AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

# PROTECTING CHILDREN FROM THE IMPACTS OF SUBSTANCE ABUSE ON FAMILIES RECEIVING WELFARE

## HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

OCTOBER 28, 1997

**Serial 105–31**

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
50–489 CC WASHINGTON : 1998

## COMMITTEE ON WAYS AND MEANS

BILL ARCHER, Texas, *Chairman*

PHILIP M. CRANE, Illinois
BILL THOMAS, California
E. CLAY SHAW, JR., Florida
NANCY L. JOHNSON, Connecticut
JIM BUNNING, Kentucky
AMO HOUGHTON, New York
WALLY HERGER, California
JIM MCCRERY, Louisiana
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
JIM NUSSLE, Iowa
SAM JOHNSON, Texas
JENNIFER DUNN, Washington
MAC COLLINS, Georgia
ROB PORTMAN, Ohio
PHILIP S. ENGLISH, Pennsylvania
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska
WES WATKINS, Oklahoma
J.D. HAYWORTH, Arizona
JERRY WELLER, Illinois
KENNY HULSHOF, Missouri

CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ROBERT T. MATSUI, California
BARBARA B. KENNELLY, Connecticut
WILLIAM J. COYNE, Pennsylvania
SANDER M. LEVIN, Michigan
BENJAMIN L. CARDIN, Maryland
JIM MCDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
RICHARD E. NEAL, Massachusetts
MICHAEL R. MCNULTY, New York
WILLIAM J. JEFFERSON, Louisiana
JOHN S. TANNER, Tennessee
XAVIER BECERRA, California
KAREN L. THURMAN, Florida

A.L. SINGLETON, *Chief of Staff*
JANICE MAYS, *Minority Chief Counsel*

---

## SUBCOMMITTEE ON HUMAN RESOURCES

E. CLAY SHAW, JR., Florida, *Chairman*

DAVE CAMP, Michigan
JIM MCCRERY, Louisiana
MAC COLLINS, Georgia
PHILIP S. ENGLISH, Pennsylvania
JOHN ENSIGN, Nevada
J.D. HAYWORTH, Arizona
WES WATKINS, Oklahoma

SANDER M. LEVIN, Michigan
FORTNEY PETE STARK, California
ROBERT T. MATSUI, California
WILLIAM J. COYNE, Pennsylvania
WILLIAM J. JEFFERSON, Louisiana

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Ways and Means are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

# CONTENTS


| | Page |
|---|---|
| Advisory of October 20, 1997, announcing the hearing | 2 |

WITNESSES

| | |
|---|---|
| U.S. General Accounting Office, Jane L. Ross, Director, Income Security Issues, Health, Education, and Human Services Division | 13 |

| | |
|---|---|
| Barth, Richard P., University of California, Berkeley | 43 |
| Center of the American Experiment, Mitchell B. Pearlstein | 77 |
| Children and Family Futures, Nancy K. Young | 34 |
| Rangel, Hon. Charles B., a Representative in Congress from the State of New York | 7 |
| Reuter, Peter, University of Maryland | 21 |
| Satel, Sally L., Yale University School of Medicine | 70 |
| Second Genesis, Inc., Gale Saler, and Judy Ogletree | 59 |
| Teen Challenge, Inc., Dave Batty | 66 |
| Westat, Inc., Nicholas Zill | 26 |

SUBMISSIONS FOR THE RECORD

| | |
|---|---|
| Child Welfare League of America, Inc., statement | 89 |
| Haymarket Center, Chicago, IL, Ray Soucek, statement | 91 |
| Legal Action Center, Washington, DC, Gwen Rubinstein, statement | 92 |
| National Association of Alcoholism and Drug Abuse Counselors, Arlington, VA, William D. McColl, statement | 97 |
| Ramstad, Hon. Jim, a Representative in Congress from the State of Minnesota, statement | 99 |

# PROTECTING CHILDREN FROM THE IMPACTS OF SUBSTANCE ABUSE ON FAMILIES RECEIVING WELFARE

---

**TUESDAY, OCTOBER 28, 1997**

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HUMAN RESOURCES,
*Washington, DC.*

The Subcommittee met, pursuant to notice, at 3:05 p.m., in room B–318, Rayburn House Office Building, Hon. E. Clay Shaw, Jr. (Chairman of the Subcommittee), presiding.

[The advisory announcing the hearing follows:]

# *ADVISORY*

FROM THE COMMITTEE ON WAYS AND MEANS

## SUBCOMMITTEE ON HUMAN RESOURCES

FOR IMMEDIATE RELEASE CONTACT: (202) 225–1025
October 20, 1997
No. HR–8

## Shaw Announces Hearing on Protecting Children From the Impacts of Substance Abuse on Families Receiving Welfare

Congressman E. Clay Shaw, Jr., (R–FL), Chairman, Subcommittee on Human Resources of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on issues related to protecting children from the prevalence and impacts of substance abuse on families receiving welfare. The hearing will take place on Tuesday, October 28, 1997, in room B–318 of the Rayburn House Office Building, beginning at 3:00 p.m.

Oral testimony at this hearing will be from invited witnesses only. Witnesses will include representatives of the U.S. General Accounting Office, welfare and substance abuse experts, State welfare officials, and treatment providers. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

**BACKGROUND:**

Last year, Congress passed, and President Clinton signed, the new welfare reform law (P.L. 104–193) that substantially changed the nation's major cash welfare program, now called the Temporary Assistance for Needy Families program. The new law established time limits on receipt of welfare benefits, set employment and training participation requirements, and authorized States to impose sanctions on recipients that fail to meet program expectations.

Researchers have identified substance abuse as a potential barrier to recipients' successfully transitioning from welfare to work. In addition, parental drug use has been linked to child abuse. Estimates of drug abuse among welfare recipients vary greatly by the type of drug, legal status, and the population studied. However, some assessments indicate that the use of illegal drugs is higher among welfare recipients than among the general population.

In announcing the hearing, Chairman Shaw stated: "The Subcommittee wants to examine the incidence of drug use among welfare recipients and the potential impacts of drug use on children. We are particularly interested in substance abuse as a barrier to work and a factor in the placement of children into foster care. Changes in national welfare rules have led many States to reform their policies for assessing, referring, and treating drug users. It is time to examine what is known about the effectiveness of drug treatment and to identify promising approaches to helping welfare recipients overcome substance abuse problems. This hearing is part of our ongoing efforts to ensure that the far-reaching changes made by the welfare reform legislation continue to meet with success."

**DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:**

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) single-space legal-size copies of their statement, along with an IBM compatible 3.5-inch diskette in ASCII DOS Text or WordPerfect 5.1 format only, with their name, address, and hearing date noted on a label, by the *close of business*, Tuesday, November 11, 1997, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Human Resources office, room B–317 Rayburn House Office Building, at least one hour before the hearing begins.

**FORMATTING REQUIREMENTS:**

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments. At the same time written statements are submitted to the Committee, witnesses are now requested to submit their statements on an IBM compatible 3.5-inch diskette in ASCII DOS Text or WordPerfect 5.1 format. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS__MEANS/'.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman SHAW. Good afternoon.

Our purpose today is to investigate drug addiction and its role in welfare dependency, child abuse, and neglect. We have invited witnesses to discuss the dimensions of the drug problem both among families on welfare and in the Nation's child protection programs. In addition we have invited witnesses who can describe programs that are designed to deal with drug addiction itself or with the consequences of drug addiction, especially the consequences for children.

There are several specific questions I hope will be addressed in the course of today's hearing. First, is there evidence of substantial drug use among parents receiving support from the Nation's welfare programs? Second, do we have programs with a track record of helping parents, especially those already dependent on welfare, end their drug addictions? Third, what actions, if any, should Congress take to reduce drugs among welfare parents and to protect the children from the consequences of parental drug addiction?

Anticipating some of today's testimony, let me state that there does appear to be good evidence that parents receiving benefits from temporary assistance for needy family programs have fairly high levels of drug use. Members of this Subcommittee would like to have information on whether this drug use will interfere with the ability of the parents to get jobs and leave welfare.

I am especially pleased we will receive testimony from the Second Genesis, the Teen Challenge Program, and several other witnesses about how we can help addicted parents deal with their drug problems and become productive workers and better parents.

There also appears to be very strong evidence that parents with children who have been taken into protective custody by the States have very high levels of drug addiction. In some jurisdictions, perhaps three-quarters of these families have drug-addicted or drug-involved parents. This, of course, is a tragedy of immense proportion.

At a time when we are hoping to encourage States to make faster determinations of whether abused and neglected children can be returned to their families or placed with adoptive parents, drug addictions put the State and local officials making these decisions on the horns of a dilemma. If the drug addiction has become serious enough to be an important factor in removing children from their home, how long should the State wait before moving to place the children with an adoptive parent? What if it takes 2 years for the parent to become rehabilitated? What if it takes 3 years? How long should children be expected to wait?

Although I am not planning to introduce legislation on drugs and welfare in the near future, at least not this year, I plan to keep an eye on this issue and carefully consider any legislative recommendations made by today's witnesses. Our Subcommittee must continue to investigate whether changes in Federal law would help States launch more effective programs to help parents and children on welfare overcome the scourge of drug addiction.

[The opening statement follows:]

**Opening Statement of Hon. E. Clay Shaw, Jr.**

Our purpose today is to investigate drug addiction and its role in welfare dependency and child abuse and neglect. We have invited witnesses to discuss the dimen-

sions of the drug problem both among families on welfare and in the nation's child protection programs. In addition, we have invited witnesses who can describe programs that are designed to deal with drug addiction itself or with the consequences of drug addiction—especially the consequences for children.

Here are several specific questions that I hope will be addressed in the course of today's hearing:

First, is there evidence of substantial drug use among parents receiving support from the nation's welfare programs?

Second, do we have programs with a track record of helping parents, especially those already dependent on welfare, end their drug addictions?

Third, what actions, if any, should Congress take to reduce drug use among welfare parents and to protect children from the consequences of parental drug addiction?

Anticipating some of today's testimony, let me state that there does appear to be good evidence that parents receiving benefits from the Temporary Assistance for Needy Families (TANF) program have fairly high levels of drug use. Members of this Subcommittee would like to have information on whether this drug use will interfere with the ability of parents to get jobs and leave welfare. I am especially pleased that we will receive testimony from the Second Genesis program, the Teen Challenge program, and several of our other witnesses about how we can help addicted parents deal with their drug problem and become productive workers and better parents.

There also appears to be very strong evidence that parents with children who have been taken into protective custody by the states have very high levels of drug addiction. In some jurisdictions perhaps three-quarters of these families have drug-addicted or drug-involved parents.

This, of course, is a tragedy of immense proportions. At a time when we are hoping to encourage states to make faster determinations of whether abused and neglected children can be returned to their families or placed with adoptive families, drug addictions put the state and local officials making these decisions on the horns of a dilemma. If the drug addiction has become serious enough to be an important factor in removing children from their home, how long should the state wait before moving to place the child with an adoptive parent? What if it takes two years for the parent to be rehabilitated? What if it takes three years? How long should children be expected to wait?

Although I am not planning to introduce legislation on drugs and welfare in the near future, I plan to keep an eye on this issue and to carefully consider any legislative recommendations made by today's witnesses. Our Subcommittee must continue to investigate whether changes in federal law would help states launch more effective programs to help parents and children on welfare overcome the scourge of drug addiction.

---

Chairman SHAW. At this time, Mr. Levin, you are recognized.

Mr. LEVIN. First of all, congratulations on your new hat.

Chairman SHAW. Thank you.

Mr. LEVIN. My favorite kids book has the phrase in it, I like your hat. I am reading it to my grandchildren.

Chairman SHAW. I am reading it to my grandchildren.

Mr. LEVIN. It is Go, Dog, Go, exactly.

Mr. CAMP. Poor literate group here.

Chairman SHAW. I seem to be behind on my reading.

Mr. RANGEL. Am I in the right place?

Mr. LEVIN. Yes, Mr. Rangel, welcome; and I will be very brief so we can get to your testimony.

I have a statement, Mr. Chairman, that I ask be placed in the record.

Chairman SHAW. Without objection. The statement of any of the Members will be placed in the record if they wish to do so.

Mr. LEVIN. Our important and solemn job is make welfare-to-work legislation, or at least to help in that direction; and to do

that, we have to be sensitive to the complex problems faced by families who are receiving TANF or who are involved in foster care, and one of the problems faced by many of these families relates to drug abuse.

And there is evidence, as you say, Mr. Chairman, that this is a considerable problem, that a substantial number of people who are receiving TANF have drug or other abuse problems. I think there is also evidence there can be a successful addressing of this problem in many cases, and treatment is not today sufficiently available. So I look forward to this hearing.

I think we have put together a very excellent set of witnesses, and we are privileged to have, as the leadoff witness, the Ranking Democrat on our Committee.

[The opening statement follows:]

**Opening Statement of Hon. Sander M. Levin, a Representative in Congress from the State of Michigan**

This afternoon's hearing is an important one and, I hope, the first of several we will hold to explore barriers facing welfare recipients moving to work. As we implement welfare reform and live up to our commitment to replace welfare with work, we will maximize effectiveness only if we are sensitive to the complex problems many of these families face.

Substance abuse is clearly one of the serious problems. Estimates vary about the extent of the problem, with the highest estimates being that about one million women on welfare need help with a drug or alcohol problem. Most research has concluded that the TANF population uses drug and alcohol at a rate that is higher than the non-welfare population and that the majority of recipients who need treatment are not receiving it. Even more troubling, it appears that parental substance abuse is implicated in the majority of foster care cases in some parts of the country.

Our challenge today and in the near future is to focus on the magnitude and the consequences of the problem, and most importantly, to learn more about successful models for overcoming substance abuse problems so that parents can move from welfare to work, can support their families, and can through example help their own children avoid drugs.

I look forward to hearing from witnesses today who have firsthand experience with these problems. A special thanks to the Ranking Democrat on the Committee on Ways and Means, Charlie Rangel, who so poignantly describes how the combination of poverty, lack of education, abuse, and hopelessness too often leads to addiction.

---

Chairman SHAW. Thank you, Mr. Levin.

I would like to give a special welcome to our first witness today, Mr. Rangel, who has, throughout his entire career in the Congress, worked very hard in the area of drug abuse, and trying to find its causes, its cure, and work to get rid of this terrible problem.

I first met Mr. Rangel 17 years ago when I came to Congress and was on the Select Committee and was on your Subcommittee—I don't know if you remember it, but I remember it as a freshman back then—and we worked very hard together throughout the years. It is an area where Mr. Rangel and I disagree on a lot of things, but I cannot think of one time that we have ever disagreed in this particular area; and I compliment you for all the good work that you have done for your country and for the people who have gotten hooked on this terrible scourge that has plagued the country. It, in itself, is a tremendous cause of people not being able to make it, not being able to get out in the work force. Drug abuse has absolutely just—has penalized people beyond belief.

With that, Mr. Rangel.

**STATEMENT OF HON. CHARLES B. RANGEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK**

Mr. RANGEL. Thank you. I don't think I will be able to bring much of a solution to the problem we face, but I am familiar with the problem and together I think we can find a solution.

Take a district like mine—which receives more per capita Federal funds than most congressional districts. But that is not something that I can run for reelection on because most of it is for health care, AIDS, welfare, crime reduction, and homelessness; and given all of this, I was able to work with Congressman Kemp and Congressman Newt Gingrich to create the empowerment zone. To make certain we weren't just considering race and all of those other controversial issues to determine eligibility for an empowerment zone, we just picked criteria—we used poverty, we used drug abuse, we used crime, we used homelessness, we used unemployment, we used all of these things, and so you would know that welfare would be a part of the criteria. In other words, if you ever really take a look at where the schools are not functioning, where you have the highest amount of unemployment, and joblessness because the family unit is not functioning the way we think it should, you are going to find hopelessness, which leads to despair, which leads to drugs, which leads to unwanted children, which leads to violence, which leads to crime, and which leads to the ridiculous situation that in the city of New York, we are paying $85,000 a year to keep a kid in a detention center, while the unions are fighting with the mayor to find out if they can get $7,000 a year to keep a kid in school.

What I am suggesting is, when it gets to rehabilitation, in most of these cases, they have not been habilitated and there is very little you can do to rehabilitate.

I remember sometimes bringing Federal officials into my district and, to my embarrassment, the rehabilitated addicts would come up and say, Rangel, you are doing a great job; I go to the same rehabilitation center all the time, they really treat me fairly, these are good people. And basically, it almost hurts to see how you can detoxify somebody, make them drug free, give them self-esteem, and find out they were just as uneducated when they were discharged and graduated as they were when they went on drugs. And because the dollar is so competitive in rehabilitation, everybody wants to know how many people went through, how many people graduated, how many people reunited with their families; but if they didn't spend the money and time to give them job skills, the self-esteem hurts them more than when they didn't have it.

Of course, I have always supported the programs because having the program reduces the habit, and to a large extent, keeps them off the street and reduces crime. And some of the programs do work, especially if the person involved has some skills and the program is dealing with training and job placement, rather than how many numbers can we run through to a graduation, which gives high expectations, but is really disappointing in the end.

But the whole point is that if we don't deal with jobs in this country—and it is not just the welfare program. My God, we have

1.6 million people that are locked up in jail as we go toward the next century, talking about high skills, high-paying jobs. We are talking about close to a trillion dollars when you include the health benefits, food, maintenance, building of the prisons, the law enforcement system, diseases related to drugs—and 80 to 90 percent of the people we are locking up are drug related, one way or the other.

It seems to me there is one thing we know definitely and that is that the prison population and, for the most part, the welfare population, are unemployable; and one of the reasons we didn't do much with putting people to work was because it took more to train them for work than to send a check.

Morally, it is the wrong thing to do. Everyone should have the dignity and the pride of working; it means something to the family, it means something to the community, it should mean something to the church or synagogue. But in dollars and cents, to get someone prepared to do what the schools didn't prepare them to do is just stupid, and this is especially so when we have legislation that comes before us that gives incentives to save money at the expense of not making certain that basically we have a good public school system and then, from there, parents can do whatever they want, with or without incentives.

So I am suggesting that even though I don't have an answer to the problem that you are facing with the welfare recipient, there is no question in my mind that we can make a difference—if we can build partnerships with businesspeople who can tell us definitely what training and skills they need to hire somebody; if we can make certain that that public school system does not just respond to a local school board, but responds to the job needs of the people in that community, including small- and middle-sized businesses. If we make it the case that when they graduate they don't just earn a diploma but a job will be waiting for them, as somehow they managed to do in the Army. Nobody asked me what I wanted to do; they just said what they needed and went on to train me for that particular job.

There is no reason why we can't have a closer working relationship with our businesspeople and our school boards and our schools, and to the extent that we are going to say that welfare recipients have to work and should be working, it seems to me it should be the private sector that we should be depending on, and if we have to, go to the drug rehabilitation centers to instill that training there. To me, making someone drug free without giving them the hope they are going to get a job is something that doesn't sustain itself.

I didn't mean to come here and raise the problems to you, Mr. Chairman, because as you said, for close to two decades, you and I have been struggling to find the answer to this problem. But it would seem to me we all should know that the better a school system, the better a job opportunity, then the better the chances we are not dealing with welfare, crime, drugs, and eventually an impediment to the progress that this great Nation can make if we didn't just lock up people and give up so many of them to AIDS and to hopelessness, as the case is with many of the welfare recipients.

And so it is a challenge that is present to all of us, and I look forward to working with all of you, toward that solution.

[The prepared statement follows:]

**Statement of Hon. Charles B. Rangel, a Representative in Congress from the State of New York**

According to the Substance Abuse and Mental Health Services Administration, at least 600,000 AFDC recipients require treatment for alcohol- and other drug-related problems; other national estimates indicate that as many as 1 million AFDC women may need such help. Most assessments of drug or alcohol use predict that the AFDC population uses drugs and alcohol more than the non-AFDC population.

