Combining Child Welfare and Substance Abuse Services: A Blended Model of Intervention

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Montgomery County, Maryland’s Child Welfare Services (CWS) and Adult Addiction Services (AAS) developed an initiative to address the requirements of the Adoption and Safe Families Act (ASFA) while meeting the needs of families and the community of providers. A blended model of intervention was determined to be the best strategy to achieve the dual mandates of CWS and alcohol and other drugs (AOD) providers. Drawing from criminal justice, systems theory, social work, and addiction treatment, the approach made use of graduated sanctions or levels of intensity in providing services, engaging client participation, and engendering motivation. This article proposes strategies at client and organizational levels to understand the process of adaptation to ASFA and to guide planning for blending services.

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Parental substance abuse contributes to at least 50% of all child welfare services cases, in some parts of the United States, prevalence may be as high as 90% [National Center on Addiction and Substance Abuse (NCASA) 1999]. Substance abusing parents usually experience multiple problems that few child welfare agencies and substance abuse treatment programs are prepared to address. With the enactment of the federal Adoption and Safe Families Act of 1997 (ASFA) requiring states to file a petition to terminate parental rights if a child has been in out-of-home care for at least 15 of the most recent 22 months, the needs of substance abusing parents have moved to the foreground. Child welfare and substance abuse treatment programs must collaborate to provide children with safe, stable homes with nurturing families as a foundation for a healthy and productive life.

Service integration is critical to working effectively with substance-abusing parents and providing intensive time-limited reunification services to children and families. Based on this premise, the local child welfare services and adult addiction services agencies in Montgomery County, Maryland, forged a relationship to integrate services across agency lines in an effort to coordinate service delivery, develop protocols to respond effectively by screening for parental substance abuse in every investigation of child maltreatment, and provide timely access and appropriate treatment for parents.

This article discusses several policy and practice issues that act as obstacles to successful implementation of ASFA and describes Montgomery County’s approach to them.

**Background**

ASFA created a renewed emphasis on immediate planning for children requiring child welfare services (CWS) to find more effective ways to achieve family stability. ASFA emphasizes timely
decisionmaking by requiring permanency decisions for abused and neglected children within a 12-month timeline and includes mandates to terminate parental rights once a child has been placed in out-of-home care for 15 of the previous 22 months unless compelling reasons exist not to initiate termination. Attention to related problems of substance abuse and child maltreatment within families is a core element of the service delivery required on the part of CWS agencies. These mandates place a burden on CWS to ensure prompt and adequate services for parents, with an emphasis on making reasonable efforts to obtain access to resources and coordination of community services.

**Child Abuse and Neglect Laws**

Many state laws governing child abuse reporting, out-of-home care and termination of parental rights implicate consideration of substance abuse as a factor in child protection decisions. Most mandatory child abuse reporting laws, however, do not explicitly mention parental substance abuse, but rather speak to physical abuse, sexual abuse, and neglect. As of 1996, seven states had laws that include perinatal drug exposure due to parental substance abuse. These laws bring children at risk of abuse and neglect to the attention of the child protection agency with an emphasis on prenatal exposure rather than on recognizing the long-term risks of living with an AOD abusing caregiver. Moreover, laws that address parental substance abuse tend to focus on consumption of illegal drugs without including alcohol, although alcohol is a significant factor in episodes of family violence.

Elements of these laws may impede an AOD-involved pregnant or postpartum woman from seeking health care or substance abuse treatment for fear that admitting a problem will lead to losing custody of her child(ren). Generally, these laws focus on parental behaviors toward children rather than conditions or circumstances that may precipitate those behaviors. These man-

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1 California, Illinois, Iowa, Minnesota, Missouri, Oklahoma, and Utah
dates do little to promote treatment or reduce potential harm or risk for children and contribute to the perception of AOD services as punishment rather than treatment of a serious disease.

**Recognition of the Problem**

Parental substance abuse is not a new phenomenon. There are homes in which AOD use may be a daily occurrence without apparent or significant impact on children. In other families, chronic substance abuse that causes significant harm or damage to children, such as fetal alcohol syndrome, or neglect of child health and educational needs, or contributes to problems of poverty and homelessness. A single episode of substance abuse may lead to a child fatality, for example, if a parent were driving while impaired.

