the increase in the use of heroin and "designer drugs" will ultimately impact on ACYF-funded programs.

3.4.1 IMPACT OF FAMILY SUBSTANCE ABUSE

When asked to describe the impact substance abuse has had on their specific agencies and the way services are delivered there, the study participants most frequently cited the following:

- Increasing numbers of, and problems related to, cases involving either parent or child HIV infection;
- Difficulties in locating of treatment and intervention resources, particularly the lack of treatment programs for pregnant women or for single women with children;
- The intensity and consistency of effort required to effectively intervene with substance abusing families which contributes to high caseloads and worker bum-out;
- Difficulties in ensuring the safety of children, families, and staff due to high rates of violent crime associated with local drug trafficking; and,
- Lack of effective intervention strategies for dealing with chronic neglect of children in substance abusing families.

3.4.2 ACYF-FUNDED AGENCY RESPONSES TO FAMILY SUBSTANCE ABUSE

In response to the growing problem created by substance abuse, most of the agencies studied in Miami have, to a greater or lesser degree, modified their existing programs, policies or procedures. The most striking example is obviously the reorganization of child welfare services discussed above. Similarly, Head Start has found it necessary to substantially modify its parent support component and Miami Bridge, although not yet having implemented specific changes, is actively pursuing a number of options including development of a specific sub-program to address adolescent substance abuse issues. A

number of these agencies have increased the size of their staffs, filling either new positions with people whose expertise is substance abuse, or adding to the staff of standard service providers in response to the enlarged caseloads. Staff education and training in the general area of substance abuse has been implemented to some degree in all of the agencies, typically addressing drugs and their effects, dynamics of drug abuse, HIV protection measures, and community treatment resources.

Some of the agencies in Miami, most notably CPS, have also actively pursued more intensive collaborative efforts with other service providers, particularly substance abuse treatment programs. Our overall impression however is that ACYF-funded programs for the most part are not as actively linked to other agencies and service organizations as might be desired. Most efforts appear to be bi-lateral in nature rather than organized collaborative networks.

CPS, Foster Care, and Adoptions staff feel that the structural changes made by Child Welfare Services to date, particularly creation of the Substance Abuse Newborn unit and the combining of TPR, foster care, and adoptions staff into teams, have had a significant positive impact on their capacity to effectively intervene in cases involving family substance abuse. These staff are guardedly optimistic planned changes to further restructure the agency as part of the Family Focused Response System program.

3.4.3 Shared Needs and Recommendations

When asked to identify specific needs or recommended strategies for addressing their agency's problems associated with family substance abuse, those interviewed presented a wide range of ideas and suggestions as briefly addressed earlier in this chapter. There were however some universal repetitive themes across agencies, including the following:

- Expanded diversity and accessibility of inpatient treatment programs including AOD treatment programs for women with children and for pregnant women; and for adolescents;

- Improved training, with specific attention to strategies for motivating cocaine-abusing mothers to engage in treatment;

- Greater flexibility in service and support programs to allow more effective and equitable treatment of children in non-traditional child-rearing arrangements (e.g., living with extended family members, family friends, etc.);

- Develop more collaborative networks to share knowledge and skills, particularly with treatment resources, and free the money consumed by duplicate services to fund other needs; and,

- Identify effective strategies for addressing chronic neglect among substance-abusing families.

Finally, there was an almost universal perception among those interviewed that outpatient-only treatment programs available in the community are ineffective in interrupting the cycle of cocaine addiction in their clients. Whether this primarily reflects the quality of outpatient treatment available locally, or a more general failure of outpatient approaches with this client population is unclear. Most respondents however stressed the need for ongoing extended outpatient treatment for clients following inpatient treatment.

CHAPTER 4: CONCLUSIONS AND RECOMMENDATIONS

In conducting the two city site visits discussed here, we attempted to capture both the substance and the flavor of the experience of ACYF-funded agencies in dealing with the problem of family substance abuse. This has been a qualitative exploration of the problem, and as such, most of the conclusions drawn are subjective interpretations of the problem rather than empirically supported findings.

Clearly, the overall negative impact of family substance abuse has been most severe on the child protective and foster care systems, followed by Head Start and other early childhood programs, adoptions services, and runaway and homeless youth programs. This appears to primarily reflect the close association between substance abuse and maladaptive parenting: Those agencies most directly involved in working with AOD abusing parents are most severely impacted.