It should come as no surprise to us that AFDC recipients, particularly those who are long-term dependent, have significant drug and alcohol abuse problems. The combination of poverty, lack of education, abuse, and hopelessness can easily lead to addiction; and treatment resources, particularly for this population, are quite limited.

In fact, according to SAMSA, the great majority of women receiving public assistance do not get treatment for their alcohol-and other drug-related problems and could benefit from treatment.

Instead of investing in education and treatment, we invest in prisons. It costs $85,000 to house each inmate at the Rikers Island detention center. That is $72,000 more than the cost to educate a child in public school for a year.

This investment in prisons and longer jail sentences does not seem to have had much, if any, deterrent effect. Investing even more in this strategy does not make much sense to me, particularly given our concern about the deficit. What we need is a strategy that links prevention, treatment, law enforcement, and demand and supply reduction. I wish I could say that I see such a strategy on the agenda of this Congress, but I do not.

All the news is not bad, however. There is evidence, from States, that treatment can substantially improve employment status for the welfare population:

—Arkansas had a post-treatment employment increase of 127 percent;
—California saw increases in employment of over 60 percent;
—Colorado increases were 60 percent;
—Florida increases were 76 percent;
—Minnesota increases among public pay clients were 64 percent; and
—Missouri increases were 136 percent.

Remember, nearly 20 percent of all children in the US have a parent who used an illicit drug in the past year; over 9 percent have parents who used illicit drugs in the past month.

Blaming the drug or alcohol dependent parent accomplishes nothing. We need to devote that same energy to solving what is a painful problem for many of America's families, including its poorest.

---

Chairman SHAW. Charlie, am I hearing you correctly, in interpreting what you are saying, in reading between the lines, that joblessness, hopelessness, leads to drug abuse, and that the rehabilitation is not addressing that question? In addition to just getting someone off of drugs, in other words, should we be looking to attaching job training to drug rehabilitation?

Mr. RANGEL. No question in my mind, Mr. Chairman.

Chairman SHAW. Is anyone doing that?

Mr. RANGEL. Some do, and they are expensive programs. As a matter of fact, I can look at the success of a program and almost see whether they are screening people to guarantee success. Where you have programs in sophisticated neighborhoods where some doctor, some lawyer, some professional person made a mistake and was hopelessly addicted, then they go to the Betty Ford Rehabilitation Center. They don't need a lot of job training, they just have to get back on track.

But when you search for the reason as to why would anybody go on drugs in the first place, our kids are smart enough to see that drugs hurt, they are smart enough to see friends dying, they are smart enough to see people going to jail. Some of these kids go to more funerals than they do graduations, so they are smart enough to see it. So why would they do this? Because they don't give a damn. There is nothing they are going to lose.

They know that fast track and increased high-tech jobs do not mean them; they know they are not going to lose their family's good name, and being arrested, to some of them—having been abused and not even having had the ability to dream—going to jail just isn't any big deal.

As a matter of fact, the tragedy is when you find some kids who have never been to jail, dressing and acting as if they have been in and out of jail, so they can be accepted as a peer on the block. And when a kid goes through all of this crying and the family love is restored at graduation from a rehabilitation center, and then finds out that his friends, who are doing something, shun him—they can't just go right back, they are still a form of junkie—it takes a lot of love, and a lot of people don't have it for the type of people who have made these types of mistakes.

But there is one group they can always depend on, that is there for them: the drug dealer; and if you don't have a family structure to carry you, and you are weak and you are young and you are immature. And if you make a baby, well, how would we counsel them?

To a large extent, we have said they have already ruined their lives, so now you apply for a check and we say, Well, you wretched soul, you had better go to work. Well, we all agree, that is a great principle, but, boy, have you got a job in habilitating someone so that they are prepared to understand what the heck work is in the first place.

So what I am saying is that we make one big mistake when we don't concentrate on stopping these things from happening, because these are the problems we will be wrestling with, whether it means welfare, whether it means HIV, whether it means crime.

I went to visit, a couple years ago, some kids in a rehabilitation hospital that was in my district, and all these kids were sitting around in wheelchairs with "Rangel is the greatest" on their T-shirts, so I knew they wanted something. And I was asking, what did they want? And the director of the program told me that these kids who have been shot in these drug wars, paralyzed for life, wanted me to support a program that would put them in a private home, an apartment, with a rehabilitation person, with a housekeeper, with a dietitian and all of this. And I was saying, Are you crazy, and they were showing me that the cost of all of this was a fraction of the cost of keeping them in that institution.

Now we know that public officials are not prepared to give money to bum kids who shot each other, but we are prepared to pay money to the institutions, the doctors, the psychiatrists, and the social workers. It is insane.

How many people in Congress could I ask for $84,000 to keep one of my kids in school? But nobody has ever challenged in the Congress the amount of money it takes to keep them in jail—and

certainly not in the city council and State legislatures, the legislative bodies.

My only plea is, do what you have to do to get reelected, but for God's sake, concentrate on building a school system that produces productive people and that is not hopeless. Because in the Army they took a lot of hopeless bums like me and turned them into somebody. And with the proper discipline, and if the hope is there and the drive is given there, because you are shown something at the end of the line—at the end of the line for me was corporal stripes, but for kids, it may be something else—but show them something that you can get out of it and it works. And the thing that hurts is that you know it works, the Congress knows it works.

So when I see tax bills described as education bills, like I did last week, I say, If this makes you feel good, do it, but build up a public school system first before you call this a K-to-12 bill.

Chairman SHAW. Do the other Members have any questions?

Mr. Collins.

Mr. COLLINS. Mr. Rangel, I know we come from different parts of the country, and you come from an area that probably has a lot more different circumstances or surroundings than I do, because you are from an inner-city area, and I am from rural—middle of Georgia. But we both see a lot of the same situations, maybe just in different patterns.

In the area of education versus prisons, we do not adequately address the problem of drugs and crime and education. I think it is going to take a large sum of money for each. The purpose of schools and education is to teach what to do and how to do it properly, appropriately. The purpose of a prison is to, in some sense of the word, teach that you didn't do it right and you have infringed on the rights of others. One is much more expensive than the other one. But we have to pay attention to both.

We can't just not put people in jail or prison—because they have done wrong. That is a lesson to others that they won't like what they might reap from that type of system. But it is expensive and it is going to be an expensive solution, but it will take a generation, maybe even a generation and a half, to change the course of the mindset of a lot of young people that are coming along. Because we have a lot of youth today who are experiencing everyday problems, they see it in the neighborhoods you spoke of, they see it in the families you spoke of, and they are probably going to wind up being taught an education medium from the prison system, rather than from the education system.

But if we don't address this—the young ones, the little ones that are coming along, and focus on their education, focus on their families, focus on the fact that their peers, their role models, their parent or parents—in many places, one parent—is a role model that does attend work, does have some type of skill or a job with no skill. I know a lot of people who don't really have what you say is a skill, but they work every day, they make a living, they provide for their family; and that, in itself, is a teacher to those young ones. It is going to be an expensive process either way.

You mainly focused on just public education, but there are some alternatives to public education out there too; and within the next few days, or the last few days, we had a bill on the floor dealing

with just a little pilot program right here in the District of Columbia, dealing with education. It is worth trying. It may not work, but a lot of things out there are not working today.

So I don't think we just say we are going to do this in public education; I think we ought to look at any type of education program or institution that we can—an education institution, not a prison—for guidance and for help. And we are going to have to pay for it.

It is a pleasure to work with you on the Ways and Means Committee and to listen to you talk. I have said once before, I would love to visit your area, your city, your district; I would also love for you to visit mine.

Thank you, Mr. Chairman.

Mr. RANGEL. We have to do that. I agree with everything you have said. I am not pessimistic that it is going to cost a lot of money. I have found that I have more private sector entrepreneurs that understand what I am saying than politicians, and they know they can't win at that bargaining table if this trend continues; and they also know that the people that are locked up are employable people and that people from the same families and the same communities that manage to discover the excitement of learning don't end up making those mistakes.

In the recently passed bipartisan tax bill, there are provisions that take first steps building in a partnership with the private sector and relieving them of the responsibility for basic training—telephone operators—the companies complain that out of every 100 applicants, they can find only one qualified candidate and they have to train that one. There is no reason why the schools can't do this; there is no reason why the specifications for each and every job—and I am not talking about rocket scientists' jobs, I am talking about work jobs—why that cannot be taught in the schools. Everybody is not going to go to college, and they don't have to go to college; there are jobs they can do, and the schools should be able to at least say, you can do this and get a job. But higher education should be made available, and other options should be there, but no one should have to leave school without having a job available to them in their community.

Mr. COLLINS. And a lot of our youth need to understand, there are a lot of jobs that would be available, but if you get this stamp on the record, it stays with you, and there are jobs that just won't allow you to be employed again.

I have a business in that range. I have a trucking company—transportation, drivers—but if you get on your record any type of drug violation, you are in deep trouble when it comes to trying to find another job driving a truck or in any other area of transportation.

Mr. RANGEL. Except when there is a shortage, and if for some reason there were enough Members of Congress that thought this surplus we are talking about should be dedicated to rebuilding our cities and our roads and our communication system and our transportation system, if somebody really thought that in order to have successful international trade, we have to have successful ports and roads and trains in order to do it; and I can tell you, there will be more job opportunities than we can take, and the guy with the misdemeanor or nonviolent behavior, if he can handle one of those

shovels or one of those trucks, you can bet your life—he can get a break and get back on the road. But, for now, if you can hire an unemployed college kid, why deal with a guy who has these problems?

As a matter of fact, one country is now looking for soldiers, and they are going to the prisons because no one wants to do that kind of work. I really think one of the best investments we can make is rebuilding our country, and creating the jobs to do it.

Anyway, we all have a lot to do, and politics is a big impediment to moving forward a lot of times. But I didn't mean it should just be the public school; all I know is, without the public school, I would not have been here today.

Chairman SHAW. That will be the final word.

Mr. RANGEL. Thank you.

Chairman SHAW. Thank you for taking the time to be with us.

The next panel of witnesses, if you would come to the table, we have Jane Ross, Director of Income Security Issues, U.S. General Accounting Office; Peter Reuter is a Ph.D., School of Public Affairs, University of Maryland, College Park, Maryland; Nicholas Zill, Ph.D., Vice President and Director, Child and Family Study Area, of Westat, Inc., in Rockville, Maryland; Nancy Young, Ph.D., Director of Children and Family Futures in Irvine, California; and Richard Barth, Ph.D., Hutto Patterson Professor, School of Social Welfare at the University of California at Berkeley.

We have each of your full statements, which will be made a part of the record, and we would invite you to proceed as you see fit, and you are welcome to summarize.

Ms. Ross.

## STATEMENT OF JANE L. ROSS, DIRECTOR, INCOME SECURITY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Ms. ROSS. Thank you. Mr. Chairman and Members of the Subcommittee.

Each year nearly 1 million children in this country are victims of abuse and neglect, and parental substance abuse is very often a contributing factor in these cases. Although estimates vary widely, parental substance abuse may be involved in the majority of foster care cases in some locations, and in New York City, about 75 percent of confirmed cases of child abuse and neglect involve substance abuse by at least one parent or care giver. In House bill 867, the Subcommittee indicated its concern about parental substance abuse by directing the Secretary of HHS to recommend to the Congress ways to improve the coordination between substance abuse and child welfare services; and today, in order to pursue your concern further, you ask us to discuss the implications of parental substance abuse for children and for the child welfare system. You also ask us to comment on permanency planning for foster care cases involving parental substance abuse. Let me briefly summarize our findings.

First, let's talk about the children. Parental substance abuse is a problem that brings many children to the attention of the child welfare system. In the case of newborns who are found to have been prenatally exposed to drugs or alcohol, there is often an inves-

tigation to determine if there has been child abuse and neglect. In some States, prenatal substance abuse—excuse me, prenatal substance exposure, by itself, constitutes abuse or neglect and is grounds for removing a child from its parents.

In the case of older children, substance abuse can damage a parent's ability to care for them and can lead to abuse or neglect. When abuse or neglect have been documented, some of the children are removed from the custody of parents and placed in foster care. So that has to do with the children.

Once the child is in the foster care system, parental substance abuse is a significant hurdle in that child's path out of the system. It is a hurdle that requires drug or alcohol treatment for the parent, in addition to other services for the family.

The nature of drug and alcohol addiction means a parent's recovery can take a considerable amount of time. These parents also face problems such as mental illness or homelessness, which further complicate their cases. Foster care cases that involve parental substance abuse, therefore, place an additional strain on the child welfare system, which is already overburdened by the number of foster care cases and their costs. There are currently about a half a million children in foster care and just the Federal cost of foster care is over $3 billion this year.

Child welfare agencies are charged with ensuring that foster care cases are resolved in a timely manner while making reasonable efforts to reunite children with their parents. Ideally, both of these goals can be achieved. However, even for parents who are able to recover from drug or alcohol abuse problems, recovery can be a long process. Child welfare officials who are now trying to speed up the process of making permanency decisions may have difficulty making those decisions before they know whether the parent is likely to succeed in drug treatment. So when parental substance abuse is an issue in a foster care case, it may be difficult to reconcile minimizing time spent in foster care with reunification of children with their parents. Fortunately, some States and localities are testing initiatives that may help reconcile the two goals.

For example, Tennessee has a concurrent planning program that allows caseworkers to work toward reunifying families while, at the same time, developing an alternate permanency plan in case the family reunification efforts don't work. Under a concurrent planning approach, caseworkers emphasize to the parents that if they don't adhere to the requirements set forth, parental rights can be terminated.

Also, the State of Illinois is just beginning a project to coordinate substance abuse treatment for parents with child welfare services for the family.

Finally, there is some early work going on to increase services available to families after reunification. This initiative seems especially important as a complement to efforts to reunify families more quickly.

To sum up, in seeking to achieve what is in the best interest of children, foster care laws emphasize both family reunification and achieving timely exits from foster care. Reconciling the goals for children whose parents have substance abuse problems requires

balancing the rights of the parents with what is truly in the best interest of the children.

Mr. Chairman, that concludes my statement.

[The prepared statement follows:]

**Statement of Jane L. Ross, Director, Income Security Issues, Health, Education, and Human Services Division, U.S. General Accounting Office**

Mr. Chairman and Members of the Subcommittee:

Each year, nearly 1 million children in this country are the victims of abuse and neglect by their parents or other caregivers, and parental substance abuse is very often a contributing factor in these cases. Although estimates vary widely, there is considerable literature that suggests that parental substance abuse is involved in the majority of foster care cases in some locations. It is not surprising, therefore, that the nature and effects of parental substance abuse are of concern to this Subcommittee, particularly in light of the dramatic increase in the foster care population, which was estimated to be almost half a million by the end of 1995.

Because of your concern, you asked us to discuss the implications of parental substance abuse for children and the child welfare system. You also asked us to comment on permanency planning for foster care cases involving parental substance abuse, given the importance of family reunification.

My testimony today is based on our ongoing work for the Senate Committee on Finance and previous work we have done in the child welfare and substance abuse areas. (See Related GAO Products at the end of this statement.) Our ongoing work on the implications of parental substance abuse for foster care primarily consists of reviews of the substance abuse histories and drug treatment experiences of parents, as well as the initiatives that might help achieve timely exits from foster care for cases involving parental substance abuse. Most of the previous work I refer to here involved an extensive review of the case files of representative samples of young foster children—those under 3 years of age—who were in foster care in Los Angeles County, New York City, and Philadelphia County in 1986 and 1991. These locations accounted for a substantial portion of their respective states' population of young foster children in 1991.[1] Furthermore, over 50 percent of the nation's foster children were under the jurisdiction of these three states in that year.

Let me briefly summarize our findings. For many children, it is parental substance abuse that brings them to the attention of the child welfare system. When a newborn has been found to have been prenatally exposed to drugs or alcohol, this often triggers an investigation of suspected child abuse and neglect. In some states, prenatal substance exposure itself constitutes neglect and is grounds for removing a child from its parents. Substance abuse can damage a parent's ability to care for older children as well, and can lead to child abuse or neglect. As a result, some of these children are removed from the custody of their parents and placed in foster care.

Furthermore, once a child is in the system, parental substance abuse is a significant hurdle in their path out of the system—a hurdle that requires drug or alcohol treatment for the parent in addition to other services for the family. The nature of drug and alcohol addiction means a parent's recovery can take a considerable amount of time. Other problems these parents face, such as mental illness and homelessness, further complicate these cases. Foster care cases that involve parental substance abuse, therefore, place an additional strain on a child welfare system already overburdened by the sheer number of foster care cases.

Child welfare agencies are charged with ensuring that foster care cases are resolved in a timely manner and with making reasonable efforts to reunite children with their parents. Ideally, both of these goals are to be achieved. However, even for parents who are able to recover from drug or alcohol abuse problems, recovery can be a long process. Child welfare officials may have difficulties making permanency decisions within shorter time frames before they know whether the parent is likely to succeed in drug treatment. So, when parental substance abuse is an issue in a foster care case, it may be difficult to reconcile these two goals. The foster care initiatives and laws that some states and localities are instituting may help reconcile the goals of family reunification and timely exits from foster care for the cases involving parental substance abuse.

---

[1] In 1991, these locations accounted for 44 percent of young foster children in California; 81 percent of young foster children in New York; and 29 percent of young foster children in Pennsylvania.

## BACKGROUND

The child welfare system encompasses a broad range of activities, including

- child protective services (CPS), which investigates reports of child abuse and neglect;
- services to support and preserve families; and
- foster care for children who cannot live safely at home.

States and localities provide the majority of funds for foster care and child welfare services, but federal funds are provided to states for the food, housing, and incidental expenses of foster children whose parents meet federal eligibility criteria. Federal funding for the administration and maintenance expenses of foster care was estimated at about $3.6 billion in 1997. Additional federal funds are provided to states for a wide range of other child welfare and family preservation and support services, and these were estimated at about $500 million in 1997.

As an integral part of the child welfare system, foster care is designed to ensure the safety and well-being of children whose families are not caring for them adequately. Beyond food and housing, foster care agencies provide services to children and their parents that are intended to address the problems that brought the children into the system. Agencies are also required to develop a permanency plan for foster children to make sure they do not remain in the system longer than necessary. Usually, the initial plan is to work toward returning the children to their parents. If attempts to reunify the family fail, the agency is to develop a plan to place the children in some other safe, permanent living arrangement, such as adoption or guardianship. According to federal statute, the court must hold a permanency planning hearing no later than 18 months after a child enters foster care.[2] Proposed federal legislation would shorten this time frame to 12 months,[3] in the hope of reducing the time a child spends in foster care. Some states have already adopted this shorter time frame.

## PARENTAL SUBSTANCE ABUSE OFTEN BRINGS CHILDREN TO THE ATTENTION OF THE CHILD WELFARE SYSTEM

Children come to the attention of the child welfare system in two ways—either shortly after birth because they were exposed to drugs or alcohol in-utero or sometime later because they have been abused or neglected. Children with substance abusing parents enter foster care in either way.

Many state statutes require that drug- or alcohol-exposed infants be reported, and some of these children are subsequently removed from the custody of their parents if an investigation determines that they have been abused or neglected. In some states, prenatal substance exposure itself constitutes neglect and is grounds for removing children from the custody of their parents. Large numbers of children in foster care are known to have been prenatally substance exposed. In an earlier study, we estimated that close to two-thirds of young foster children in selected locations in 1991 had been prenatally exposed to drugs and alcohol, up from about one-quarter in 1986.