Most parents who apply for public assistance or are reported to CWS have not been screened or evaluated for a diagnosis of substance abuse [Rittner & Dozier 2000]. Despite public and professional attention to AOD use and related social problems, Montgomery County’s experience and data from the National Center on Addiction and Substance Abuse (NCASA) show that the actual identification of parental substance abuse by CWS staff is as low as 5% to 20%. Many CWS investigations are focused on single incidents, not a longitudinal or historic view of the family’s functioning. Rather than focusing on parental addiction or dependence as a critical factor, CWS assessment targets behavioral consequences or the physical impact of parental substance use on child and family functioning.

**Professional Differences**

Organizational priorities or professional practices may serve to minimize responses to symptoms of AOD use in parents or inhibit willingness to identify or confront parents who are clearly alcoholic or drug dependent [Beckman & Amaro 1986; U.S. Department of Health and Human Services 1994; NCASA 1999; Zelvin 1988]. Professional education tends to focus on a helping relationship and rapport building rather than on working with
clients to enhance motivation and personal responsibility. Within organizations, a lack of strong leadership, clear policy, or supervisory directives may reflect an intellectual awareness of substance abuse problems in child welfare-involved families without having reached the point of organizational and behavioral change to meet the demands of ASFA.

Social workers who lack training on the presence of AOD use as a precipitating event or causal factor may require a diagnosis of "dependence" before being willing to intervene. As social work curricula and licensure standards do not require training in substance abuse for master’s level practitioners, they frequently have no prior expertise in working with AOD-involved adults or family dynamics. CWS workers also express fear of client anger and retaliation for making "false" accusations. This is complicated by the nature of addiction, which by definition involves sophisticated defense mechanisms and lifestyle factors that are difficult for the naïve or untrained professional to respond to.

Complexities within CWS and AOD treatment systems, coupled with different perspectives and world views make cooperation and collaboration between service systems difficult to establish and maintain. Several key differences in perspective underlie the majority of misunderstandings and frustration CWS and AOD providers feel toward one another. These include: different definitions of the "client," outcomes, expectations, timelines, and definitions of "success." Additional factors that burden these families, such as gender, youth, poverty, racial discrimination, and lack of adequate housing and social support, are typically not evaluated or addressed by the CWS or substance abuse intervention. The lack of a comprehensive approach may undermine resolution of both CWS and AOD concerns.

Lack of Collaborative Efforts

Collaboration between CWS agencies and substance abuse treatment providers is an essential link if families are to be given real opportunities for recovery and children are to have a chance to
grow up in safe family situations. In many communities, when children are removed from parental custody, the response is to offer parents a list of local treatment agencies with instructions to seek treatment and abstain from drug use. If the parent happens to be successful (with or without help from the child welfare agency), reunification is possible. If not, the agency may move toward termination of parental rights. Using concurrent planning strategies, CWS may place a child in a family foster home with adoption potential. This approach may secure a permanent home for the child, but the family is likely to have received little or no treatment. Thus the probability of recidivism remains high with the birth of a newborn delivered drug positive. The underlying problem has not been solved for the parent or the children.

Improved collaboration requires greater understanding of how to respond to the needs of parents with alcohol and other drug (AOD) problems and the ability to access high quality, appropriate treatment. If treatment is available quickly and includes aggressive outreach as well as a focus on retention and monitoring as integral service components, ASFA timeframes may be sufficient to achieve family stability.

Related legal and policy environments under which agencies operate may create a context that restricts joint activities and affects the ability of agencies to work together, including:

- the sense of crisis under which CWS agencies operate;
- the chronic shortages of substance abuse treatment services, particularly services appropriate for women with young children;
- confidentiality requirement of both fields, which are often perceived as impediments to cooperation; and
- timing factors.

Families involved with CWS and AOD treatment systems are often receiving services from other public institutions (e.g., welfare-to-work, probation). This may place multiple time constraints
on the parents that may be at odds with one another and that may frustrate interagency cooperation. AOD providers, counseling programs, and CWS do not usually share in service planning that considers these time constraints. AOD providers may be more concerned with established protocols of 28-day treatment cycles or limits set by insurance authorizations for care. CWS workers tend to focus on predetermined deadlines set by regulations and court procedures. Young and colleagues [1998] have introduced the metaphor of four hourglass clocks to illustrate the timeframes that greatly impact CWS practice. They indicate:

**Child welfare mandates for decisions regarding permanent placements for children who are in out-of-home care.** ASFA requires permanency hearings to determine the long-term plan for a child be held within 12 months of a child’s entry into care. A petition to terminate parental rights must be filed after a child has resident in out-of-home care for 15 of 22 months unless there are compelling reasons not to do so. Specific circumstances that may extend timelines include a child living with a relative or the family not receiving planned services.