In comparing information gathered in interviews in 1992 with these conducted in 1994, our overall impression is that, despite the persistent and somewhat intractable problems created by family substance abuse, these agencies and staff are learning to adapt and cope with this changed social services environment. Although staff across these agencies continue to express a great deal of frustration in dealing with substance abusing families, overall they appear to be better able to cope with these frustrations than was the case in 1992. Improved agency staff training, policies, and procedures undoubtedly have contributed to this change, but to a significant degree this change appears to primarily reflect desensitization and adaptation to the changing social realities rather than any fundamental improvement in agency approaches. Stated simply, these agencies and staff appear to be learning to live with the problem.

Staff of ACYF-funded agencies programs report an increased level of agency responsiveness to the problems associated with family substance abuse in 1994 when compared to 1992. This responsiveness is reflected in increased levels of staff training and an increase in specialized agency programs, policies, and procedures specifically addressing the problem of family substance abuse. Despite these changes, staff in general – irrespective of specific program area -- perceive family substance abuse as a continuing major challenge to the capacity of their agencies to meet their mandated functions.

Irrespective of agency type, there appears to be an ongoing trend toward staff and program specialization to address problems associated with family substance abuse. Although there are clear differences between agencies, most of these agencies either have initiated, are in the process of initiating, or hope to initiate a special program components specifically addressing family substance abuse issues. These efforts range from hiring staff specializing in AOD abuse prevention or intervention strategies to establishing major organizational sub-units to specifically manage cases involving family AOD abuse.

The effectiveness of these specialized intervention strategies remain for the most part untested. While agencies appear to have substantially increased their capacity to document the nature and extent of the family substance abuse problem in their client populations, there remains a lack of process outcome data regarding the effectiveness of agency response strategies.

> *These parents [crack using mothers] don't seem to care very much about the removal of their children -- until they realize their financial assistance is being cut.*
>
> *Twenty years ago when a child was removed everybody cried and the mother would scream, "Mommy's gonna get you back!". Now mother just sits and looks out the window.*

It is also apparent that most respondents perceive cocaine -- particularly crack cocaine -- abuse as presenting a qualitatively different and more serious challenge than other forms of family substance abuse. Cocaine addicted mothers are perceived as more likely to engage in maladaptive parenting, more difficult to engage in drug treatment programs, and less responsive to other agency intervention efforts when compared to alcohol, heroin, or other substance abuse. While CPS staff for example frequently report success in working with both alcohol and heroin involved mothers without successfully addressing their underlying substance abuse problem, respondents almost universally reported a lack of comparable intervention success with cocaine-involved mothers. Many respondents typify cocaine-involvement as fundamentally disrupting one's capacity to parent, and express pessimism regarding intervention strategies in the absence of effective cocaine addiction treatment.

> *Child welfare has two groups of advocates to deal with. One says if the parents are drug users, get the children out and give the parents one year to get clean or then terminate parental rights. The other group says keep the children in the home, help the parents get treatment but don't pursue a TPR unless absolutely necessary.*

This perception of cocaine-involved mothers as being incapable of effective parenting in the absence of effective substance abuse treatment, has important implications for current child and family welfare policies and practices. More generic family preservation and family support strategies are not perceived as effect in working with this group. Rather, the overwhelming trend appears to be one of coupling initial intensive attempts to obtain parental compliance with a drug treatment program with alternative strategies for ensuring the appropriate care of the child if these attempts are unsuccessful. Accelerated termination of parental rights and increased reliance on intrafamily placement for abused or neglected children, and the development or adaptation of programs to better meet the needs of non-parental caretakers in Head Start programs are indicative of this trend. If anything, our overall impression was that **CPS** and foster care workers in particular feel that ensuring permanency for the child can

only be achieved through alternative placement of the child in the absence of effective parental substance abuse treatment,

Despite some minor differences, there is a remarkable consistency across these two cities in terms of the overall findings and impressions. These two city case studies provide a compelling and intensive picture of the day-to-day issues and problems encountered by ACYF-funded programs in attempting to meet their mandated responsibilities while dealing with AOD abusing families. Based on these case studies and the previous interviews conducted in six cities in 1992, the following conclusions appear inescapable:

I) While all ACYF-funded programs are negatively impacted by family substance abuse, both the nature and degree of impact vary substantially across programs. It is obvious that of all these systems, CPS is most seriously negatively impacted by family AOD abuse, followed by Foster Care, Head Start and the other early childhood education programs, then RHY programs, and finally, adoption services. For CPS the issues are complex and multifaceted, including devising more effective ways of managing cases where parents are incapacitated to a significant degree due to their AOD abuse, developing effective policies and procedures for addressing AOD-exposed and HIV-positive infants, and addressing increasing concerns regarding worker safety in the field. For foster care, unresolved problems include the increasing number of "special needs" placements needed for AOD-exposed or HIV-positive children, the need for more effective intervention strategies geared toward family reunification, and the inherent conflict between a focus on family reunification on the one hand, and the need for accelerated termination of parental rights to facilitate permanency for the child on the other hand.