In both years, cocaine was the most prevalent substance that young foster children were known to have been exposed to, and the incidence of this exposure increased from about 17 percent of young foster children in 1986 to 55 percent in 1991. Moreover, among those who had been prenatally exposed who were in foster care in 1991, about one quarter had been exposed to more than one substance. The actual number of young foster children who had been exposed to drugs or alcohol in-utero may have been much higher because we relied on the mother's self-reporting of drug or alcohol use or toxicology test results of the mother or infant to document prenatal exposure. Yet, not all children or mothers are tested at birth for drugs, and even when they are tested, only recent drug or alcohol use can be confirmed.

Older children of substance abusing parents also may enter foster care because they have been abused or neglected as a result of their parents' diminished ability to properly care for them. Abuse and neglect of children of all ages, as reported to CPS agencies, more than doubled from 1.1 million to over 2.9 million between 1980 and 1994, and a Department of Health and Human Services (HHS) report found that the number of CPS cases involving substance abuse can range from 20 to 90 percent, depending on the area of the country. For example, we recently found that about 75 percent of confirmed cases of child abuse and neglect in New York City

[2] 42 U.S.C. 675(5)(C).

[3] Adoption Promotion Act of 1997 (H.R. 867); Promotion of Adoption, Safety, and Support for Abused and Neglected Children (S. 1195).

involved substance abuse by at least one parent or caregiver. Many of these parents live in drug-infested and poor neighborhoods that intensify family problems.

Neglect is most frequently cited as the primary reason children are removed from the custody of their parents and placed in foster care. According to the Office of Child Abuse and Neglect, the children of parents who are substance abusers are often neglected because their parents are physically or psychologically absent while they seek, or are under the influence of, alcohol and other harmful drugs. Sixty-eight percent of young children in foster care in California and New York in 1991 were removed from their parents as a result of neglect or caretaker absence or incapacity. No other reasons for removal accounted for a large portion of entries of young children into foster care. Physical, sexual, and emotional abuse combined accounted for only about 7 percent of removals of these young children.

## PARENTAL SUBSTANCE ABUSE PLACES ADDITIONAL STRAIN ON THE CHILD WELFARE SYSTEM

Parental substance abuse not only adversely affects the well-being of children, it also places additional strain on the child welfare system. The foster care population increased dramatically between 1985 and 1995 and is estimated to have reached about 494,000 by the end of 1995. As a consequence, foster care expenditures have risen dramatically. Between 1985 and 1995, federal foster care expenditures under title IV–E of the Social Security Act increased from $546 million to about $3 billion. We found that a greater portion of foster care expenditures in some locations shifted to the federal government between 1986 and 1991 because much of the growth in the population of young foster children involved poor families who were eligible for federal funding.

Parental substance abuse is involved in a large number of cases. We have previously reported that an estimated 78 percent of young foster children in 1991 in selected locations had at least one parent who was abusing drugs or alcohol. Our recent interviews with child welfare officials in Los Angeles County, California, and Cook County, Illinois, have confirmed that the majority of foster care cases in these counties for children of all ages involve parental substance abuse. Officials in these locations stated not only that cocaine use among parents of foster children is still pervasive but that the use of other highly addictive and debilitating drugs, such as heroin and methamphetamines, appears to be on the rise. In addition, officials confirmed that use of multiple substances is common.

In addition to the large number of foster care cases involving parental substance abuse, the complexities of these family situations place greater demands on the child welfare system. Most of the families of the young foster children in selected locations whose case files we reviewed had additional children in foster care, and at least one parent was absent. About one-third of the families were homeless or lacked a stable residence. Some had at least one parent who had a criminal record or was incarcerated, and in some families domestic violence was a problem. In addition, child welfare officials in Los Angeles and Cook Counties recently told us that dual diagnosis of substance addiction and mental illness is common among foster parents. The National Institute of Mental Health reported in 1990 that most cocaine abusers had at least one serious mental disorder such as schizophrenia, depression, or antisocial personality disorder.

To illustrate the complexities of these cases and the influences the complexities can have on outcomes from foster care, let me describe a case we recently reviewed as part of our ongoing work. This case involves a woman with four children, all of whom were removed from her custody as a result of neglect related to her cocaine abuse. The youngest child entered foster care shortly after his birth. By that time, the three older children had already been removed from their mother's custody. All four of the children were placed with their grandmother. The mother had a long history of cocaine abuse that interfered with her ability to parent. At least two of her four children were known to have been prenatally exposed to cocaine. She also had been convicted of felony drug possession and prostitution, lacked a stable residence, and was unemployed. The father was never located, although it was discovered that he had a criminal record for felony drug possession and sales.

Despite the mother's long history of drug use and related criminal activity, she eventually completed a residential drug treatment program that lasted about 1 year, participated in follow-up drug treatment support groups, and tested clean for over 6 months. In addition, she completed other requirements for family reunification, such as attending parenting and human immunodeficiency virus (HIV) education classes, and she was also able to obtain suitable housing. Although the mother was ultimately reunified with her youngest child, it took a considerable amount of time and an array of social services to resolve this case. The child was returned to his

mother on a trial basis about 18 months after he entered foster care. The child welfare system retained jurisdiction for about another year, during which family maintenance services were provided.

In addition, many foster children have serious health problems, some of which are associated with prenatal substance exposure, which further add to the complexity of addressing the service needs of these families. We found that over half of young foster children in 1991 had serious health problems, and medical research has shown that many of the health problems that these children had, such as fetal alcohol syndrome, developmental delays, and HIV, may have been caused or compounded by prenatal exposure to drugs or alcohol.

Special supportive services and treatment will be needed by many of these children. Early identification of children who are HIV positive is particularly critical because medical advances in identification and treatment can enhance and prolong the lives of these children. Some of these children require foster care either in institutions that can accommodate their medical needs or in foster family homes where the caregivers are specially trained. Reunifying families can also be more difficult because of the additional strains that caring for medically fragile children places on parents, who are at the same time recovering from drug or alcohol addictions.

Some caseworkers find it difficult to manage the high caseloads involving families with increasingly complex service needs. Some states have experienced resource constraints, including problems recruiting and retaining caseworkers, shortages of available foster parents, and difficulties obtaining needed services, such as drug treatment, that are generally outside the control of the child welfare system. Caseworkers are also experiencing difficulties resolving cases. Once children are removed from the custody of their parents, they sometimes remain in foster care for extended periods.

## PARENTAL SUBSTANCE ABUSE ADDS TO THE DIFFICULTY OF MAKING PERMANENCY DECISIONS

The problem of children "languishing" or remaining in foster care for many years has become a great concern to federal and state policymakers. While most children are reunified with their parents, adopted, or placed with a guardian, others remain in foster care, often with relatives, until they age out of the system. The circuitous and burdensome route out of foster care—court hearings and sometimes more than one foster care placement—can take years, be extremely costly, and have serious emotional consequences for children.

Yet, making timely decisions about children exiting foster care can be difficult to reconcile with the time a parent needs to recover from a substance abuse problem. Current federal and state foster care laws emphasize both timely exits from foster care and reunifying children with their parents. However, even for those who are able to recover from drug and alcohol addictions, it can be a difficult process that generally involves periods of relapse as a result of the chronic nature of addiction. Achieving timely exits from foster care may sometimes conflict with the realities of recovering from drug and alcohol addictions. The current emphasis on speeding up permanency decisions will further challenge child welfare agencies.

Current federal law requires that states conduct a permanency planning hearing within 18 months after a child enters foster care to determine whether family reunification should continue to be the goal, or whether some other permanent living arrangement, such as adoption or guardianship, should be pursued. The current emphasis on speeding up permanency hearings reflects concerns about children spending long periods of time in foster care. Pending federal legislation would shorten the time allowed before holding a permanency planning hearing from 18 to 12 months. As of early 1996, 23 states had already enacted shorter time frames for holding a permanency planning hearing than required under federal law. In two of these states, the shorter time frames apply only to younger children. It should be emphasized, however, that while a permanency planning hearing must be held within these specified time frames, the law does not require that a final decision be made at this hearing as to whether family reunification efforts should be continued or terminated.

Some drug treatment administrators and child welfare officials in these same locations believe that shorter time frames might help motivate a parent who abuses drugs to recover. However, expedited time frames[4] may require that permanency

[4] Recently, both California and Illinois enacted expedited time frames for holding a permanency planning hearing within 12 months. In addition, California enacted an even shorter time frame of 6 months for children entering foster care under the age of 3. The changes to Illinois'

decisions be made before it is known whether the parent is likely to succeed in drug treatment. While one prominent national study found that a large proportion of cocaine addicts failed when they attempted to stay off the drug, we previously reported that certain forms of treatment do hold promise. In addition, progress has been made in the treatment of heroin addiction through traditional methadone maintenance programs and experimental treatments. However, even when the parent is engaged in drug treatment, treatment may last up to 1 or 2 years, and recovery is often characterized as a lifelong process with the potential for recurring relapses.

Some drug treatment administrators in Los Angeles and Cook Counties believe that treatment is more likely to succeed if the full range of needs of the mother are addressed, including child care and parenting classes as well as assistance with housing and employment, which help the transition to a drug-free lifestyle. These drug treatment administrators also stressed how important it was for parents who are reunited with their children to receive supportive services to continue their recovery process and help them care for their children.

Determining the potential for an individual's success in drug treatment is extremely difficult given the variety of substances abused, types of treatment and program quality, differences in addiction and readiness for recovery, and definitions of what constitutes "recovery." However, the longer an individual is in treatment, the greater the potential for improved behavior. Some caseworkers in Los Angeles and Cook Counties said that shorter time frames for holding a permanency planning hearing may be appropriate in terms of the foster child's need for a permanent living arrangement. However, they also said that the likelihood of reunifying these children with their parents when permanency decisions must be made earlier may be significantly reduced when substance abuse is involved. In their view, the prospects of reunifying these families may be even worse if the level of services currently provided to them is not enhanced.

In our ongoing work, we have found that states and localities are responding to the need for timely permanency for foster children through programmatic initiatives and changes to permanency laws. Most of these initiatives and changes to permanency laws are very new, so there is little experience to draw upon to determine whether they will help achieve timely exits from foster care for cases involving parental substance abuse. Furthermore, some of these initiatives and changes are controversial and reflect the challenge of balancing the rights of parents with what is in the best interest of the child, within the context of a severely strained child welfare system.

For example, California and Illinois have enacted statutory changes that specifically address permanency for foster care cases involving parental substance abuse. The Illinois legislature recently enacted new grounds for terminating parental rights. Under this statute, a mother who has had two or more infants who were prenatally exposed to drugs or alcohol can be declared an unfit parent if she had been given the opportunity to participate in treatment when the first child was prenatally exposed. California has enacted new statutory grounds for terminating family reunification services if the parent has had a history of "extensive, abusive, and chronic" use of drugs or alcohol and has resisted treatment during the 3-year period before the child entered foster care or has failed or refused to comply with a program of drug or alcohol treatment described in the case plan on at least two prior occasions, even though the programs were available and accessible. While such laws may help judges make permanency decisions when the prospects for a parent's recovery from drug abuse seem particularly poor, these changes are not without controversy. Some caseworkers and dependency court attorneys in Los Angeles and Cook Counties expressed concerns that a judge may closely adhere to the exact language in the statutes without considering the individual situation, and may disregard the extent to which progress has been made toward recovery during the current foster care episode.

States and localities are undertaking programmatic initiatives that may also help to reconcile the goals of family reunification and timely exits from foster care, which may conflict, particularly when parental substance abuse is involved. New permanency options are being explored as are new ways to prevent children from entering foster care in the first place. We previously reported on Tennessee's concurrent planning program that allows caseworkers to work toward reunifying families, while at the same time developing an alternate permanency plan for the child if family reunification efforts do not succeed. Under a concurrent planning approach, caseworkers emphasize to the parents that if they do not adhere to the requirements

---

permanency legislation are currently in effect only in Cook County; they will go into effect throughout the rest of the state beginning January 1, 1998.

set forth in their case plan, parental rights can be terminated. Tennessee officials attributed their achieving quicker exits from foster care for some children in part to parents making more concerted efforts to make the changes needed in order to be reunified with their children.

In addition, both California and Illinois have federal waivers for subsidized guardianship, under which custody is transferred from the child welfare agency to a legal guardian. In Illinois, CPS cases involving prenatally substance exposed infants can be closed by the child welfare agency without removing the child from the mother's custody if the mother can demonstrate sufficient parental capacity and is willing to participate in drug treatment and receive other supportive services.

One jurisdiction is developing an approach to deliver what its officials describe as enriched services to the parent. Illinois' new performance contracting initiative provides an incentive for private agencies to achieve timely foster care exits for children by compensating these agencies on the basis of their maintaining a prescribed caseload per caseworker. This necessitates that an agency find permanent living arrangements for a certain number of children per caseworker per year, or the agency absorbs the cost associated with managing higher caseloads. A component of this initiative is the provision of additional resources for improved case management and aftercare services in order to better facilitate family reunification and reduce the likelihood of reentry. Providing enriched services may make it less likely that judges will rule that the child welfare agency has failed to make reasonable efforts to reunify parents with their children and thereby reduce delays in permanency decision-making.

## OBSERVATIONS

In summary, children with substance abusing parents often come to the attention of the child welfare system either at birth, because of prenatal substance exposure, or later in life when they are found to have been abused or neglected. The families of these children have increasingly complex service needs. Many are dually diagnosed with drug or alcohol addictions and mental illnesses, some are involved in criminal activities, some are homeless, and most have additional children in foster care. Burgeoning foster care caseloads entailing these complex family situations have placed enormous strains on the child welfare system.

In seeking to achieve what is in the best interest of children, foster care laws emphasize both family reunification and achieving timely exits from foster care for children. Given the time it often takes a person to recover from drug and alcohol addictions, and the current emphasis on speeding up permanency decisions for foster children, these goals may conflict. Reconciling these goals for children whose parents have a substance abuse problem presents a tremendous challenge to the entire child welfare system in determining how to balance the rights of parents with what is truly in the best interest of children. New state and local initiatives may help address this challenge. Through our ongoing work, we are continuing to explore the impact of parental substance abuse on foster care, by, for example, examining parents' substance abuse histories and their drug treatment experiences, as well as exploring initiatives that might help achieve timely foster care exits for cases involving parental substance abuse.

Mr. Chairman, this concludes my prepared statement. I would be happy to respond to any questions from you or other Members of the Subcommittee.

## RELATED GAO PRODUCTS

*Child Protective Services: Complex Challenges Require New Strategies* (GAO/HEHS–97–115, July 21, 1997).

*Foster Care: State Efforts to Improve the Permanency Planning Process Show Some Promise* (GAO/HEHS–97–73, May 7, 1997).

*Cocaine Treatment: Early Results From Various Approaches* (GAO/HEHS–96–80, June 7, 1996).

*Child Welfare: Complex Needs Strain Capacity to Provide Services* (GAO/HEHS–95–208, Sept. 26, 1995).

*Foster Care: Health Needs of Many Young Children Are Unknown and Unmet* (GAO/HEHS–95–114, May 26, 1995).

*Foster Care: Parental Drug Abuse Has Alarming Impact on Young Children* (GAO/HEHS–94–89, Apr. 4, 1994).

*Drug Abuse: The Crack Cocaine Epidemic: Health Consequences and Treatment* (GAO/HRD–91–55FS, Jan. 30, 1991).

*Drug-Exposed Infants: A Generation at Risk* (GAO/HRD–90–138, June 28, 1990).

Chairman SHAW. Thank you.
Mr. Reuter.

**STATEMENT OF PETER REUTER, PH.D., SCHOOL OF PUBLIC AFFAIRS AND DEPARTMENT OF CRIMINOLOGY, UNIVERSITY OF MARYLAND, COLLEGE PARK, MARYLAND**

Mr. REUTER. Thank you. I was asked to address the question of whether there are elevated levels of drug use among mothers on welfare. This is very much a presentation about data and estimates.

The first thing to note is there are very few measurements of drug use among AFDC recipients, in part because agencies had, until recently, very little incentive to know anything about the drug substance abuse problems of their clients. Moreover, it is inherently difficult to develop such measures, both for the agencies and in more general settings, because they largely rely on self-report, which has its own frailties as a method of learning about these kinds of behaviors.

Moreover, the figures are likely to change very substantially over time in response to changes in the business cycle. There are periods of high unemployment where the AFDC rolls have on them a large number of short-term clients with very different substance abuse patterns, including drug dependence, than those who are long-term clients.

Moreover, in terms of making comparisons between AFDC and the rest of the population, it is not obvious what is the right comparison group to offer. The AFDC population has a much higher percentage of females than the general population; you certainly would want to adjust for differences in usage by gender. Age is different. There are very low rates of use in the population over the age of 50, very few welfare recipients are over the age of 50.

One might also want to make adjustments for other characteristics that distinguish the AFDC population from that of the general population—for example, education, marital status, and so forth. Once you start making those kinds of adjustments for purposes of doing these kinds of comparisons, you have to ask the question, What is the purpose of the comparison? And if this were a Committee concerned with the Nation's drug problems, the question you might be attempting to answer is, What share of the Nation's drug problems are found in the AFDC population. Then knowing something about relative usage rates, in particular, in the two groups, would in fact be highly relevant.

But if one's concern is, as I believe this Subcommittee's hearing description suggests, a concern about the transition from welfare to employment or reducing child abuse and neglect on the part of AFDC recipients, then the question is less the comparison between AFDC and the rest of the population and simply, What is the rate of substance abuse of various kinds in the AFDC population?

Having said that, there are a few pieces of evidence available. They look very conflicting, but in fact I believe that is largely an artifact of how analysts have gone about defining the problem and, to some extent, the characteristics of the data that they have used.

Consistently, we see higher rates of use or abuse of illicit drugs among AFDC clients than any reasonably defined comparison group in the general population. I think the best analysis of this is a recent study by the Office of Applied Studies of the Substance Abuse and Mental Health Services Administration, which found that, after adjusting for all the things that seemed relevant, the rate of problem use among welfare recipients, female welfare recipients, seemed to be twice as high as that for an appropriate comparison group. That still—and it is hard to do the calculations from what was presented in the report—suggests that problem drug use among that population might well be less than 10 percent.

Another way of looking at this is to go to the other end of the system and ask, What share of those in treatment are themselves recipients of AFDC payments? There are about 250,000 women in treatment, and approximately one-half, I think, are AFDC recipients. One reason we want to be focusing on the back end is that the household surveys I cited before as providing estimates of the prevalence of drug abuse or dependence among AFDC population are known to generally provide substantial underestimates of drug dependence. You might use them for these kinds of comparisons, but they are probably poor ways of getting at the prevalence of substance abuse generally in the AFDC population. So I suggest, looking at treatment program data may be a useful way of supplementing those data.

Finally, let me say this is not a static problem. Patterns of drug use have changed substantially over the last 20 years in this country. The rate of initiation into drug use has been down substantially from its peak rates in the eighties. It shows some sign of upturn now. Thus, it may well be that the figures we are now looking at are reasonable indicators of the next few years, but that further out there will be larger increases in drug use in the AFDC population.

Thank you, Mr. Chairman.

[The prepared statement follows:]

**Statement of Peter Reuter, Ph.D., School of Public Affairs and Department of Criminology, University of Maryland, College Park, Maryland**

SUMMARY

We have been asked to address the question of whether drug use is elevated among mothers on welfare. The answer is almost certainly yes but the bits of data available suggest that the differences are moderate. Looking at the more serious problem, abuse or dependence on illicit drugs is found in only a small percentage of welfare mothers. A figure as high as 15% would be hard to justify and it may be less than 10 percent. Trends in drug use in the general population, suggest that drug dependence within the welfare population is likely to become smaller rather than greater in the next few years.