**The pace of recovery from addiction.** Addiction is a complex illness. Multiple treatment attempts may take place over a period of time before significant improvement occurs. Relapse is common, particularly in the early stages of recovery. The duration of treatment required for those with multiple problems may conflict with the shorter timelines associated with child welfare decisionmaking.

**Children's developmental timelines.** Children mature quickly and need consistent parental attention. Although several months or years is a short period to parents and service providers, to children that time is critical developmentally. A child cannot be put on hold during a parent’s addiction and recovery without serious developmental consequences. Children’s developmental
timeframes are the rational choice for speedy child welfare mandates discussed above. This is especially relevant when considering the attachment needs of an infant or young child.

**Time limits for welfare recipients.** Some parents in substance abuse treatment are welfare recipients and subject to federal and state work requirements and time limits on case assistance. In addition to CWS and AOD service requirements, parents may face benefit time limits that threaten their source of income or may be required to participate in extensive work activities. Treatment programs will increasingly need to accommodate clients' other activities and responsibilities.

**Readiness to Change as a Construct for Blending Perspectives**

A family crisis, such as a child protective services intervention, can be the catalyst to prompt a substance-abusing parent to seek treatment. As all acute crisis states are short-lived, the resolve of an addicted person is often brief. Unless treatment is available promptly, the opportunity for intervention may be lost. CWS pressure on the parent must coincide with the tension that creates motivation for change by directly referring an AOD-involved parent to treatment.

Change as a phenomenon that results from tension created by a crisis or a series of crises has been described by psychologists Prochaska and DiClemente [1982] as a progression of stages that are discrete yet fluid and cyclical. This model offers five stages through which an individual progresses: precontemplation, contemplation, preparation/determination, action, and maintenance. People may cycle among the stages or may move through several cycles before change becomes permanent. In applying this change model to working with addictive behaviors, a sixth stage is added to reflect that even after maintaining a period of sobriety, relapse may occur and the client will cycle back through the
stages. Thus, in the sixth stage the client either manages a permanent change or experiences a relapse in the addictive behavior.

Miller and Rollnick [1991] expanded the model of change to identify motivation as an identifiable state of awareness and readiness. A client’s state of motivation is thus viewed as potentially under the influence of a counselor. By determining the client’s current stage of change and using a motivational approach of specific techniques, a client can become receptive to moving to another stage in the progression from precontemplation to action or maintenance. Hohman [1998] illustrates this approach and its usefulness in working with substance-abusing parents who come to the attention of CWS. Specifically discussed is the importance of identifying the specific stage of change the parent may be in with regard to his or her substance abuse and using “stage appropriate” motivational approaches to move a client toward seeking help.

Although the discussion thus far has focused on personal change, similar “stage” models may have further applications to organizations as they adapt to the blending of CWS and AOD practices. Greiner [1967] identified six predictable stages of change through which organizations move as they adjust to change. This model was later revised to five stages to be more applicable to business growth from start-up onward. The original model, as applied in this discussion, is more relevant to the experience of change in this area of human service. The stages and their description are described in figure 1.

Montgomery County: A Case Example.

**Environmental Context**

Montgomery County is the most populous jurisdiction in Maryland. The county’s population in 1997 was estimated at 823,500 and is now thought to exceed 835,000. In 1999, there were ap-
approximate 314,000 households, of which 53.2% were female-headed with over 200,000 families having children under age 18. The population of households with an income less than $24,999 is approximately 10% of total households.

The county provides social services, behavioral health, income supports, and homeless programs through a single government entity. Within a single organizational structure, the county Department of Health and Human Services (HHS) administers both public child welfare and adult substance abuse programs through separate divisions. The majority of staff within child welfare are licensed, master’s level social workers. Publicly funded AOD treatment services are provided in a combination of programs directly by HHS employees who are master’s level staff and

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Demographic information is from the 1990 U.S. Census and the 1994 U.S. Census update.
through contractual services that employ licensed addiction counselors.