For Head Start and early childhood education programs, the most fundamental impact of family AOD abuse has been on the number and types of special needs children entering the programs, followed closely by difficulties encountered in engaging substance-abusing mothers in ancillary service programs. For the most part, runaway and homeless youth programs appear relatively unaffected by the family substance abuse problem, although programs acknowledge that parental substance abuse is a factor in a significant percentage of their cases and frequently poses a problem in terms of family reunification efforts. Addressing the needs of substance-abusing runaway or homeless youth also is an increasing area of concern for these programs, but for the most part these programs avoid confronting the problem by denying access to substance abusing youth. Finally, the major impacts of family substance abuse on adoptions appears to be first in the increased need for subsidized adoptions for children with special needs, and second in terms of more effective policies, procedures, or programs for dealing with "sleeper" effects of AOD-exposure which may not appear until after the adoption has been finalized.

2) Front-line staff in most ACYF-funded programs are ill-equipped and poorly trained for dealing with substance abusing families. Particularly in CPS, Head Start, and foster care, staff express a lack of preparation and confidence in dealing with AOD abusing families. Although the reported levels and intensity of training appear to have increased when comparing 1994 interviews to those from 1992, staff do not perceive this training as having been particularly useful. Critical issues for staff include how to successfully engage and motivate substance abusing clients in both AOD treatment and in other service programs, risk assessment in these families, and how to effectively deal with ongoing patterns of child neglect in substance abusing families which, while not life threatening or posing imminent danger to children, has long term deleterious effects.

3) *Effective intervention in cases of family substance abuse by ACYF-funded programs is significantly hampered by the lack of appropriate AOD treatment outlets.* Although many staff interviewed felt that the overall availability of AOD treatment resources in the community were inadequate, the more universal and compelling plea was for inpatient detoxification and treatment programs which would accept pregnant women and for similar programs which provided for the special needs of mothers with children. The lack of such programs was almost universally cited as a barrier to effective intervention, frequently requiring a parent to choose between in-patient treatment and voluntary relinquishment of their children, or only outpatient treatment.

4) Family substance abuse has resulted in fundamentally new challenges to all ACYF-funded programs in meeting their mandated functions. The problems posed by family substance abuse have resulted in fundamental shifts in program approaches to providing services as each program grapples with the issues of which policies, procedures, and practices are most effective in addressing the problem. Examples include, among others: accelerated TPR policies and procedures; increased and enhanced post-adoption support services and pre-adoptive foster placement programs; expansion and modification of Head Start programs to address the needs of non-parental caretakers; and, special programs to address the needs of runaway and homeless youth who cannot safely return home due to parental or family substance abuse issues. The efficacy or of most of these approaches remains untested.

If ACYF service delivery systems are to meet the needs of children and families involved with substance abuse, they will require a better understanding of, and the development of more effective approaches to providing services that:

- help families with substance abuse problems overcome their problems and stay together while concurrently ensuring protection of children;

- help children compensate for the developmental and other problems caused by AOD exposure ; and,

- provide for the safety and nurture of adolescents from substance-abusing families.

Meeting these challenges will not be easy. Current efforts and program initiatives, although well-intentioned, lack a sound basis in research or program evaluation findings to justify the redirection of scarce program resources. Critical efforts are needed not only to devise new programs to meet the needs of substance abusing families but to carefully monitor, assess, and evaluate the outcomes of such programs. The *Impact* study, represented but a tentative beginning in this direction. Additional studies are needed to provide the Administration on Children, Youth and Families (ACYF) with information of critical importance to future policy and program decision-making regarding children and families with AOD (alcohol or drug) abuse problems. These studies must have practical utility for each of the ACYF Bureaus (e.g., NCCAN, Head Start, FYSB) as well as for ACYF as a whole. An enhanced understanding of the impacts of substance abuse on these service programs and agency responses to this challenge will contribute to the development of more effective administrative and managerial responses to AOD problems and improved quality and effectiveness of ACYF service delivery programs.

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