THE DATA AND ANALYTIC APPROACH

Because welfare agencies did not in the past have to concern themselves with what led their clients to seek AFDC, little data are available on the extent of substance abuse in this population. Certainly agencies themselves claim little knowledge.[3] Instead we have to rely largely on self-report surveys either of the general household population, which include welfare clients, or specifically just of the latter

[3] "Only five states [out of 32] reported having estimates of the number of welfare recipients with alcohol and drug problems." Legal Action Center Making Welfare Reform Work: Tools for Confronting Alcohol and Drug Problems Among Welfare Recipients New York, 1997, p.38.

population. There is also one indirect source, namely data on the extent of AFDC participation by drug treatment clients. None of these is very satisfactory but weaving the three together can provide a moderately credible statistical portrait.

Nor is it easy to decide on the appropriate method of making comparisons of drug use rates among welfare clients and the rest of the population. For example, surveys show that young adults are much more likely than those over 35 to be current drug users; in 1996 3.1 percent of those aged 26–34 reported use of cocaine in the prior year, compared to only 0.8 percent of those 35 or over. Since adult welfare recipients include few elderly, welfare recipients would show higher rates of drug use than the population generally even if they had the same age-specific rates. Hence it is necessary to make adjustments to reflect factors other than welfare status that might affect drug use rates; the appropriate adjustments are very much a matter of the analyst's judgment.

Note also that the relative rate of drug use and abuse in the welfare population is likely to be cyclical. When unemployment is high, AFDC rolls (and presumably TANF rolls in the future) will include large numbers of short-termers whose long-term employment prospects are relatively good. Measured rates of drug dependence among welfare clients may decline, relative to the non-welfare population. Thus the ratio may be highest when enrollment is lowest. We know of no study that has attempted to adjust for this.

Finally, there is the question of what one should employ as a measure of drug use and, more importantly, drug abuse or dependence. Some analysts rely on the frequency of drug use to define dependence or abuse. Other surveys have imbedded in their questionnaire a version of a clinical definition of abuse or dependence. Problematic though the latter are, they are preferable to mere frequency definitions both on conceptual and instrumental grounds; the clinical measures pose questions about less stigmatized behaviors than do those focused on details of drug use.

## ESTIMATES

The most widely cited estimates of the prevalence of drug use among welfare mothers come from two national household surveys. They appear to show large differences but these are principally artifacts of the definitions chosen by analysts.

The Center on Addiction and Substance Abuse (CASA) published a short report in 1994,[4] apparently based on the 1991 National Household Survey on Drug Abuse (NHSDA),[5] asserting that "[m]others receiving AFDC are three times more likely to abuse or be addicted to alcohol and drugs than mothers not receiving AFDC (27 percent compared to 9 percent)" (p.3) It concluded that "[a]t least 1.3 million adult welfare recipients currently abuse or are addicted to drugs and alcohol." (p.7) With fewer than 5 million adult welfare recipients, this is an alarming number.

More recently researchers at the National Institute on Alcohol Abuse and Alcoholism (NIAAA) published an analysis of the 1992 National Longitudinal Alcohol Epidemiologic Survey (NLAES) which concluded that only 3.6% of AFDC recipients over 18 were drug dependent or drug abusers and that 7.6% were alcohol dependent.[6] Moreover the authors concluded that rates for welfare recipients were "comparable to rates of heavy drinking (14.8%), drug use (5.1%), alcohol abuse and/or dependence (7.5%) and drug abuse and/or dependence (1.5%) among the subpopulation of the United States not receiving welfare benefits." (p.1453)

The principal explanation for these differences simply lie in the definitions of drug abuse. The CASA report never explicitly described how it classified an individual as a drug abuser or drug addict but it appears that using an illicit drug at least once per month was sufficient for that diagnosis.[7] In contrast, the NIAAA researchers focused on behavioral problems related to drug or alcohol abuse, which are part of diagnostic instruments.

The CASA estimate seems far too high, particularly when we note that the vast majority of the drug users in the NHSDA consumed only marijuana. A monthly user of marijuana is certainly flouting the law regularly but may not have a serious be-

---

[4] Center on Addiction and Substance Abuse Substance Abuse and Women on Welfare New York, 1994.

[5] The report makes no specific reference to the source of its data; there is however no other data source that would permit precisely the analyses that are reported. A later CASA report Substance Abuse and Federal Entitlement Programs (1995) does refer to the 1991 NHSDA but uses different categorizations in its charts so that it is impossible to determine if the analyses are the same in the two documents.

[6] Grant, B. and D. Dawson "Alcohol and Drug Use, Abuse and Dependence among Welfare Recipients" American J. Public Health 86 1450–1454.

[7] This is the definition used in the later publication Substance Abuse and Federal Entitlement Programs.

havioral health problem with important adverse consequences either for the mother or family. A more sophisticated analysis of the 1994 and 1995 NHSDA shows that, adjusting for a number of demographic and family characteristics, a woman on welfare is almost twice as likely as those not on welfare to be classified as a problem drug user.[8] However, this suggests a rate for welfare women of less than 10 percent perhaps even much less.[9]

That is not to say that rates as low as those reported by the NLAES or NHSDA should be accepted at face value. These nationwide household surveys are known to underestimate the prevalence of drug abuse and dependence. For example, in recent years the NHSDA has produced estimates of the total number of frequent cocaine users of about 700,000;[10] yet other estimates, reflecting the results of urinalysis of arrestees, generate estimates of about double that figure.[11] Heroin dependence, estimated to affect about 600,000 persons,[12] cannot be determined from the NHSDA, mostly because of the instability of the lifestyles of heroin addicts. It would be naive to rely solely on these general population surveys for estimates of the extent of drug use and abuse among AFDC recipients.

Many factors contribute to the weakness of these surveys in estimating the number of frequent users. First, many cocaine and heroin abusers are found outside of households, whether they are homeless, incarcerated or otherwise institutionalized. Though 98 percent of all Americans live in households, these other settings may contain a substantial share of the tiny fraction that have drug abuse problems. For example, if there are 4 million persons outside the houshold population and 15% of them are drug dependent, not an unreasonable figure, then this 600,000 would constitute nearly 10% of the estimated number of drug dependent individuals and probably a much larger share of those dependent on cocaine or heroin. Second, drug abusers are probably harder to reach when they are in households; they are less likely to be there and available to respond at a specific time. Third, they are less likely to report the full extent of their drug use.

An alternative approach has been to obtain data directly from samples of AFDC clients. The Alcohol Research Group at the University of California, Berkeley has been conducting research on a variety of public program settings in Northern California. They published initial results in 1993, reflecting data collection carried out between 1986 and 1989.[13] They found that 21 percent of welfare clients were multiple drug users, on a past year basis. In a general population survey in the same geographic area, they found only 1 percent using more than one illicit drug.[14] That is an alarmingly large difference, suggesting that welfare recipients are twenty times more likely to use drugs other than marijuana. However the results should be treated with considerable skepticism because the rate in the general population sample is so far below that found in national household surveys; the 1988 NHSDA data for example suggests that about 5 percent had used more than one illicit drug in the previous year.[15]

Another more speculative approach to estimation starts at the other end of the process, namely with drug treatment. A large share of the 250,000 women reported by state officials as being in drug treatment programs[16] are welfare recipients. With a number of assumptions of varying plausibility about the probability that a woman

---

[8] Department of Health and Human Services Substance Use Among Women in the United States 1997. Table 3.10. Problem drug use is defined as: dependent on an illicit drug (using DSM–IV criteria); injection drug use; frequent user of illicit drug (e.g. weekly user of cocaine or daily user of marijuana); used heroin or received treatment in the previous year. Factors used to calculate the relative odds ratio include: age, race, marital status, education and family size. The relative odds ratio of 1.92 is statistically significantly different from 1 at the 5 percent level.

[9] The report does not present adjusted figures for the non-welfare population. Note however that for women aged 18–24 the unadjusted rate for problem drug use is 4.3% and falls sharply after that.

[10] Department of Health and Human Services National Household Survey on Drug Abuse: Population Estimates Rockville, Md. 1996. The cited figure is for weekly users.

[11] These estimates are cited in the annual National Drug Control Strategy.

[12] Rhodes et al. What America's Drug Users Spend on Illicit Drugs 1988–1993 Washington, Office of National Drug Control Policy, 1995.

[13] Weisner, C and L. Schmidt "Alcohol and Drug Problems among Diverse Health and Social Service Populations" American J. Public Health 83 824–829.

[14] The results for the welfare population are adjusted to represent the age, sex and ethnic distributions in the general population.

[15] The 1988 NHSDA reported that 7.5% of the household population used some drug other than marijuana in the previous year. Other survey data suggest that most users of cocaine, heroin and other "harder" drugs contemporaneously use marijuana; if two thirds used marijuana, that would suggest a household multiple drug use rate of at least 5 percent.

[16] National Association of State Alcohol and Drug Abuse Directors State Resources and Services Related to Alcohol and Other Drug Problems1993 Washington, DC 1995.

who is drug dependent will enter treatment, it is possible to develop rough estimates of how many adult female welfare recipients are currently drug dependent. We report here just some initial indicative calculations.

A study of the patient population of California's drug and alcohol treatment programs in 1991–92 reports that 41 percent of female patients had received welfare payments in the year before treatment.[17] A survey of 17 treatment programs recently reported by the Legal Action Center reports that 56% of female clients are AFDC recipients.[18] If indeed half of the clients are welfare recipients and there are 4 million women over the age of 18 receiving welfare, then approximately 3% of any year's welfare recipient population would be classified as problem drug users under the NHSDA definition for that reason alone. Given that treatment is thought to reach only about one quarter of those most in need, that would suggest a figure closer to 10 percent for drug dependence among female adult welfare clients.

Given all these uncertainties, we suggest that it is likely that the rate of dependence on illicit drugs among AFDC mothers in recent years has been between 5 and 10 percent. Improving these estimates ought to have some urgency as the nation moves to a welfare system aimed at getting clients into work.

## THE FUTURE OF DRUG ABUSE AMONG WELFARE RECIPIENTS

The issue for welfare reform is only partly drug use levels among current recipients. Welfare reform is a policy change for the long haul and should reflect the prevalence of drug use likely to be found in new applicants for TANF.

Drug use patterns among the welfare population reflects those in the general population. Despite rising adolescent marijuana use, the available evidence suggests that drug dependence among future cohorts of young adults is likely to decline for a few years. Indeed, cocaine initiation rates have been low for the last decade in the highest risk population groups. For example, the District of Columbia Pretrial Services Agency (PSA) has conducted drug tests on all juvenile arrestees since 1987; it is the only agency in the nation that does so. Marijuana positive rates have skyrocketed, from less than 10 percent in 1990 to 72 percent in 1997. However for all other drugs the rates for drug positives among juvenile arrestees have been extremely low since 1990. Whereas in 1988 about 23 percent of juvenile arrestees tested positive for cocaine the rates since 1990 have never been higher than 9 percent and frequently less than 5 percent. Similar declines in rates of cocaine use have been reported among juvenile arrestees in other cities.[19]

In the general population, as reported in the NHSDA, cocaine initiation rates, i.e. the number who start use of that drug in each year, have been relatively low for some time, reflecting the sharp increase in the perception of the drug's dangerousness. In 1984 an estimated 1.35 million persons used cocaine for the first time; that figure was down to 650,000 in 1995. However it has risen sharply from its floor of 450,000 in 1992. Moreover, initiation rates have increased most rapidly for the youngest age group tracked, 12–17; whereas in 1991 only 4.6 percent of 12–17 year olds who had not previously tried cocaine experimented for the first time, the figure had risen to 10.6 percent in 1995.[20]

It is difficult then to make projections as to the future patterns of drug use among welfare mothers. General population initiation rates are still very much below their 1980s peaks. However, recent trends do suggest that there may be at least a modest upturn in both use and abuse rates. It is unlikely though that this will lead to any notable increase in drug dependence rates in the near future.

Peter Reuter[21]
Patricia Ebener[22]

---

[17] Gerstein, D. et al. Alcohol and Other Drug Treatment for Parents and Welfare Recipients: Outcomes, Costs and Benefits Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 1997. The report is not specific as to the definition of a welfare recipient, so this figure may include some who receive General Assistance.

[18] Legal Action Center Making Welfare Reform Work: Tools for Confronting Alcohol and Drug Problems Among Welfare Recipients New York, 1997.

[19] See "Drop in Homicide Rates Linked to Decline in Crack Epidemic" New York Times October 27, 1997, p.A12.

[20] Department of Health and Human Services Preliminary Results from the 1996 National Household Survey on Drug Abuse Substance Abuse and Mental Health Services Administration, 1997.

[21] School of Public Affairs, Department of Criminology, University of Maryland. Mr. Reuter delivered his testimony at the Committee hearing on October 28, 1997.

[22] Drug Policy Research Center, RAND Corporation.

Chairman SHAW. Thank You.
Mr. Zill.

**STATEMENT OF NICHOLAS ZILL, PH.D., VICE PRESIDENT AND DIRECTOR, CHILD AND FAMILY STUDY AREA, WESTAT, INC., ROCKVILLE, MARYLAND**

Mr. ZILL. Good afternoon, Chairman Shaw and Members of the Human Resources Subcommittee. My name is Nicholas Zill. I am a research psychologist and director of the Child and Family Study Area at Westat, a survey research firm here in the Washington area. As part of my work at Westat and an earlier position as the executive director of Child Trends, I have done a good deal of research on the characteristics of welfare families and the development and well-being of children in those families and in low-income families that are not receiving welfare.

Chairman Shaw invited me here today to share with you what this research has shown about the frequency of parental substance abuse in welfare families and to comment on what the implications of such abuse might be for the children in these families and for efforts to move parents off welfare and into steady jobs.

The data I report to you come from two Federal surveys. One is the National Household Survey on Drug Abuse, conducted regularly by the Substance Abuse and Mental Health Services Administration; the other is the National Pregnancy and Health Survey that Westat conducted for the National Institute on Drug Abuse. This was a survey of 2,612 women who gave birth during a 12-month interval in 1992 and 1993. The women were located and interviewed in a probability sample of maternity hospitals across the United States.

What both of these surveys showed was the use of illicit drugs, such as cocaine, heroin, and marijuana, is significantly more common among female welfare recipients than among the general population of American women. The Household Survey found illegal drug abuse to be twice as common among female welfare recipients as among women who did not receive welfare. The hospital survey found illicit drug use during pregnancy was three times more common among women receiving AFDC than among those not receiving AFDC. Cocaine use during pregnancy, usually in the form of crack, was 10 times higher among pregnant welfare recipients than among nonrecipients.

The majority of women who, during pregnancy, used cocaine were on welfare. At the same time, it is important to note it was only a minority of welfare recipients who used prohibited drugs. Of all female welfare recipients, about one in five used some illegal drugs during the last year; of female recipients who were expecting, about one in seven used some unlawful drug, and about one in twenty used crack or cocaine during their pregnancies. These proportions are disquieting enough, but we must be careful not to characterize all or even most AFDC recipients as drug abusers.

It is also the case, women in low-income families who did not receive AFDC used some drugs with almost the same frequency as

welfare mothers; thus, the phenomenon we are addressing could be characterized as a poverty problem as much as a welfare problem.

Are young children whose mothers use illicit drugs, and crack in particular, at greater risk of health and learning problems than children whose mothers are not chronic drug users? We know expectant mothers who use cocaine are more likely to produce low-birth-weight babies and babies who die during infancy. Some researchers believe they are also more likely to produce babies who grow up to have neurological disorders and learning disabilities, although the long-term effects of prenatal crack exposure on children's development are still being studied and debated.

Common sense suggests a woman who is not able to give up cocaine in order to protect the health of an unborn child in her womb is likely to neglect other aspects of the child's care as well, both during pregnancy and after the child's birth. There are lots of data to support this supposition. The National Pregnancy and Health Survey found, compared to expectant mothers not on welfare, women in welfare families who became pregnant were 2½ times more likely to get prenatal care late or not at all. They were 60 percent more likely to gain inadequate amounts of weight during pregnancy, and twice as likely to have a pregnancy too soon after the birth of a previous child for optimum development of either. These other neglectful behaviors were correlated with maternal drug use.

Another Federal study, the National Maternal and Infant Health Survey, found that infants from a welfare family were two-thirds more likely to die during the first year of life as infants from nonpoor families. An epidemiological study in North Carolina found that young children in welfare families had significantly higher rates of death due to unintentional injuries than those in nonwelfare families. Furthermore, the National Health Interview Survey has found school-aged children from welfare families have significantly higher rates of grade repetition, classroom conduct problems, and special education placements than their classmates from nonpoor families. It is unlikely these negative outcomes for welfare children are solely due to maternal drug use. Factors like low maternal IQ, poverty, and low maternal education are also important, but there are clearly negative consequences for children when their mothers engage in persistent patterns of detrimental health-related behavior. Chronic drug use is often part of such a high-risk behavior pattern.

To close my testimony, I would like to leave the survey data and turn to the question of whether welfare recipients who are drug abusers should be treated differently from other recipients with respect to being required to find jobs and being subject to time limits on their receipt of cash assistance. Should they, for example, be allowed to continue receiving welfare until they have been successfully treated for their substance abuse problems? I would argue they should not.

Treatment of chronic substance abuse is a difficult and often frustrating process. Successful outcomes are associated with the abuser becoming fed up with their own self-destructive behavior and being ready to change. Being given a guarantee of continued welfare support does not increase motivation to change; it reduces

it. Although it seems like the humane thing to do, it is not wise. It is also bad for the many welfare recipients who are not drug abusers to have temporary assistance to needy families linked in the public mind with subsidized addiction.

I am going to conclude my testimony there. I have a little more I had to say about that, but I would request my extended statement and accompanying data tables be inserted into the record; they provide fuller documentation of the survey findings I have presented.

Thank you.

Mr. SHAW. It shall be, Dr. Zill.

[The prepared statement and attachments follow:]

**Statement of Nicholas Zill, Ph.D., Vice President and Director, Child and Family Study Area, Westat, Inc., Rockville, Maryland**

Good afternoon, Chairman Shaw and Members of the Human Resources Subcommittee. My name is Nicholas Zill. I am a research psychologist and the Director of the Child and Family Study Area at Westat, a survey research firm based in the Washington area. As part of my work at Westat and in an earlier position as the Executive Director of Child Trends, I have done a good deal of research on the characteristics of welfare families and the development and well-being of children in those families and in low-income families that are not receiving welfare. This research was partly supported by contracts from federal agencies, such as the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services, and partly by grants from private foundations. Chairman Shaw invited me here today to share with you what this research has shown about the frequency of parental substance abuse in welfare families and to comment on what the implications of such abuse might be for the children in these families and for efforts to move parents off welfare and into steady jobs.

The data I report to you come from two federal surveys. One is the National Household Survey on Drug Abuse conducted regularly by the Substance Abuse and Mental Health Services Administration (SAMSHA). This is a survey of the civilian population aged 12 years of age and older living in households in the United States. The other is the National Pregnancy and Health Survey that Westat conducted for the National Institute on Drug Abuse. This was a survey of 2,612 women who gave birth during a 12-month interval in 1992–93. The women were located and interviewed in a probability sample of maternity hospitals across the U.S.

What both of these surveys showed was that the use of illicit drugs such as cocaine, heroin, and marijuana is significantly more common among female welfare recipients than among the general population of American women. The household survey found illegal drug use to be twice as common among female welfare recipients as among women who did not receive welfare. The hospital survey found that illicit drug use during pregnancy was three times more common among women receiving Aid to Families With Dependent Children than among those not receiving AFDC. Cocaine use during pregnancy (usually in the form of "crack") was ten times higher among pregnant welfare recipients than among non-recipients.