The combination of directly operated and contractual services allows HHS to support and maintain a publicly managed “treatment on demand” capacity through its Adult Addiction Services (AAS). The continuum of substance abuse services includes: assessments, treatment, urine monitoring services, residential and outpatient programs, and psychiatric services for those with co-occurring mental health and substance abuse disorders. Rather than operating as a standalone service, the goal of AAS is to provide horizontal support to key social, public health, employment and corrections programs to maximize the benefit to individuals, agencies and communities.

During the fiscal year ending June 2000, AAS had over 5,000 service contacts with individual adults to provide screening, assessment, referral, outpatient and residential treatment, case management, and family support. Approximately 82% of persons assessed for treatment were determined to be in need of substance abuse services according to existing criteria. In addition, more than 200,000 urine tests were conducted for drug abuse as a service provided to treatment agencies, child welfare services, criminal justice, mental health, homeless, and group home programs.

**Background to the Initiative**

In 1997, CWS and AAS formed a joint task force to develop and utilize a cooperative interagency relationship with the larger HHS organization to address the requirements of ASFA and welfare reform. At that time, statewide data on length of stay in placement for children was 35.4 months and 34.7 months in the county. The total number of county children in out-of-home placement was 533. Although data reflected a rate of increase in reports to

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3 This data is compiled from HATS, SAMIS, and logs maintained by individual programs as there is no single, unified database to track treatment episodes in Montgomery County.
CPS of 40% from 1996 to 1997, a similar increase in the proportion of referrals to AAS did not exist.

Prior to this initiative, there were no coordinated efforts between CWS and AAS. Clients were referred to various treatment providers on a case-by-case basis. Social work staff felt that clients with their own financial resources would not be comfortable using a public agency for assessment or treatment services. Therefore, those with more personal resources were allowed to seek treatment on their own. This practice allowed many clients to slip through the cracks. Second, CWS staff were not able to track attendance and participation in private treatment. A client could provide the social worker with the name of a therapist and often the case would be closed. After closure, the client would drop out of treatment. CPS would later receive another abuse or neglect complaint from the community. Investigators would find that the well-being of the children had deteriorated and the parent's substance abuse problem had worsened.

The task force comprised supervisory and direct service staffs who represent both operations and service delivery systems. The task force recognized that substance abuse among consumers of HHS resources is a complex problem that requires a focused, consistent, and organized response from HHS staff, supervisors, and administrators. Secondly, it was recognized that consumers of HHS services who are chronic substance abusers have not been adequately identified, assessed, or referred to treatment and as a result have not fully benefited from available HHS services. Third was a recognition that a coordinated effort by CWS and AAS would be of benefit to consumers, staff, supervisors and administrators as well as safety of citizens.

A multidimensional approach was developed to effect changes that would support the CWS objectives of reducing recidivism and decreasing the length of stay for children in out-of-home placements. The strategy consisted of four approaches: (1) philosophy shift—staff development, cross-training and training
with internal support for staff efforts and dilemmas; (2) skill building—education and skill building on understanding and intervening with the addicted parent; (3) standards—development of clear protocols and standards for assessment, referral, and follow-up; and (4) quality assurance—development of standards and consequences to be integrated into services for CWS and AAS consumers that will meet treatment and service objectives as well as legal standards.

**Philosophy Change and Skill Building**

A training sequence was developed and attended by both CWS and AOD staff. The initial training provided basic information of AOD use and abuse, assessment tools, strategies for responding to defense mechanisms and information on access to treatment resources. The second level of training, “Social Necessity and Working with the Substance Abusing Child Welfare Client,” consisted of a workshop series to address the philosophical change of combined services, risk assessment, the skills to conduct interventions (see “Structured Response” below), and techniques for constructive engagement with clients. Other cross-training provided AOD treatment staff with an overview of child protection laws, mandates, and the continuum of services offered to families. Once these training workshops became available, demand emerged from other parts of HHS, including public health nurses, income support programs, domestic violence, and juvenile justice. Site visits and “shadowing” experiences were also arranged.

An approach labeled “Structured Response” was developed to suggest a framework for effective collaborative, coordinated social services for persons in need of multiple interventions to achieve social stability for themselves and their families. This required an emphasis from AOD services providers to meet the needs of parents, especially parents who were at risk or already involved in CWS who may be facing time limits imposed by ASFA. Partnering with CWS systems and clients requires an orientation
toward finding solutions that will remove obstacles of identification, access to services, and barriers (e.g., child care, housing) as well as toward developing strategies that focus on treatment retention, motivation, and behavioral change. AOD providers need to provide services that are timely and relevant for parents that encompass social mandates, such as those of CWS and welfare reform.