At the same time, it is important to note that it was only a minority of welfare recipients who used prohibited drugs. Of all female welfare recipients, about one in five used some illegal drugs during the last year. Of female recipients who were expecting, about one in seven used unlawful drugs, and about one in twenty used crack or cocaine during their pregnancies. These proportions are disquieting enough, but we should be careful not to characterize all or even most AFDC recipients as drug abusers. It is also the case that women in low-income families who did not receive AFDC used some drugs with almost the same frequency as welfare mothers. Thus, the phenomenon we are addressing could be characterized as a poverty problem as much as a welfare problem.

Are young children whose mothers use illicit drugs, and crack in particular, at greater risk of health and learning problems than children whose mothers are not chronic drug users? We know that expectant mothers who use cocaine are more likely to produce low birth weight babies and babies who die during infancy. Some researchers believe they are also more likely to produce babies who grow up to have neurological disorders and learning disabilities, although the long-term effects of prenatal crack exposure on children's development are still being studied and debated.

Common sense suggests that a woman who is not able to give up cocaine in order to protect the health of an unborn child in her womb is likely to neglect other aspects of the child's care as well, both during pregnancy and after the child's birth. There are lots of data to support this supposition. For example, the National Pregnancy and Health Survey found that, compared to expectant mothers not on welfare, women in welfare families who became pregnant were two-and-a-half times more likely to get prenatal care late or not at all. They were 60 percent more likely to gain inadequate amounts of weight during pregnancy, and twice as likely to have a pregnancy too soon after the birth of a previous child for optimum development of either. These other neglectful behaviors were correlated with maternal drug use.

Another federal study, the National Maternal and Infant Health Survey, found that infants from welfare families were two-thirds more likely to die during the first year of life as infants from non-poor families. An epidemiological study in North Carolina found that young children in welfare families had significantly higher rates of death due to unintentional injuries than those in non-welfare families. The National Health Interview Survey has found that school-aged children from welfare families have significantly higher rates of grade repetition, classroom conduct problems, and special education placements than their classmates from non-poor families. It is unlikely that these negative outcomes for welfare children are solely due to maternal drug use. Factors like low maternal IQ, poverty, and low maternal education are also important, perhaps more important. But there are clearly negative consequences for children when their mothers engage in a persistent pattern of detrimental health-related behavior. Chronic drug use is often part of such a high-risk behavior pattern.

To close my testimony, I would like to leave the survey data and turn to the question of whether welfare recipients who are drug abusers should be treated differently from other recipients with respect to being required to find jobs and being subject to time limits on their receipt of cash assistance. Should they, for example, be allowed to continue receiving welfare until they have been successfully treated for their substance abuse problems? I would argue that they should not. Treatment of chronic substance abuse is a difficult and often frustrating process. Successful outcomes are associated with the abuser becoming fed up with her own self-destructive behavior and being ready to change. Being given a guarantee of continued welfare support does not increase motivation to change, it reduces it. Although it seems like a humane thing to do, it is not wise. It is also bad for the many welfare recipients who are not drug abusers to have Temporary Assistance to Needy Families (TANF) linked in the public mind with subsidized addiction.

Certainly, TANF should provide treatment programs for recipients who have drug problems. But treatment should occur in parallel with preparation for work and transitional employment, not prior to it. There are plenty of examples outside of the welfare world of people with substance abuse problems who are able to hold down jobs. Like other recipients, those with substance abuse problems should be subject to time limits on their receipt of cash assistance. It may be necessary to provide employers with extra inducements to take on welfare recipients who are drug abusers, because drug abusers often steal to support their habits. The whole process is not going to be easy. There are going to be painful failures. But this kind of approach is still preferable to one which provides no incentive for overcoming drug dependence.

That concludes my testimony. I would request that my extended statement and accompanying data tables be entered into the record. They provide fuller documentation of the survey findings I have presented. Thank you.

**Supplementary Statement by Nicholas Zill, Ph.D., Westat, Inc.**

According to the National Household Survey on Drug Abuse (NHSDA) conducted by the Substance Abuse and Mental Health Services Administration (SAMSHA), the use of illicit drugs such as marijuana, cocaine, and heroin is more prevalent among welfare recipients than in the general population (Colliver and Quinn, 1994). Specifically:

- Among females aged 15 and over living in households where AFDC benefits were received, 21 percent reported some illicit drug use in the last year, and 10.5 percent reported use in the last month. These rates were twice as high as those for females in non-AFDC households. (Table 1).
- The illicit drug most commonly abused by welfare recipients is marijuana, with 16 percent reporting use of this drug in the last year. This is double the rate of use among females not in welfare households.
- Cocaine abuse is also common, usually in the form of crack, with 5.5 percent of females in welfare households reporting cocaine use in the last year. This is nearly triple the rate of use among non-welfare females.
- Non-medical use of psychotherapeutic drugs such as tranquilizers, stimulants, or barbiturates in the past year is reported by 6.9 percent of welfare females.
- Daily alcohol use is no more common among welfare recipients than among other females. But binge drinking—having five or more drinks one or more times in the past 30 days—is reported by 12.5 percent of females in welfare households, nearly sixty percent higher than the rate among females from non-welfare households.

Illicit drug use is more common among some AFDC subgroups than among others. In particular:

- Nearly 30 percent of welfare mothers who have never married have used illicit drugs in the past year. This drug use rate is more than three times higher than the rate among welfare mothers who are currently married. Welfare recipients who are divorced or separated fall in between, with 19 percent having used some illegal drug in the past year. (Table 2).
- Drug use is more common among welfare mothers who are looking for work than among those currently employed full-time or not in the labor force.
- Drug use is more common among welfare recipients in their teens or twenties than among those in their thirties or forties.
- Drug use is more common among white non-Hispanic or black non-Hispanic recipients than among Hispanic recipients.
- Drug use is less common among female recipients who are high school graduates (but no more) than among those who have not finished high school or those who have some postsecondary schooling.

It is important to note that the above estimates are based on self-reported drug use by welfare recipients and other survey respondents. Self-reports of drug use have to be interpreted with caution, even when they come from surveys like the NHSDA that go to extra lengths to assure respondents of anonymity and that no negative consequences will occur to them from acknowledging use of illegal substances. Methodological studies in which chemical testing or other methods are used to validate self-reports of drug use have found underreporting to be common, and more so in some groups than in others. Questions that ask whether the person has ever used illegal drugs or used them in the last year tend to produce more complete self-identification of drug use than questions dealing with current use (use in last month or week). Based on findings to date, we can be fairly confident that drug abuse is more common among welfare recipients, but less confident about the exact extent of use.

ILLICIT DRUG USE DURING PREGNANCY

Expectant mothers who use cocaine or other illicit drugs during their pregnancies are more likely to produce low birth weight babies, babies who die during infancy, and babies who grow up to have neurological disorders and learning disabilities. The National Pregnancy and Health Survey found that among women who were receiving AFDC and gave birth during 1992–93, more than 13 percent reported using some illicit drug during their pregnancies. This was more than three times the rate of illicit drug use among expectant mothers who were not receiving AFDC, which was about 4 percent (Table 3).

The study found that more than 5 percent of the expectant mothers receiving AFDC reported cocaine use (usually in the form of "crack") during their pregnancies. This was ten times higher than the cocaine use rate (0.5 percent) among expectant mothers not receiving AFDC. Sixty percent of all the pregnancies in which cocaine

use was involved were to women receiving AFDC, whereas these women represented less than 13 percent of all pregnancies during the study period.

Expectant mothers on welfare appeared to be more likely than nonwelfare mothers to have smoked marijuana—6 percent versus 3 percent—or made nonmedical use of psychotherapeutic drugs, such as tranquilizers or antidepressants—3 percent versus 1 percent. However, the differences involved were not large enough to be statistically significant. A small proportion of expectant mothers on welfare (1.6 percent) reported using methamphetamine, inhalants, or hallucinogens during their pregnancies. Although this rate appeared to be 3 times higher than the rate among nonwelfare mothers (0.5%), and more than twice as high as the overall rate of use among expectant mothers (0.6%), these differences were also not statistically reliable. The proportion reporting use of heroin or methadone was much lower (less than 0.1 percent) and not different from the overall rate or the rate for nonwelfare mothers (both of which were 0.2 percent).

The study also found that welfare mothers were twice as likely as non-welfare recipient mothers to have smoked cigarettes during their pregnancies—37 percent versus 18 percent. On the other hand, there was no significant difference in the reported use of alcohol during pregnancy—21 percent and 19 percent (Table 3).

The illicit drug use rate among all women living in AFDC households who gave birth during the study period was more than 11 percent. (The group included here includes teenage daughters or other female relatives who gave birth during the study period, as well as the welfare recipients themselves.) This was more than three times higher than the 3 percent rate of illicit drug use among expectant mothers from nonpoor, nonwelfare households, and twice as high as the rate among all expectant mothers, which was 5-and-a-half percent. It also appeared higher than the rate found among women in poor, nonwelfare households (8 percent). However, the latter difference was not statistically reliable (Table 4).

With regard to use of specific types of drugs, cocaine use and use of methamphetamine, inhalants, or hallucinogens seemed to be higher among welfare mothers than among nonwelfare poor mothers. Again, however, the differences involved were not statistically significant. Rates of marijuana use, nonmedical use of psychotherapeutic drugs, and heroin or methadone use were similar in the two low-income groups (Table 4).

## REFERENCES

Coiro, M.J., Zill, N., & Bloom, B. (1994). Health of our nation's children. National Center for Health Statistics. Vital and Health Statistics 10. Washington, DC: U.S. Government Printing Office.

Colliver, J., & Quinn, E. (1994) Patterns of substance use and program participation. Report prepared for the Office of the Assistant Secretary for Planning and Evaluation and the National Institute on Drug Abuse, U.S. Department of Health and Human Services, Washington, DC.

Nelson, M.D., Jr. (1982). Socioeconomic status and childhood mortality in North Carolina. American Journal of Public Health. 1131–3 (August).

Zill, N., Moore, K.A., Nord, C.W., and Stief, T. (1991). Welfare mothers as potential employees: a statistical profile based on national survey data. Washington DC: Child Trends, Inc.

Zill, N., Moore, K.A., Smith, C.W., Stief, T., and Coiro, M.J. (1995). The life circumstances and development of children in welfare families: a profile based on national survey data. In: Chase-Lansdale, P.L., & Brooks-Gunn, J., editors. Escape from poverty: What makes a difference for poor children? New York: Cambridge University Press.

Zill, N. (1996). What we know about welfare families and what it means for welfare reform. Report prepared for the American Enterprise Institute. Rockville, MD: Westat, Inc.

Table 1. Prevalence of Reported Illicit Drug and Alcohol Use Among Females Aged 15 and Over Who Live in AFDC Recipient Households, Compared To Use by Females in Nonrecipient Households, United States, 1991

| | Females in: | | |
|---|---|---|---|
| | AFDC recipient households | Nonrecipient households | Recipients' use rate as percentage of nonrecipients' use |
| *Type of drug or alcohol use:* | | | |
| Any illicit drug use in past year | 21.1% | 10.6% | 200% |
| Marijuana use | 16.2% | 7.2% | 227% |
| Cocaine use | 5.5% | 1.9% | 285% |
| Nonmedical use of psychotherapeutic drugs | 6.9% | 4.5% | 154% |
| Daily alcohol use in past year | 6.6% | 5.4% | 122% ns |
| Binge drinking in last month | 12.5% | 8.0% | 157% |

Note: Difference between recipients and nonrecipients is statistically reliable unless indicted by "ns."

Source: Author's retabulation of data from Colliver, J., & Quinn, E. (December 1994). Patterns of Substance Use and Program Participation. Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation and National Institute on Drug Abuse.

Table 2. Prevalence of Reported Illicit Drug Use Among Female AFDC Recipients by Marital Status, Age, Race and Ethnicity, Educational Attainment, and Employment Status, United States, 1991

| | Percentage of AFDC Recipients | Rate of illicit drug use in last year |
|---|---|---|
| All female AFDC recipients aged 15 and over | 100% | 21.1% |
| *Marital status:* | | |
| Never married | 44% | 29.8% |
| Separated or divorced | 32% | 19.3% |
| Currently married | 20% | 8.2% |
| Widowed | 4% | —— |
| *Age group:* | | |
| 15–19 years old | 14% | 30.2% |
| 20–25 years old | 22% | 31.6% |
| 26–30 years old | 17% | 31.2% |
| 31–35 years old | 14% | 20.5% |
| 36–40 years old | 12% | —— |
| Over 40 years old | 21% | 4.3% |
| *Race/ethnicity:* | | |
| White (non-Hispanic) | 45% | 22.5% |
| Black (non-Hispanic) | 36% | 23.4% |
| Hispanic | 14% | 12.5% |
| Other | 5% | —— |
| *Educational attainment:* * | | |
| Less than high school | 45% | 22.4% |
| High school graduate | 37% | 17.4% |
| Some postsecondary schooling | 18% | 23.3% |
| *Employment status:* * | | |
| Employed full time | 14% | 17.8% |
| Employed part time | 11% | —— |
| Looking for work | 22% | 29.6% |
| Not in labor force | 53% | 18.1% |

—— Subsample too small for stable estimate.

* Recipients aged 18 and over only.

Source: Author's retabulation of data form Colliver, J., & Quinn, E. December 1994). Patterns of Substance Use and Program Participation. Washington, DC: U.S. Department of Health and human Services, Office of the Assistant Secretary for Planning and Evaluaiton and National Institute on Drug Abuse.

Table 3. Illicit Drug, Cigarette, and Alcohol Use During Pregnancy by Women Receiving and Not Receiving AFDC During 12 Months Prior to Birth of Child, United States, 1992–93

| | Women giving birth during 12-month study period | | | Recipients' use rate as percentage of nonrecipients' rate | Percentage of all drug-involved mothers who were receiving AFDC |
|---|---|---|---|---|---|
| | Women currently receiving AFDC | Women not receiving AFDC | All women giving birth during period | | |
| *During pregnancy mother used:* | | | | | |
| Any illicit drug | 13.3% * | 4.4% | 5.5% | 304% | 30% |
| —Cocaine | 5.3% * | 0.5% | 1.1% | 1,019% | 60% |
| —Marijuana | 5.8% | 2.5% | 3.0% | 229% | 25% |
| —Nonmedical use of psychotherapeutic drug | 3.3% + | 1.3% | 1.5% | 259% | 27% |
| —Methamphetamine, inhalants, or hallucinogens | 0.6% | 0.5% | 0.6% | 339% | 33% |
| —Heroine or methadone | <0.1% | 0.2% | 0.2% | ..... | ..... |
| Cigarettes | 37.4% * | 17.9% | 20.4% | 208% | 23% |
| Alcohol | 20.6% | 18.6% | 18.8% | 111% | 14% |
| Unweighted sample size | 361 | 2,251 | 2,612 | ..... | ..... |
| Estimated number in population | 506,17 | 3,515,319 | 4,021,494 | ..... | ..... |
| Weighted percentage | 12.6% | 87.4% | 100.0% | | |

* Significantly different from use rate of nonrecipients, p<.05
+ Significantly different from use rate of nonrecipients, p<.10
Source: Zill, N., and Loomis, L. Analysis of unpublished data from the National Pregnancy and Health Survey, National Institute on Drug Abuse, 1992–93. Westat, Inc., 1995.

Table 4. Illicit Drug, Cigarette, and Alcohol Use During Pregnancy by Women from AFDC Households, Poor Non-AFDC Households, and Nonpoor Households, United States, 1992–93

| | Women giving birth during 12-month study period | | | |
|---|---|---|---|---|
| | Women in households receiving AFDC | Women in poor non-AFDC households | Women in nonpoor, non-AFDC households | All women giving birth |
| *During pregnancy mother used:* | | | | |
| Any illicit drug | 11.4% | 8.1% | 3.4% | 5.5% |
| —Cocaine | 3.8% | 0.9% | 0.5% | 1.1% |
| —Marijuana | 5.6% | 5.7% | 1.6% | 3.0% |
| —Nonmedical use of psychotherapeutic drug | 2.8% | 2.5% | 1.0% | 1.5% |
| —Methamphetamine, inhalants, or hallucinogens | 1.1% | 0.4% | 0.5% | 0.6% |
| —Heroine or methadone | 0.2% | 0.2% | 0.1% | 0.2% |
| Cigarettes | 32.6% | 25.4% | 16.0% | 20.4% |
| Alcohol | 18.2% | 10.9% | 20.9% | 18.8% |
| Unweighted sample size | 486 | 416 | 1,710 | 2,612 |
| Estimated number in population | 698,047 | 634,037 | 2,689,410 | 4,021,494 |
| Weighted percentage | 17.4% | 15.8% | 66.9% | 100.0% |

Source: Zill, N., and Loomis, L. Analysis of unpublished data from the National Pregnancy and Health Survey, National Institute on Drug Abuse, 1992–93. Westat, Inc., 1995.

## STATEMENT OF NANCY K. YOUNG, PH.D., DIRECTOR, CHILDREN AND FAMILY FUTURES, IRVINE, CALIFORNIA

Ms. YOUNG. Good afternoon. I am here today as a policy researcher, as an adviser to several States and communities and also as an adoptive parent of two children, whose lives embody this problem, families affected by alcohol and other drugs.

At the most important moment in the life of our children's birth mother, the moment when she had been told she was going to lose custody of her children, she said, I want help, I will do anything to get them back. Unfortunately, the answer which the child welfare system gave to her was, Call me next week; I will give you a list of phone numbers for treatment, but I don't have access to help you get into the program and I don't know if they have any vacancies. My testimony today is in hopes you will do all you can to provide a better answer to the hundreds of thousands of parents who find themselves in that position.

Many, not all, but many of those parents are ready to do what they need to do to end their abuse of alcohol and other drugs. But the response they get from the three systems that are funded separately—welfare, child welfare, and substance abuse treatment—is utterly inadequate, because those systems usually don't talk to parents in a unified way and often don't have the language to talk to each other.

My message today includes three essential points. First, these systems typically do not work together despite the fact that the vast majority of the families entering the child welfare system have substance abuse problems.

A basic first step has to be collecting better information on these overlaps. We need the provision in H.R. 867, the Adoption Promotion Act, which requires the Secretary of HHS to look at the substance abuse needs among the welfare system.

Second, focusing services and supports on children of substance abusers assures the children most at risk that the next generation of substance abusers will receive the help they need to break the cycle of intergenerational dependency. Children of substance abusers, particularly substance abusing mothers, are at a greater risk than their peers for alcohol and drug use, delinquency, poor school performance, as well as depression and other psychiatric disorders. They deserve and need services targeted directly to them, regardless of their parents' compliance with treatment and recovery.

Third, we know treatment for alcohol and drug problems saves tax dollars. It may not work for all people the first time, but it works for enough people to have a very high payoff. The basic fact about the poor connections between programs for children and families and substance abuse programs is that most treatment agencies don't count children as part of their caseloads. At the same time, child welfare agencies don't systematically assess for alcohol and drug problems.

The P.A.S.S. legislation, in its original form, required State agencies to report on these issues or to tell the Secretary of HHS what they needed to be able to make this data available. We supported that requirement because we believe that counting children who need these services is vital. Counting children isn't important for the sake of the data alone; rather, we believe we will never be able to stop the intergenerational aspect of alcohol and drug problems until we get a handle on just how many children of substance abusers need more than a generalized prevention message.

We have found very few people fully understand the funding streams for these fragmented systems. Each system has its own rules, jargon, eligibility requirements, and expertise. The child welfare system is just beginning to move beyond a recognition that the families they are trying to help have significant alcohol and drug problems. Some are beginning to put the funding pieces together.

The good news is there are some powerful exceptions to the rule of fragmentation among welfare, child welfare, and substance abuse treatment programs. These models and early efforts exist in Sacramento County, in Florida, and in Cleveland, to name only a few of the sites. Congress could do a great deal to make these programs more comprehensible and to create hooks and glue to make it easier for communities to put these programs together.