The "Structured Response" is a planned, clear, consistent, and coordinated approach to addressing parental substance abuse similar to the technique of intervention long used in the chemical dependency field.

Level I response is nonpunitive and encourages those who may have a substance abuse problem to seek an in-person assessment with HHS staff and then follow whatever recommendations that may made for treatment or follow-up to Alcoholics Anonymous, Narcotics Anonymous, or other services.

Level II response increases pressure through coordination of HHS services (including access to resources) to provide a unified approach to those who may not have responded to the Level I response. Parents may be required to follow up with a urine test or formal assessment for AOD treatment to qualify for supplemental HHS services. Such a requirement is not negotiable and must be met before wider access to resources (e.g., extended visitation) would be allowed.

Level III response implements logical consequences for non-compliance, which may be perceived as punitive by denying or restricting benefits until there is follow through with the requirements spelled out in Level II. The goal is to return to Level I or Level II once action begins.

 Standards and Quality Assurance

The task force investigated existing practice models and methods and current knowledge in the field of substance abuse intervention. Based on this survey and standards for the best prac-
tices a blended model of intervention was determined to be best strategy to achieve the dual mandates of CWS and AOD providers. Drawing from fields of criminal justice, systems theory, social work, and addiction treatment, an approach was developed that made use of graduated sanctions or levels of intensity in providing services, engaging client participation, and engendering motivation.

A substance abuse specialist was colocated to the central site of CWS operations. The responsibilities of the liaison were to consult with all CWS staff on substance abuse cases, assist and educate staff about substance abuse in general, to assist and model intervention with substance abusing parents, and to facilitate referrals for evaluation for treatment and urine screening. The liaison also served to assist in the collection of data to more accurately reflect CWS activities with AOD-involved families and the response of the AOD system to CWS referrals. Assignment of an AOD staff member to the CWS office is formal in nature; however, the selection of the person to fill the position was influenced by informal factors. The liaison had prior experience working in CWS, had worked in an AOD program for women with young children (many of whom were CWS referrals), and as a result had established relationships with several CWS staff.

An emphasis on timeframes and responsiveness from the treatment providers to CWS clientele emerged from less formal efforts to further the agenda of blending services. It included the use of existing relationships between and among staff in both systems. HHS set expectations that both program areas were motivated to improve communication and information exchange between the two services, to simplify direct access to urine testing and substance abuse assessments, and to colocate AOD staff to CWS. As both AOD and CWS are administered within the same department (HHS), there are supervisory and direct service staff who have had working relationships established over a number of years. These staff members came together to establish stan-
standards, such as admission to detoxification for CWS parents within 24 hours and immediate access to urinalysis, that were supported by departmental tools such as memoranda of agreement and clarification of confidentiality guidelines to streamline communication.

Existing relationships proved most useful in furthering the goals of developing cross-training experiences, exchanging ideas, and sharing information regarding philosophy, policy, and practice in both areas of service. In this regard, there was a basis for communication and information exchange between the two service areas. Although voluntary, the cross-training afforded the opportunity for all adult addiction staff and child welfare staff to meet again, giving rise to improvement in communication. It was through the discussion at cross-training and workshop sessions that suggestions were made to simplify access to urine testing and substance abuse assessment services. Increased informal communication and receptiveness to make program changes were the first demonstrable indication that the blending process was in place, reflecting Greiner’s third stage of organizational change.

Discussion

The Montgomery County initiative began in 1997. At that time there were no specific data to indicate how well the problem of substance abuse was being addressed in child welfare services. As more accurate methods of tracking information and referrals were developed, the need for change became more apparent. Significant and lasting change, the systems have learned, is a process that requires three to five years, as reflected by the degree to which necessary changes in awareness, attitudes, and behavior (practices) have occurred. At the three-year point there are measures in place that show a change in awareness and attitude of CWS social workers toward addressing substance abuse among their clients.
Utilization of the AAS liaison by CWS tracked by month from July 1999 to June 2000 serves as one measurement. In July 1999, 10 CWS staff members requested 15 consultations with the liaison on 12 cases of 169 investigations. By May 2000, 32 CWS staff requested 69 consults regarding 35 cases of 282 investigations. This indicates an increase in willingness to address substance abuse and to make use of resources to assist in that process. Based on this marked increase in the number of CWS cases referred for consultation, it is anticipated that this increase will continue and future measures will expand understanding of the impact of the "Structured Response" framework for intervention with parents to leverage entry to AOD treatment.