In the final analysis, it is about setting priorities. With limited resources, the hard decisions come down to weighing the long-term cost benefits of a focus on those children who are more likely to develop their own problems as a result of growing up in a family affected by alcohol and drug abuse.

I know how I would make that decision. I would make it in favor of the children who will be affected by intergenerational poverty and substance abuse. I would choose that way because it is more cost effective, because it would ultimately benefit more people, and because it is right. I believe we could have public policy at the State and Federal level that says we should help every parent who

is chemically dependent who wants to do the hard work to overcome their addiction. That is not an entitlement, it is an investment.

No parents are entitled to the custody of their child if they will not do all that is in their power to keep that child safe, but when parents are ready and willing to do the work of recovery, the rest of us should be there to help them. It is a good investment and a necessary step in our overall efforts to keep families together and children safe.

Thank you for your time today.

[The prepared statement follows:]

**Statement of Nancy K. Young, Ph.D. Director, Children and Family Futures, Irvine, California**

INTRODUCTION

The need for AOD (alcohol and other drug) treatment services among parents in both the welfare and child welfare systems is substantial, and far greater than current policy or practice recognize. These systems have many barriers to working together, including differences in attitudes toward clients, training and education, and funding streams. The typical response to clients in the child protective services (CPS) system needing AOD treatment is inadequate to assure that the intended outcomes of either system will be achieved. In the welfare system, the initial feedback from states and communities preparing to implement welfare reform suggests that very few have given the AOD problem the attention it deserves as a barrier to permanent work.

We can be more demanding of parents if we are more effective in securing resources needed for treating parents' addiction. We have the tools we need to improve our assessments of parents in the CPS and welfare systems who need resources from the AOD system, but particularly in the child welfare system we need to use assessment of both chemical dependency and family functioning that translates into an assessment of risk to the children.

The adequacy of the connections between these systems can be assessed using a five-part comprehensive policy framework that addresses: (1) daily practice; (2) information systems, evaluation, and outcomes; (3) budget and finance; (4) training and staff development; and (5) alternative methods of service delivery.

WHAT IS NEEDED

1. Tools to assess the addiction problems of families, and training of welfare and child welfare workers who can use those tools with an understanding of addiction problems as they affect risk to the children.
2. A commitment to target prevention and intervention funding and programs to the children of substance abusers in the welfare and child welfare systems, regardless of the parents' status in securing and complying with treatment protocols.
3. Improved information systems that can monitor clients' outcomes and distinguish between AOD clients with children and those without. Treatment agencies must collect and track the number and child welfare status of children in clients' families.
4. Assessment of both drug dependency and of family functioning, along with awareness of the developmental stage of the child, in making judgments about removal or reunification. If treatment is fully available for the parent, a presumption in favor of reunification should remain only as long as the parent has engaged in treatment or an aftercare program.
5. A higher priority for the availability of AOD treatment slots and programs for parents who are willing to make an effort to stay in treatment and follow-up services.
6. Inventories of the full range of funding sources and services available to parents which can fund expanded treatment and supportive services.
7. A focus on children, particularly the children of substance abusers, in each of the reports that are issued by the federal government which monitor the nation's drug problem.
8. Marketing information about treatment effectiveness and cost offsets from effective treatment.

9. A commitment from community partners to ensure that supportive services to families who have been reunified are available to families who have entered recovery from AOD problems.

10. Assessments of the effectiveness of AOD treatment programs using the latest tools of treatment outcomes, and the shifting of resources from the least effective to the most effective programs.

*The Larger Context: Children, Families, Drugs and Alcohol*

Beyond the boundaries of the CPS and welfare systems, there are extensive effects of alcohol and other drug abuse on children. There are millions of children affected by drugs and alcohol, living in families where use of drugs and alcohol pose risks to child well-being. Seven million infants were exposed to alcohol during gestation, nearly seven million children under 18 live in families with one or more alcoholic parents and over six million children live with 3.4 million parents who used an illegal substance in the last 30 days. An estimated total of 29 million children of alcoholics includes 13–25% likely to become alcoholics. [National Pregnancy and Health Survey, National Institute on Drug Abuse; Russell, Henderson, & Blume, 1985; U.S. Department of Health and Human Services, 1994.]

The overall economic impact of substance abuse on society was estimated by the Substance Abuse and Mental Health Services Administration in 1992 at $116 billion annually for alcohol abuse and $79 billion for drug abuse. These include costs of lost productivity, health impact, criminal justice costs, motor vehicle accidents, and prenatal effects.

Philosophical differences between AOD treatment and welfare agencies

The differences in philosophical outlook between the two systems are based on different perspectives on:

- who is the client: children, parents, the family, or the community?
- which timetable should apply: child welfare law, the new welfare reform law, AOD treatment timing, or the developmental needs of children at different ages?
- how can we reconcile zero tolerance, harm reduction, child safety, and family preservation as contrasting philosophies in protecting children and stabilizing families?

The practical result of these differences is that the two systems find it difficult to work together. In discussing front-line workers' reactions to AOD issues, one child welfare professional said in recent California discussions of these issues "For years the workers have been saying it [substance abuse] isn't on the form and it usually isn't in the allegation—so I don't go looking for it." A parallel comment from a treatment agency official was "We have not seen children as part of our responsibility."

*The Timing Barriers*

The timing differences are a very powerful driving force that underlies system incompatibility. We use the phrase "the four clocks" to refer to the four different timetables that may be affecting a family's response to CWS–AOD problems: (1) the CWS timetable of six-months reviews of a parent's progress and the timing under state and federal law governing termination of parental rights; (2) the timetable for treatment and recovery, which often takes much longer than AOD funding allows; (3) the timetable now imposed for TANF (former AFDC) clients who must find work in 24 months and have a lifetime clock of 5 years for income assistance; and (4) the developmental timetable that affects children, especially younger children, as they achieve bonding and attachment with parents or loving adults—or fail to do so.

Since the late 1980's, when the epidemic of crack cocaine began affecting child protective services caseloads, more attention has been given to the question of how much time to give to parents who have been reported for abuse or neglect and had their children removed. The problem is that each system runs on a different clock. The child protective services system increasingly focuses its concern on the developmental needs of children, especially younger ones, while the treatment system attempts to take into account the cycle of parents' recovery and relapse that may take much longer to stabilize and may have little to do with the needs of children whose developmental sense of time is very different from adults. In effect, the basic assumptions about treatment are very different, with CPS focused upon AOD treatment as a means for achieving the goal of child safety, while AOD treatment seeks the goal of clients' functioning as a healthy adult, in which parenting is only one facet of clients' behavior.

Timing also varies according to the age of the children involved. With new discoveries about brain development over the past ten years, we have learned how important the first eighteen months of life are in forming the basis for a considerable amount of both cognitive learning and emotional development. We also know more

about early bonding and what its absence from a child's first years can cost in later life. This all argues for faster vices, especially for younger children.

But in the treatment field, some of the lessons are contrary in their implications: treatment is not a one-time event which happens and is over, but a lifetime journey. That is why alcoholics and addicts often refer to themselves as "recovering" instead of "recovered." The treatment field has also evolved, with reduced emphasis on intensive residential care and more on longer-term interventions with "stepped-down," ongoing aftercare services and community supports.

The treatment perspective, therefore, argues for a longer-term perspective—at the same time that child welfare is moving toward greater emphasis upon shorter-range impact on children. When these two perspectives on timing collide in the life of a child and her parent, the difficulties of getting these two systems to work together are compounded.

As stressed previously, we believe that we can be more demanding of parents if the resources are there. By resources we mean not only the treatment resources but also adequate assessments at the front-end of the process and a full partnership with the community that mobilizes after care and family support resources to help a newly sober parent stay clean and sober. This kind of community partnership is described in depth in the recent report authored by Frank Farrow of the Center for the Study of Social Policy.[1] This community partnership model is being piloted in four communities around the country with funding from the Edna McConnell Clark Foundation.

If a 12-month clock is what fits best with the child's developmental needs, the realities of welfare time limits, and proposed CPS policy changes, then we have to be realistic about the community support needed to enhance the process of recovery on a faster time table. The community has the right to ask the recovering parent to do all that she can to keep her children safe and, at the same time, the community should hold itself responsible for helping that parent in that critical work.

But, we need to understand the daily reality of a lower-income parent, often a single parent, struggling to raise his or her children while early in recovery. Nearly all of us need respite from our daily balancing acts in the worlds of work and family. But upper- and middle-income families can call a babysitter to get out of the house for a few hours. It's not that easy for a lower income parent in recovery. To have a peer group, self-help group or a faith-based organization willing to provide that support could make all the difference in the early months of recovery. That need not be a governmental function; but the community needs to step up to the challenge. Taking the process of recovery seriously as a part of family reunification requires a more gradual transition from publicly-supported reunification services to broad-based community support for these kinds of after care and respite care assistance. Terminating reunification services at the end of 12 months ignores the continuing need assuming that the parent is making progress in recovery for different kinds of parent and family support services, both public and voluntary. Those services may make the difference between relapse and continued progress for a parent who is trying to respond to the stress and responsibilities of having her children returned to her care.

While existing federal family support money could be used for this purpose, it is extremely rare that the relationship between child welfare and treatment agencies would be strong enough to ensure that this would happen.

*The Emerging Consensus*

At the same time, in those communities where the systems have worked together, a consensus does emerge. Participants in this work agree that better-connected welfare, child welfare, and treatment agencies could achieve four purposes:

- Provide more effective services to more children and parents than the current fragmented systems (the effectiveness goals);
- Do so in a way that preserves more families with greater child safety than today's system (the family stability goal);
- Assist in making decisions about removal of children from those parents and caretakers whose addiction remains a threat to their safety and well-being (the child safety goal);
- Combine resources from the two systems which would serve more children and families than either system could do separately, while working more actively to enlist other community agencies and organizations for families with less intensive needs (the resource mobilization goal).

---

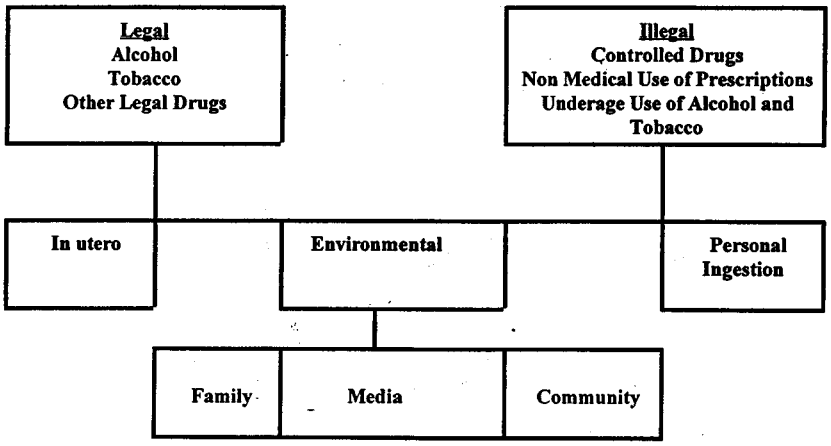
[1] Farrow, F. Building Community Partnerships for Child Protection. Cambridge, MA: The John F. Kennedy School of Government Harvard University. 1997.

Efforts to support children within their chemically dependent families must attempt to address chemical dependency in the family while meeting the developmental and safety needs of the children.[2]

*The Client Targeting Barriers*

Identifying which children and families should be targeted is also an issue. In the view of some experts on the impact of substance abuse on children, there continues to be disproportionate emphasis upon the problems of children who are born prenatally exposed to alcohol and other drugs, relative to the much larger number of children affected by AOD problems after birth. With the dominant emphasis upon prenatal exposure and adolescent drug use, the years between birth and adolescence are under-emphasized, despite the obvious evidence that risk to children and youth from AOD problems occurs during these years due to family and environmental exposure which has lasting effects in ways that in utero exposure doesn't always have. The substantial evidence that this is true includes the thousands of children in this age group who are reported to CPS units, despite never having come to the attention of these agencies as a result of prenatal exposure. Some estimates place the total percentage of all children affected by AOD at fifty times greater than those testing positive for exposure to drugs at birth. Yet, the birth of a child who tests positive for drugs is so traumatic and so clearly an occasion requiring intervention that this critical juncture has been rightly perceived as an opportunity to take decisive action in a family which is undeniably high risk. The chart that follows places in utero exposure in the larger context in which it belongs in the full range of ways that children are exposed to alcohol and other drugs.

**Chart 1: Paths of Exposure of Children to Alcohol and Other Drugs**




Carol Coles summarizes the message of this chart well in the edited collection, *Children, Families, and Substance Abuse*

...the nature of interactions with parents, as well as other more directly experienced factors, often appear to have more effect on outcomes like emotional and cognitive development than does prenatal exposure to specific drugs.[3]

A further basis for the problems between the systems arises in the competing demands for AOD services for populations other than children and families. In part due to the improving information base about what kinds of treatment work for which kinds of clients, demands for AOD support services have multiplied from the criminal justice system, the mental health system, and now, notably, the overlapping welfare/TANF system. Treatment for inmates has been an area of increasing emphasis, given the number of drug offenders in state prisons and local jails. Resources in the AOD system are scarce in the short run, and the call for expanded

[2] The CWLA North American Commission on Chemical Dependency and Child Welfare. *Children at the Front*. Washington, D.C.: Child Welfare League of America.

[3] Coles, C.D. "Addiction and Recovery" in G. Harold Smith, et al, (eds) *Children, Families, and Substance Abuse*. Brookes Publishing.

responsiveness to the special needs of children and families in the CPS system conflicts in important ways with these other demands.

*Disagreements about the Nature of Addiction*

Welfare and child welfare practitioners, like the general public, are part of a continuing debate over the fundamental nature of addiction as "bad acts by individuals with free will" (in the language of the 1992 National Drug Control Strategy report) or a public health problem caused by a condition that changes brain chemistry once clients have progressed from use to abuse and dependency. As a result, the public debate is often conducted in polar extremes, ranging from medicalization and legalization on one hand to zero tolerance and punitive strategies on the other. This argument from extremes often rules out middle-ground options such as treatment on demand for all clients willing to comply with a treatment and aftercare plan.

It is now clear that both brain chemistry and motivation matter. Clients can be held responsible for their actions, especially once consequences have been clearly set out and treatment services have been clearly offered. And clearly offering services doesn't mean simply giving clients a list of phone numbers, which is an all-too-typical response of the two systems. Participants in the discussions between AOD and CPS agencies in California point out that research in the addiction field shows conclusively that coerced clients are not more or less successful in treatment than "voluntary" clients. "Coerced" and "involuntary" are words sometimes used loosely in child welfare and AOD treatment. Is a parent who has been told he/she will lose parental rights acting voluntarily when checking into treatment—or being coerced? Either way, such a parent has been held personally responsible, given a clear message about treatment, and offered help—which are essential preconditions for successful treatment—but not guarantee that success will follow.

However, it is also important to consider the reality of treatment compliance rates when treating conditions that require substantial behavioral changes. Less than 50% of patients treated for insulin-dependent diabetes are compliant with their doctor's orders regarding their medication. Less than 30% are compliant with their diet and foot care. Among patients treated for hypertension, less than 30% are compliant with their medications and diet.[4] This data should not be used to excuse the behavior of persons in AOD treatment and all parents must be held accountable for the safety of their children. Rather, this data should be used to assist clinicians and policymakers as they explore their expectations of AOD treatment and any sanctions for noncompliance with treatment regimens.

The difference between how the child welfare and treatment systems respond to licit and illicit drugs must also be addressed with greater realism. The fact is that alcohol causes substantially more family disruption and lost economic benefits than illegal drugs. As one child welfare official put it in a recent California meeting: "CPS focuses on illegal substances and overlooks alcohol abuse and consequences on the family." To the extent that the CPS system does pay attention to substance abuse issues, it is far more disproportionately focused on illicit than legal drugs, given the overall damage done to children both prenatally and environmentally by alcohol. The same is true, as shown by the recent debate on welfare reform, in the income support arena.

We must also not lose sight of the front-line workers' perspectives on all these proposed reforms to work across system boundaries to help chemically dependent parents. Reform does not flourish among workers with caseloads far beyond recommended levels. At the same time, new mandates affecting AOD workers also create externally-driven pressures on front-line workers. In both fields, the CWS–AOD reforms we are proposing ask both sets of front-line workers to make large changes in their daily practice, and going beyond pro forma consultation to serious involvement of workers in these changes in practice and policy is the only hope that workers will not view them as just another round of mandates without resources.

To insure that workers have the tools to make these changes, training funds must be redirected and our universities must begin to include significant information about AOD problems in the human service curriculum. Federal IV(e) training funds for child welfare professionals have rarely been used to increase workers' in-depth knowledge of addiction and treatment. Both systems need added training content that would enable both sets of workers to work across systems:

---

[4] McLellan, A.T., Metzger, D.S., Alterman, A.I., Woody, G.E., Durell, J. & O'Brien, C.P. Is Addiction Treatment "Worth It?" Public Health Expectations, Policy-based Comparisons. Philadelphia: The Penn-VA Center for Studies of Addiction and the Treatment Research Institute.

Chart 2: How Should Training Be Changed?

| Desired CWS Training Content | Desired AOD Training Content |
|---|---|
| AOD dependency: use, abuse, and dependency | How the CPS system works |
| How to identify and intervene with AOD dependency. | Trends in local CPS and out-of-home-care |
| Treatment modalities and effectiveness—what providers do and their capacity—What local resources exist and how they differ. | Local resources in the child welfare system: parenting education, shelters, foster homes |
| AOD as a family disease; the dynamics of AOD-abusing families; impact on parenting. | AOD as a family disease; the dynamics of AOD-abusing families; impact on parenting |
| Confidentiality laws ..... | Confidentiality laws |
| Matching level of functioning to levels of care .. | Resources available for family-oriented interventions and family support/aftercare |
| The special needs of women and fathers/significant others. | Developmental impact of AOD use—both prenatal and environmental—on children |
| The language used in AOD and other systems | The language used in CWS and other systems |
| The "four clocks"—different timetables in the other systems. | The "four clocks"—different timetables in the other systems |

In a recent discussion of training issues among AOD and CWS administrators, several additional points were made:

- We need to train people for our vision of the new system, realistically presented, not just let them adapt to today's status quo.
- We are seeking links between a generic child welfare worker with direct ties to and knowledge of AOD issues and an AOD worker who understands CPS, so that an AOD counselor and child welfare worker can work together, not so that one worker can do both jobs.
- Administrator and mid-level supervisor training is also needed, since some front-line workers are much readier to make these changes in the interests of better outcomes for their clients while some supervisors protect traditional ways of doing things.
- Training only CPS and AOD workers will miss the other workers in other systems that need to know more about how these two systems can work with each other.
- Training needs to actively involve both AOD providers and CPS clients with AOD history. Academically-based training needs to recognize that front-line workers and clients should have equal standing, not second-class roles.
- Training alone will not do the job; training has to be in the context of agency-wide commitments to change policy and practice, or workers will return from their innovative training programs to an unchanged agency and go back to doing what they did before.

*What Would a New System Look Like?*

A newly linked CWS–AOD system would operate differently at the level of front-line workers, client contacts with both children and families, assessment of risk, referrals for services, accountability for results based on outcomes-driven information systems, training for its workers, and the role of the community in support of families at the "front end" of CPS services but not yet in the formal system. The new system would be capable of assessing and providing a differentiated response to children and families, responding to more sensitive and detailed assessment of both family and substance abuse issues.

To summarize, a new partnership between CPS and AOD needs to be comprehensive, negotiated among equals, carefully staged in its development, and driven by results-based accountability. Above all, the new system would have new partners, primarily at the community level, who could accept a responsibility for those families who are not seriously enough engaged with CPS to merit formal investigations, but who undeniably need help. As one AOD administrator put it, the reality test for the concept of community partnerships was that "somebody else would step up

to the microphone" when a public explanation of child safety issues was needed, rather than the media solely holding the CPS system accountable.