With the more coordinated system, CWS has one point of contact with AAS that offers a continuum of care and urinalysis. CWS is informed of all positive drug or alcohol screens within 24 hours. The CWS is contacted by the addiction services therapist when a client drops out of treatment or progress is stagnant. CWS and AAS staff often hold case conferences to review client progress and to engage in treatment planning as a team.

The AAS liaison is available to accompany CWS staff on home visits. Substance abuse assessments and urine monitoring are available to CWS clients by appointment and on a walk-in basis on 24-hour notice. As a result of the increased level of partnership, CWS staff have volunteered to be trained to collect on-the-spot urinalysis. CWS staff have collected samples during court hearings when working with resistant clients.

As blending of services becomes more a part of daily practice, CWS personnel are making their needs known to their supervisors. In turn, this requires supervisors to become better informed, prepared, and supportive. Change, then, is taking place among direct service staff, and that change is impacting the organization in an upward direction. In addition, there are indications that behavior is shifting, which reflects CWS as an agency is moving to the action stage of change. CWS staff now request
training on urine collection procedures to be better equipped to promptly address allegations of parental AOD problems.

Such initiative from direct service staff is reflective of stages of change that involve recognition of problems and taking action to address them, while management and supervisory staff for the most part remain in the contemplative stage. Management has introduced a quality assurance tool to track staff activity to address parent AOD use during the investigation phase. It requires CWS staff to indicate their attendance to four problem or "focus" areas including AOD use. As a case is closed, the social worker indicates if there were "signs of AOD use by children, parents, or other family members" and whether the substance abuse liaison was consulted. The form also requests information on indicators of domestic violence and mental health problems.

In parallel, AOD service providers must be ready and willing to make changes in how, when, and where services are provided to better serve the needs of the CWS client. Our experience has been that many AOD service providers are unwilling to invest in the active collaboration that is needed to improve outcomes for this population. In Montgomery County’s initiative, AAS is the program that serves as the assessor and gatekeeper for AOD treatment referrals. Senior management in this part of the system has been more directive with staff so that direct service staff were given incentives from management with regard to changes that would be made and then assisted in adjusting to those changes. Although this is a publicly operated continuum of care, the ability to influence entrenched programs and individual clinicians requires a long-term effort to engage in a change process and achieve the maintenance stage.

Conclusion

Children of parents who are substance abusers tend to remain in out-of-home care longer than do other children. Typically this is
due to the time required to address substance abuse or the failure to treat substance abuse. Because ASFA places all children on a fast track within the out-of-home care system, CWS and AAS had to focus on these time constraints and on the stages of change to address the co-occurring problems of addiction and child maltreatment. The two program areas worked together to increase the level of parental motivation to change and organizational adaptation to the new atmosphere of collaboration created by ASFA.

Guided by the maintenance stage of change, CWS social workers must be able to assess when a child may safely return to his or her home while recognizing that relapse may be part of recovery. Treatment providers need to work more closely with CWS social workers to assist parents in maintaining the lifelong process of recovery. As individuals and heads of households, women benefit from further assessment and matching based on social service needs rather than the traditional male models of AOD treatment. Through collaborative efforts and interagency training, service and treatment providers can develop treatment models and protocols that address the multiple and, to date, competing needs that women must address when receiving services from both systems.

The changes are necessary to successfully integrate the services of substance abuse evaluation and treatment providers and child welfare professionals must occur at personal (individual), organizational, and systems levels. Change within the organizations requires a philosophy shift, skill building, development of standards, and quality assurance. This approach to change has proved to be effective in the sense that direct service staff are experiencing an ability to be more effective with substance-abusing parents if they are more informed, better prepared, and supported in their efforts.

While the pace and style of change has varied among stakeholders and organization’s leadership, the process continues to move toward more effectively integrated services at the personal
and institutional levels. The larger system of service delivery may, and likely, will change as the needs of substance abusing parents continue to present themselves. The days of standalone services are coming to an end. For this change to be successful, it will require a commitment on the parts of policymakers, the courts, program administrators, and social workers as they seek to recognize and collaborate towards the common goal of facilitating sustainable healthy intact families. As demonstrated by the Montgomery County model, this change takes time and negotiation between the various agencies involved.

References


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