The new system would also include more than a two-way bridge between CPS and AOD agencies, since for many of its clients more than these services and supports are needed. Community-based aftercare, family supports, mental health, job training, literacy training—these are some of the many services and supports which go beyond CWS and AOD services that are needed by families in the CWS system. As one participant in an earlier session put it, "AOD treatment is not a stand-alone service."

*What Could Congress Do?*

Many of these changes require action at the most local levels of the system, in the communities where welfare reform, child welfare policy, and treatment programs co-exist today in largely separate worlds. Putting the pieces together is ultimately local work. But federal action could make a great difference. To review the areas where congressional initiatives could be helpful:

- We need the PASS legislation (S. 1195), with its emphasis on identifying children in the system, making it easier to blend funds from different systems, and creating greater incentives for combining funding from welfare, child welfare, and treatment funding sources.
- Congress could also issue annual inventories of all three sets of funding—welfare, child welfare, and AOD treatment—as a guide to communities who rarely get an overview of all funding sources available to help children and families affected by AOD issues.
- Congress could ensure that the data collection procedures in both the child welfare and AOD systems are changed so that they include data on both the parents with AOD problems among child welfare cases and data on the children of parents seeking AOD treatment. We need the provision in the Adoption Promotion Act (HR 867) which requires the Secretary of HHS to report on the substance abuse needs in the child welfare system.
- Congress could ensure that reports issued from the national surveys on drug abuse always include analyses of the data on the children in substance using families. At present, only special follow-up studies of the National Household Survey on Drug Abuse have analyzed the data on children; the routine reports do not include information on the children in the families affected by AOD.
- Congress could continue the oversight represented by these hearings through inviting representatives of the model programs to talk about what they have done and what additional support they need form the federal level.
- Congress could exercise its oversight for the TANF legislation to review the actual experience of parents with the greatest barriers to making the transition to work. The range of estimates is wide, but we are building up a body of experience every day that will tell all of us which estimates are most nearly accurate—and more importantly, whether the resources set aside for treatment are adequate. The dramatic declines in welfare caseloads do not tell us what is happening to the children in these families, or whether those leaving are those without AOD problems, while those remaining may have even greater problems.

## CONCLUSION

Many children's lives are diminished by the inability of their parent to care for them, and the inability or unwillingness of the larger society to help and compel those parents to help their children by addressing their problems of addiction. Thinking and acting more clearly about this critical dimension—accepting the challenge of creating a true family support system—could help far more children and families than continuing to deny the equally important realities of addiction and the potential of recovery in these families.

---

Chairman SHAW. Thank you, Dr. Young.

Dr. Barth.

**STATEMENT OF RICHARD P. BARTH, PH.D., HUTTO PATTERSON PROFESSOR, SCHOOL OF SOCIAL WELFARE, UNIVERSITY OF CALIFORNIA, BERKELEY, CALIFORNIA**

Mr. BARTH. Thank you, Chairman Shaw and Members of the Subcommittee, for the opportunity to testify today. I am a professor in the School of Social Welfare at the University of California, Berkeley, where I have done research with the Child Welfare Research Center, which was originally funded by ACF. I also serve as the principal investigator of the Abandoned Infants Assistance Resource Center, where we provide technical assistance and evaluation to Abandoned Infants Assistance Programs nationwide, and are currently exploring innovative ways of serving drug- and HIV-infected families.

My objectives for today include identifying five points and providing supporting information for these recommendations. The first point is that the children whose parents are persistently poor and involved with substance abuse are the families most likely to require child welfare services. Standard services provided by TANF are unlikely to provide substantial benefit to the majority of these very troubled families and additional efforts are needed.

Second, reporting drug-exposed children for child abuse should be followed by thorough assessments of their needs. Placing them into foster care may not infrequently be necessary to protect them from the interactive risks of their own drug exposure and living in compromised environments; however, this is not a sufficient approach.

Third, reunification services for drug-involved families must be supplemented with a broader array of strategies to help minimize the forces that result in relapse. These include intensive postreunification services, residential treatment programs for mothers and children, shared family care, and service-enriched housing.

Fourth, shorter timeframes for children in substance-abusing families, and indeed in all families, can be fairly and successfully administered if child welfare and substance abuse services are redesigned to be more timely and comprehensive.

Fifth, extended services are needed for drug-affected children and families, as these have a good chance of mitigating serious, long-term problems for them.

As we have heard so far, there is much consensus that the overlap between substance abuse and child welfare is greater than it is between substance abuse and public welfare. Indeed, as the Chairman indicated, there are estimates that as many as 75 or 90 percent of families involved with child welfare services are also involved with substance abuse problems.

However, these problems do interact with persistent poverty. Clarise Walker and her colleagues found that among African-American parents in five major U.S. cities whose children entered foster care in 1986, those that abused drugs were much more likely to be receiving AFDC prior to the placement of their children. In fact 85 percent of the substance-abusing parents were receiving AFDC and many had experienced long-term poverty.

We have recently examined infants who came into foster care in California and compared their family situations to those of infants who did not. One of the things we found was that being poor made

a difference, but that being poor and having a parent older than 30 made a much greater difference. These were often women who had been poor and involved with childbearing for many years, and they were the ones who had the greatest likelihood of having their children enter foster care.

Even when a child is born drug exposed and child welfare authorities assess the situation, they may decide there are other alternatives besides placing a child into foster care. When they do, they may still provide some in-house services, but these tend to be so limited that the risks of harm to the child endure.

In a number of different studies in a number of different States, we have seen that the children who are reported for abuse and neglect and assessed early on but who do not get services, later on do come back into the child welfare system. This, I think, is a clarion call for providing more continuous services to those families, even when foster care is not indicated.

Other information about a drug-involved family's living situation, their willingness to engage in efforts at recovery, and their use of other services should, of course, be considered when a decision is made in response to a report of child abuse and neglect. Is your point that inadequate assessments result in overplacement or underplacement, i.e., assuming willingness for recovery? Yet many families do not receive such an adequate assessment. We must see a time in the future when newborns who are born drug exposed receive such assessments that can lead to better treatment planning.

One thing we have learned from our years of working with these families that are involved with drug abuse is that there are often many children involved. For this testimony, we took a sample of newborns who had come into care in 1995 and looked to see how many of their siblings were already in care when the newborn entered into care.

Out of approximately 1,600 newborns, we found about 1,000 of them had one or more siblings already in care. Overall, they had about 2,600 siblings in care. On average, the siblings had been there 4½ years; 81 percent of those who had been in care had not gone home or had come back into care. If one-third of the nearly 1,000 mothers who gave birth to these newborns in 1995 had been successfully engaged in treatment upon the first birth recorded in our data base and had no more drug-exposed births, nearly 4,000 foster care years would have been avoided at a savings of at least $40 million for just the direct foster care placement costs.

So whatever our views are about the causes of substance abuse and however much frustration we may have about this problem, we must understand that from an economic standpoint, we must address the whole family. Helping mothers achieve recovery could substantially reduce the number of children coming into foster care.

One of the approaches we need to expand is something we are calling "shared family care." We are currently piloting this program in California and Colorado, and it is being used in other States as well. In addition to the kinds of residential treatment programs you know of, shared family care involves placing mothers in recovery with their children, in the homes of foster parents. In this way, we are not separating children from their parents but are still pro-

tecting the children by placing them with their family in foster care. This approach helps support them and provides shelter for them during the time of recovery. There is more about this in my written testimony.

I thank you for the opportunity to testify.

[The prepared statement follows:]

**Statement of Richard P. Barth, Ph.D., Hutto Patterson Professor, School of Social Welfare, University of California, Berkeley, California**

My name is Richard Barth. Thank you for the opportunity to testify today. I am the Hutto Patterson Professor in the School of Social Welfare at the University of California at Berkeley and the leader of the Child Welfare Research Center which was originally established in 1990 with support from the Children's Bureau and ASPE. In this capacity, I have studied a variety of issues regarding the impact of substance abuse on families and children and on child abuse and child welfare services dynamics. In particular, my colleagues and I have studied outcomes of the adoption of drug-exposed children, the impact of substance abuse on reunification from foster care, and the service outcomes of newborns and infants who enter foster care. I am also the Principal Investigator of the Abandoned Infants Assistance Resource Center, and in that role, I have provided technical assistance and evaluation services to Abandoned Infants Assistance programs which are generating innovative ways to serve infants and families affected by drugs and HIV.

OBJECTIVES FOR THE PREPARED TESTIMONY

My objective for the prepared testimony is to present and support five major points.

- Children whose parents are persistently poor and involved with substance abuse are most likely to require child welfare services. TANF is unlikely to provide substantial benefit to the majority of these families.
- Reporting drug-exposed children for child abuse should be followed by thorough assessments of their needs. Placing them into foster care may, not infrequently, be necessary to protect them from the interactive risks of being born drug-exposed and living in compromised family and community environments. This is not, however, a sufficient approach.
- Reunification services for drug-involved children must be supplemented with a broader array of strategies that help minimize the forces that result in relapse—these include, intensive post-reunification services, residential treatment programs for mothers and children, shared family care, and service-enriched housing.
- Shorter time frames for young children in substance abusing families can be fairly and successfully administered if child welfare and substance abuse services are redesigned to be more timely and comprehensive.
- Extended services are needed for drug-affected families and have a good chance of preventing serious long-term problems for them.

BACKGROUND: SUBSTANCE ABUSE AND CHILD ABUSE AND THEIR OVERLAP

Little data but much consensus exists regarding the predominant role of substance abuse in families that are involved with child abuse and neglect and who lose their children to foster care. In general, substance abuse appears to have a far greater overlap with child welfare services than with public assistance programs. Analysts have estimated that between 24–90% of all child maltreatment reports involving substance abuse (Feig, 1990; NCCAN, 1993; Tracy, 1994; Magura & Laudet, 1996). More than three-quarters of state child protection administrators across the country report substance abuse as one of the top two problems presented by their caseloads, the other one being housing (Wiese & Daro, 1995). Doug Besharov (1989) concluded that over 73% of neglect-related child fatalities in 1987 were attributable to parental alcohol and drug abuse. Ten years later, there is not good reason to argue that this has changed.

Substance abuse clearly pre-disposes caregivers to neglect and abuse. A large NIMH-funded study concluded that substance abusers had 3 times the odds of committing physical abuse and neglect—after controlling for social, demographic, and psychiatric variables (Chaffin, Kelliher, & Hollenberg, 1996). These findings are supportive of their earlier conclusions in which "close to half or more of abusive or neglectful parents have a lifetime prevalence substance abuse disorder" (Kelleher, Chaffin, Hollenberg, & Fischer, 1994; p. 200).

Whereas parents on welfare appear to have elevated rates of substance abuse and child abuse, substance abuse is clearly more prevalent among maltreating families than in poor families. In Zuravin and Grief's (1989) comparison of maltreating and non-maltreating AFDC mothers, non-maltreating mothers were significantly less likely to report problems with alcohol or hard drugs (heroin, cocaine, LSD, PCP) than CPS-involved mothers. Alcohol binges were reported by 3 times as many maltreating mother and four times as many maltreating mothers reported hard drug use.

Many families struggle with poverty and substance abuse and do not engage in child abuse or neglect. Yet, poverty and substance abuse undoubtedly interact to increase the need for child protection by community child welfare services. Clarice Walker and her colleagues attempted to profile African-American children who entered foster care in 1986 in five major U.S. cities. They found that of parents whose children entered foster care, those that abuse drugs are more often single parents, were significantly more likely to not have a high school education, and were more likely to be receiving AFDC prior to placement of their children. In fact, 85% of substance abusing parents were receiving AFDC and many had experienced long term poverty. Although we lack direct evidence on the interactive effects of persistent poverty and substance abuse on child welfare services, my colleague Barbara Needell and I recently compared mothers who lose their infants to foster care and those who do not (Needell & Barth, 1997). Whereas women receiving publicly-funded medical services had a higher risk in general, being poor was a much more significant predictor of placement into foster care if the mother was older than 30 at the time of birth and had more prior births.

Even when a child is born drug-exposed and child welfare authorities do not assess the seriousness of the problem as requiring foster care, the risks for the drug-exposed child endure. Jaudes, Ekwo and Van Voorhis (1995) tracked cases of maltreatment among a sample of 513 infants born exposed in-utero to illicit substances, and found that about a third were later reported as maltreated. Of these, two-thirds were subsequently substantiated. Overall, the rate of substantiated maltreatment was found to be two to three times that of the general child population living in the study area (the south side of Chicago). A follow-up study by Jaudes and Ekwo also found higher eventual mortality among the drug-exposed sample. Goerge and Harden (1993) looked to see what happened to infants born in Illinois who are reported to child protective services because of a positive drug test (this is a mandated report under Illinois law). Only about 10% of those cases enter foster care immediately, although about one-third eventually end up in substitute care within three years. Once admitted into care, these infants have particularly long stays in foster care. In California, about one-in-six infants who entered foster care in 1988 was still there eight years later.

While parental substance abuse is considered a critical risk factor in the assessment of child abuse reports and positive drug toxicology tests may lead to an abuse report, child welfare service agencies now generally concede that positive toxicology tests are not, on their own, sufficient basis for legal action or the involuntary removal of children (NAPCWA, 1991). As the National Association of Public Welfare Administrators advises in its guiding principles for working with substance abusing families:

Parent(s) abuse substances to varying degrees. When substance abuse significantly interferes with parental responsibility and causes harm to the child, these failures of parental duty provide the basis for substantiating a finding of abuse or neglect (NAPCWA, 1991).

Thus, neither the use of substances while pregnant, nor parental substance abuse per se, legally constitutes child neglect. Other information about the living situation, willingness to engage in efforts at recovery, and the family's use of other services must also be considered. This seems to me to be the correct standard. Still, parental substance abuse during pregnancy is clearly reason for a child welfare services assessment upon the birth of a child to determine whether additional grounds for establishing abuse exist and to ascertain whether the dyad might benefit from voluntary or mandated services.

I believe that we must see a time in the future when newborns affected by drugs are routinely and thoroughly assessed by public health or child welfare services and a range of services are made available to them. There are several reasons why this is so important. First, we clearly need to pay greater attention to the safety of drug-exposed children—the data on their high mortality rates is not to be ignored. Secondly, this helps us to provide intervention services at the earliest possible time. Children who are born drug-and alcohol-exposed have needs for early assessment and intervention; in their study for the CDC, Ann Streissguth and her colleagues (1996) found that early intervention and living in a stable and nurturing home were

two of the most important predictors of good adult functioning for children born with fetal alcohol syndrome and fetal alcohol affects. David Olds and his colleagues (1997) have also shown important prevention effects from early and prolonged home visiting services.

Third, is the impetus that early assessments provide toward prompt decision making and the shortening of unnecessarily long stays in foster care. Children who are born drug-exposed and come back into foster care at age 3 may have experienced a variety of developmentally threatening environments and have a far greater likelihood of subsequently being adopted if they cannot return to their biological home. Indeed, children who enter foster care between the ages of 3 and 5 have the lowest rates of reunification within the first six years because they are too young to protect themselves at home but not easily placed for adoption (Barth, 1997).

Substantial concerns about the approach of assessing and engaging virtually every family that gives birth to a substance-exposed child will not subside, however, until we are able to show a fundamental fairness in determining who gets assessed for substances and until we have adequate resources to provide to families. They most be more varied and effective than the current status quo which is to place children in foster care while providing little or no service to their mothers. I will discuss some of these desirable service changes later in this testimony.

Removing children at birth without providing substantial assistance to their mothers has other serious limitations as a strategy. Child welfare programs that fail to address parental substance abuse and focus primarily or exclusively on child protection will not help prevent subsequent substance-exposed births. For this testimony, my colleague Barbara Needell examined the foster care and family histories of a cohort of 1,576 newborns brought into foster care in 1995 in California for reasons of neglect and abandonment (signals that these were cases involving substance abuse). We learned that 60% of these children (nearly 1,000) already had at least one sibling in foster care. Indeed, they had a total of 2,634 siblings who were in foster care at some time from 1988 to their date of entry in 1995; about 25% of these newborns had 3 or more siblings in foster care. About 75% of these children were 3 years old or younger—children with long and expensive spells in foster care ahead of them. Among the siblings of the infants who came into care, 81% of them were still in care or back in care. Newborns had siblings in foster care, on average, for four and one-half years—a total of about 12,000 foster care years. About half of the mothers (47%) who had multiple siblings entering foster care were younger than 21 at the birth of the first sibling. However, when you examine maternal age of the mothers at the time of the last newborn entering care, 47% of those mothers are over age 30. Clearly, a few parents who continue to generate births of children born exposed to substances have a substantial impact on the foster care caseload. If one-third of these nearly 1,000 mothers had been successfully engaged in treatment upon the first birth recorded in these data, and had no more drug-exposed births, a minimum of 4,000 foster care placement years would be avoided at a saving of, at least, $40,000,000 for these children alone. So whatever our views about the causes of substance abuse and however much frustration we may have with mothers who use drugs and alcohol during pregnancy (and fathers who encourage it), we cannot ignore their impact on child welfare, medical, and educational costs that are likely to accrue. Right now, about one-in-five children who enter foster care in the United States is an infant. We must build our intervention capacity and resources to interrupt these dynamics and reduce the rate of births of substance-exposed children who may enter foster care.

Although the substance abuse treatment services that are being provided in some states as a component of TANF may help some families to become more attached to the labor force than they are to destructive life styles, the families who are having multiple births of children who enter foster care are unlikely to benefit from standard TANF services. These parents need outreach and treatment services that are available to them even if they lose TANF eligibility because they no longer have custody of their children.

Nor is substance abuse only a cause of infants entering foster care. Substance abuse certainly predicts poorer case outcomes under existing service models for parents of children of older ages. Parental substance abuse has been identified as a predictor of poorer family functioning among child welfare cases, and repeated reporting to child welfare agencies (Wolock & Magura, 1996). Parents with documented substance abuse problems are more likely to have previous child welfare services involvement, to be rated by court investigators as presenting a "high risk" to their children, to reject court-ordered services, and to have their children permanently removed (Murphy et al., 1991).

Two of my colleagues at Berkeley, Jill Duerr Berrick and Laura Frame (1997) recently completed a study of infants returning to foster care, trying to provide some

explanation for an earlier finding that 28% of infants who went home from foster care returned to foster care within 3 years in California (Needell, Webster, Barth, Armijo, 1996). They found that substance abuse by mothers at the time of placement was pervasive among all clients, but it was far more present in the re-entry group and increased the odds of re-entry substantially. Interestingly, the odds of a child re-entering care were not diminished by receipt of post-reunification services—indeed, they were increased. It turns out, that the families that received post-reunification services in Alameda County were also the families with the longest history of referrals to child welfare services. Basically, the level of post-reunification services that were provided were not sufficient to counteract these elevated risk factors and preserve the placements. We can only hope that these higher levels of services protected the children from harm and that the children were replaced into foster care after early signs of parental relapse from treatment and not after substantial injury to the children or their futures occurred. We have so much to learn, and have so far done so little to try to learn it, about the necessary ingredients of reunification services.

## TOWARD CHILD WELFARE AND SUBSTANCE ABUSE SERVICES REFORM

Although we have not previously gathered much longitudinal data that shows how child welfare careers are affected by prior substance or the use of substance abuse treatment services, researchers and program innovators have generated enough information to suggest some reasonable new approaches to programs and policy.

### *Timely and Coordinated Child Welfare and Substance Abuse Services*

The ideal time frames for decision making vary considerably for children, substance abuse providers, parents, child welfare services, and the courts. Envisioning the clocks above the registration desk in an international hotel offers a sense of the disparate time frames for a child welfare case involving substance abuse (Cole, Barth, Crocker, & Moss, 1996). Child welfare service providers certainly understand the centrality of effective substance abuse services to the achievement of permanency outcomes, but the proportion of substance abusing families is overwhelming to service providers, and their access to prompt and powerful substance abuse services is limited. Although child welfare services families may have priority for referral to substance abuse services in a given locality, they may have little clout in other localities. Now that some states are requiring substance abuse services for TANF recipients, the challenge of obtaining timely services may be greater. The difficulty of obtaining substance abuse services for child welfare clients would be substantially less under the provision of'S 1195 that child welfare service clients be served first by programs receiving federal substance abuse treatment funds.

Child welfare service providers are frustrated with the difficulty of getting prompt services, the unwillingness of substance abuse treatment providers to share information about the progression of treatment, and their reluctance to support decisions to end services and terminate parental rights when treatment is not successful. Some states are moving to fund substance abuse treatment programs under the child welfare services authority; direct funding of child welfare agencies for substance abuse services is also a strategy worth additional consideration by the federal government.

Shortening the time to a permanency planning decision from 18 months to 12 months—as is proposed in HR 967 and S 1195—is a sensible idea but has the potential to exacerbate the mismatch between the legal time frames. Expedited decision making generates greater concerns about the time allowed for families to enter into and take advantage of substance abuse services. I believe that there are hopeful signs that we can bring these time frames together so that children are moved into potential permanent placements at the earliest feasible time, so that parents have a chance to take advantage of substance abuse services, and so that child welfare service providers and the courts can make the best decisions in the shortest time.

When timely and comprehensive services are available, they can make a significant difference. Colorado's new configuration of services for children under six entering foster care includes several features of such a restructured system that deserve replication (Shirley Rhodus, personal communication, August 12, 1997). Child welfare services have received funding to develop their own slots for substance abuse treatment so that they can ensure that families that need service begin them in the first week after placement. They have reduced caseload sizes to 15 families in several counties and provide each case with two workers. These added resources allow staff to provide intensive reunification services and concurrently plan for adoption if the odds of reunification start to drop. The case receives a full case review at three months—at that time, they may make a recommendation to place a child into

a concurrent planning foster home (one interested in adoption, if reunification with the biological family does not succeed). By six months, they have enough information from their drug treatment providers and other service providers to determine whether reunification is possible and, if not, to accelerate the plans for parental rights termination and adoption. With few exceptions, permanent placements must be made by 12 months.

The Oklahoma Infants Assistance Program provides comprehensive services to families of drug-exposed mothers over a six to nine-month timeframe in order to ensure that the substance abuse treatment time frames can work within the permanency planning time frames. Their services often begin within a week of intake and address issues of parenting and domestic violence as well as substance abuse treatment. Their experience suggests that early and comprehensive services can identify the families that are benefitting from the services at far earlier points in the decision making process than have historically been the case (Martin Ward, personal communication, October 25, 1997).

Although there are some who would make the axiomatic assertion that "relapse is a predictable part of treatment," there is evidence that the kind of relapse involved can signal whether there is a likelihood of treatment completion. Certainly, we know that many parents will never make a serious start in drug treatment. In a review of the outcomes of drug-treatment research, the reviewers concluded that few users even completed the treatment, much less completed control over their addictions (Hoffman, Caudill, Koman, Luckey, Flynn & Hubbard, 1994). Many participants (between 42 and 85% in different studies) had dropped out of treatment by the first month. Whereas, a single relapse is not enough to judge drug treatment a failure, if that relapse ends involvement with drug treatment it is much more serious than if the parent resumes treatment quickly after the relapse.

Even when parents do complete six months of substance abuse services, this is often not enough to end services and reunify children. Failed substance abuse treatment is heavily implicated in failed reunifications. Longer substance abuse services and post-substance abuse case management could greatly improve the likelihood of generating lasting treatment changes (Wells, Peterson, Gainey, Hawkins, & Catalano, 1994; Seigal, Fisher, Rapp, Kelliher, Wagner, O'Brien, & Cole, 1996).

*Longer-term Interventions for Drug-Exposed Children and Their Families*

In addition to earlier provision of substance abuse services for parents, we need to continue to explore and expand our interventions for children. Although the research on the immediate and long-term consequences of prenatal cocaine exposure has not demonstrated any singular impact on children, it is fair to characterize drug-exposed children as "at risk," whether due to maternal substance use and/or other environmental factors or the interaction between the two. These "at risk" characteristics interact with a substance-abusing parent's lifestyle, stressors including poverty, and pre-existing parenting difficulties to create conditions which support a higher incidence of violence and child maltreatment (Kelley, 1992). The steady entrances into foster care for children who were not immediately taken into foster care in the aforecited Illinois study and the continued reentries into foster care for at least three years for infants found in our California work show the continuing risks for children born into families involved with drugs and alcohol. We do not know much about what occurs during those three years, but we can only guess that a vast opportunity to make a developmental difference has been squandered.

There is clearly sufficient evidence about the problem of repeat drug-exposed pregnancies to fund demonstration projects and rigorous evaluations to assess the impact of continuous case management for parents who have drug-exposed births. At minimum, we must maintain ongoing services to substance involved families who do have their children reunified into their care.

We have new evidence that children who are reported for maltreatment after the age of seven and not given child welfare services have about twice the likelihood of later entering the California Youth Authority than children who receive in home or foster care services (Jonson-Reid & Barth, 1997). Imagine what the impact might be on building successful futures if we began those services at seven days or seven weeks of life, instead of seven years. Abandoned Infants Assistance programs have developed new models of reaching out to and following some of our most troubled and addicted parents, but these services are available only on a demonstration basis and only in the very first years of life. We must work toward a seamless stream of services for the families that first come to our attention because they have mixed parenting and substance abuse.

*Programs to Improve Living Conditions for Drug-Involved Families Pursuing Recovery*

Without adequate housing, it is extremely difficult for individuals to focus on their recovery, and returning to the pretreatment living environment places women at higher risk for relapse (Lewis, Haller, Branch, & Ingersoll, 1996). Yet affordable housing which provides an environment conducive to recovery and quality family life remains extremely scarce. Applicants for public housing must wait an average of 19 months and as long as eight years for housing that is often unsafe and riddled with drug problems and other criminal activity. Additionally, the average wait for Section 8 rental assistance is more than two years, and families wait as long as five years in some cities (U.S. Conference of Mayors, 1996). This housing crisis is particularly problematic for households headed by chemically addicted parents who often have difficulty securing jobs which pay them enough to support their families or afford decent market rate housing. Additionally, many of these families have other social, emotional and/or physical issues that make it difficult for them to maintain housing. As a result, families affected by alcohol or other drugs often end up homeless or in emergency shelters which is not conducive to recovery and does little toward helping them become self-sufficient. Without stable housing, it is difficult for parents to obtain gainful employment or provide their children with the stability that is so critical for a child's healthy development.

Inadequate housing or homelessness, accompanied by other factors such as parental drug abuse, was the primary reason for removing children from the home or keeping them in foster care in over 25% of foster care cases (Zangrillo & Mercer, 1995). There is reason to believe that access to safe, affordable, and adequate housing, along with some form of treatment or recovery and a wide range of support services, will assist chemically addicted parents to remain clean and sober, move toward self-sufficiency, and avoid re-involvement in the child welfare system. Shields for Families in Compton, CA provides residential drug treatment services with permanent service-enriched housing to boost the likelihood that families can resist relapse. Programs like this need more attention and evaluation.

Shared family care is another approach to helping substance abusing families in recovery to achieve their goals to preserve their families. Originated in Europe as an extension of drug-and alcohol treatment services, shared family care involves the placement of a recovering parent and her children into a host family (Barth, 1995; Price & Barth, 1996). Now operational in Minnesota, Wisconsin, Colorado, and California, shared family care offers families the opportunity to live with and learn from host families for between 6 and 12 months in order to reconstruct an orderly and responsive family life. Because this approach does not meet the IVE requirement of mother and child separation, it is not easily funded under our existing public policy. The provisions of S 1195 that allow time limited reunification services for mothers and children to live together in residential setting would greatly expand the availability of this promising program.

## CONCLUSIONS

Child welfare services are intended to protect the future of our most vulnerable children. Historically, these have been children living in homes overwhelmed with problems of substance abuse and violence. We know more about the extent of this problem than ever before. Researchers and program innovators have many ideas about ways that we might protect the developmental futures of children and, at the same time, provide opportunities for rehabilitation to their parents. This is an opportune time to test the promise of programs that support more thorough assessments of drug-exposed children, more timely and focused drug treatment services for child welfare clients, a variety of supportive housing options for families in recovery and reunification, and extended services to drug-and alcohol-exposed children who have come to the attention of the child welfare service programs. The substance-affected child and family are the core constituency of child welfare services and greater efforts are required to address their needs.

*Note: I am grateful to Laura Frame, Sora Han, Sharon Ikami, Sophia Lee, Barbara Needell, and Amy Price for their assistance preparing this statement.*

## REFERENCES

Barth, R.P. (1997). Effects of race and age on the odds of adoption vs. remaining in long-term foster care. *Child Welfare, 76*, 285–308.

Barth, R. P. (1993). Shared family care: Child protection without parent-child separation. In R. P. Barth, J. Pietrzak, & M. Ramler, (Eds.), *Families living with drugs and HIV: Intervention and treatment strategies* (pp. 3–17). New York: Guilford Press,

Berrick, J. D., & Frame, L. (1997). *Factors associated with successful family reunification*. UC Berkeley: Bay Area Social Services Consortium, Center for Social Services Research.

Besharov, D. (1989). The children of crack: Will we protect them? *Public Welfare*, 46(4), 7–11.

Chaffin, M., Kelleher, K., & Hollenberg, J. (1996). Onset of physical abuse and neglect: Psychiatric, substance abuse, and social risk factors from prospective community data. *Child Abuse and Neglect*, 20(3), 191–203.

Cole, E. S., Barth, R. P., Crocker, A. C., & Moss, K.G. (1996). *Policy and practice challenges in serving infants and young children whose parents abuse drugs and alcohol*. Boston, MA; Family Builders Network, 418 Commonwealth Avenue, Boston, MA 02215.

Ekwo, E. E. & Jaudes, P. K. (1997). Outcomes for infants exposed in utero to elicit drugs. *Child Welfare, 76*, 521–534.

Feig, L. (1990, January). *Drug-exposed infants and children's service needs and policy questions*. Washington, D.C.: U.S. Department of Health and Human Services.

Goerge, R. M. & Harden, A. (1993). *The impact of substance-affected infants on child protection services and substitute care caseloads: 1985–1992*. A report to the Illinois Department of Children and Family Services. University of Chicago: Chapin Hall Center for Children.

Jaudes, P. K., Ekwo, E., & Van Voorhis, J. (1995). Association of drug abuse and child abuse. *Child abuse and Neglect*, 19(9), 1065–1075.

Jonson-Reid, M., & Barth, R.P. (1997). Pathways from child abuse to the California Youth Authority. Paper presented to the California State Assembly Public Safety Committee, Los Angeles, CA. Available from the authors.

Kelley, S.J. (1992). Parenting stress and child maltreatment in drug-exposed children. *Child Abuse and Neglect*, *16*, 317–328.

Kelleher, K., Chaffin, M., Hollenberg, J., & Fischer, E. (1994). Alcohol and drug disorders among physically abusive and neglectful parents in a community-based sample. *American Journal of Public Health*, *84*, 1586–1590.

Lewis, R.A., Haller, L.H., Branch, D., & Ingersoll, K.S. (1996). Retention issues involving drug-abusing women in treatment research. In E.R. Rahdert (Ed.), *treatment for drug-exposed women and their children: advances in research methodology*. Rockville, MD: U.S. Department of Health & Human Services, NIH, NIDA.

Magura, S. & Laudet, A.B. (1996). Parental substance abuse and child maltreatment: Review and implications for intervention. *Children and Youth Services Review*, *18*(3), 193–220.

Murphy, J. M., Jellinek, M., Quinn, D., Smith, G., Poitrast, F. G., & Goshko, M. (1991). Substance abuse and serious child maltreatment: Prevalence, risk, and outcome in a court sample. *Child Abuse and Neglect*, *15*, 197–211.

NAPCWA. (1991). Working with substance-abusing families and drug-exposed children: The child welfare response. *Public Welfare*, *49*(4), 37.

NCCAN (1993). *Understanding child neglect*. Washington, D.C.: Author.

Needell, B. & Barth, R.P. (1997). Infants entering foster care compared to other infants using birth status indicators. Unpublished manuscript submitted for publication..

Olds, D.L., Eckenrode, J., Henderson, C.R., Kitzman, H. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect: Fifteen-year follow-up of a randomized trial. JAMA, 278, 637–643.

Price, A. (1997). *Permanent, Service-Enriched Housing for Families Affected by Alcohol and Other Drugs*. Berkeley, CA: University of California, School of Social Welfare, Abandoned Infants Assistance Resource Center.

Price, A. & Barth, R.P. (1996). *Shared family care program guidelines*. Berkeley, CA: University of California, School of Social Welfare, Abandoned Infants Assistance Resource Center.

Siegal, H. A., Fisher, J. H., Rapp, R. C., Kelliher, C. W., Wagner, J. H., O'Brien, W. F., & Cole, P. A. (1996). Enhancing substance abuse treatment with case management: Its impact on employment. *Journal of Substance Abuse Treatment*, *13*(2), 93–98.

Streissguth, A.P., Barr, H.M., Kogan, J., & Bookstein, F.L. (1996). Understanding the occurrence of secondary disabilities in clients with FAS and FAE. Seattle, WA: University of Washington School of Medicine.

Tracy, E. M. (1994). Maternal substance abuse: Protecting the child, preserving the family. *Social Work*, *39*(5), 534–540.

U.S. Conference of Mayors (1996). A status report on hunger and homelessness in America's cities: 1996. Washington, DC; United States Conference of Mayors.

Walker, C. D., Zangrillo, P., & Smith, J. M. (1994). Parental drug abuse and African-American children in foster care. In R. Barth, J. D. Berrick, & N. Gilbert (Eds.), *Child Welfare Research Review, Vol. I*. New York: Columbia University Press.

Wells, E. A., Peterson, P. L., Gainey, R. R., Hawskins, J. D., & Catalano, R.F. (1994). Outpatient treatment for cocaine abuse: A controlled comparison of relapse prevention and twelve-step approaches. *American Journal of Drug and Alcohol Abuse*, *20*(1), 1–17.

Wiese, D. & Daro, D. (1995). *Current trends in child abuse reporting and fatalities: The results of the 1994 annual fifty state survey*. National Committee to Prevent Child Abuse.

Wolock, I. & Magura, S. (1996). Parental substance abuse as a predictor of child maltreatment re-reports. *Child Abuse and Neglect*, *20*(12), 1183–1193.

Zuravin, S. J., & Grief, G. (1989). Normative and child-maltreating AFDC mothers. *Social Casework*, *70*, 76–84.

Chairman SHAW. Thank you, Dr. Barth.

Mr. McCrery.

Mr. MCCRERY. Just a quick followup on something you just said, Dr. Barth; and I have other questions I want to get to.

You said, we can save money basically if we put money up front in drug treatment, so that we avoid the cost of foster care later. Is that correct?

Mr. BARTH. For additional children, that is right.

Mr. MCCRERY. I seem to recall some statistics about the success of drug treatment not being particularly good, so how can you guarantee if we spend money up front on drug treatment that we are not going to have to spend money on foster care for subsequent children, given the record of success in drug treatment programs?

Mr. BARTH. Well, my estimate of success on this was fairly modest, about one-third. I believe it is somewhat higher because I don't think we have fully explored what is involved in providing comprehensive drug treatment and how successful it could be.

One of the Abandoned Infants Assistance Programs in Oklahoma that I reference in my written testimony is now providing intensive drug treatment services, including parenting work and domestic violence and drug treatment at a very early point when the family comes into care, usually in the first week. They are finding substantial success in working with families who are mandated to come there in this particular program.

I don't think there are guarantees, but I do believe we have learned enough through the demonstration projects we have been doing to have a good sense that such sources really can make a difference. When we see evidence on the repeated patterns of foster care placements among the children of drug-involved mothers, we can understand what is at stake with some of these families who are having so many children come into foster care.

Mr. MCCRERY. Is there any data you are aware of that indicates a higher success rate in drug treatment programs for parents than for nonparents?

Mr. BARTH. I am not aware of such data. I would defer that to anyone else on the panel who might have knowledge about that.

I think we are really just at the beginning of understanding how to best save parents. Most custodial parents are women, and it has really just been in the last few years that we have begun to understand what their particular treatment needs are.

Ms. YOUNG. If I can add to that, some of the major studies of treatment effectiveness have neglected to look at exactly that issue. Although we have good cost offset data from some of the studies—Oregon, California—it has not been something we have looked at specifically to look at the differences for parents or for women.

There is a secondary analysis of a California study that did look specifically at the cost offsets for women and found lower cost offsets than the whole population, primarily related to the fact that women are not as involved in the criminal justice system before treatment as men are. There was still a cost offset that was derived from providing treatment to the women in the CALDATA data study.

Mr. MCCRERY. Thank you.

Dr. Zill, you have reached the conclusion that for welfare recipients that are drug abusers, it would not serve them well to exempt

them from the 5-year time limit. For example, and I think you said the work requirements as well.

Does any of the rest of the panel have a problem with that? Do you disagree with that conclusion? Have you thought about it?

Ms. YOUNG. I hate to do an "it depends," but I think it does depend.

If someone is making progress in their treatment program and is not yet ready to take on the responsibilities, which can be significant, of parenting and working and getting the transportation, the things that are now required of them, then there should perhaps be some extensions available for those particular cases. Again, I would condition that on families that are participating and meeting the compliance requirements of their plan in order to participate in work and to continue to receive benefits.

Mr. MCCRERY. Dr. Zill, can you expound a little bit on why you reached that conclusion? Why is it not to their benefit to exempt them?

Mr. ZILL. First of all, because you are providing public support for addiction, and I think that is bad for the person. I think it is bad for the program; it gives a bad name to the program and the many people who need temporary assistance who are not addicted.

Second, what seems to be a common thread when drug treatment is successful, people come to the point they are prepared to change, and I think all the motivation you can give people externally will be a help. I don't think it is a guarantee; I think you will have lots of failures. In fact, you may need to give extra incentives to employers who hire such people because there is a problem of theft. But certainly there are examples of people who are not on welfare who hold down jobs and also have substance abuse problems, so it is not unprecedented.

I don't think there is any guaranteed success here, but I do think the alternative is worse. I don't think we should be subsidized.

Mr. MCCRERY. Basically, you are saying the motivation for success and treatment is less if they have an income stream from the Government?

Mr. ZILL. Exactly.

Mr. REUTER. Can I just suggest there is one aspect that has to be balanced against that?

The issue of how criminally active are recipients of public assistance when they are no longer receiving public assistance is one that must also be weighed. I don't have an answer, but I don't think it should be ignored.

Mr. MCCRERY. If we had an answer to that, we would all be better off. It is a very fundamental question and we may find out, if we are successful in sticking to the welfare reforms that are in place and 10 years down the road, looking back on the data of crime and the commission of crime, people might have a better sense of what the answer is. But that is a great question. I wish we knew the answer now.

Thank you all very much for your testimony.

Chairman SHAW. Mr. Levin.

Mr. LEVIN. Well, I was thinking, you seem in sufficient agreement, but it wasn't clear what the question should be. But Mr. McCrery raises an interesting issue, and I think it probably vali-

dates the wisdom of our giving the States power to exempt a limited number of people, 20 percent, from the cutoff. Because I assume, if they want to, where there are people who are indeed moving along and moving away from their addiction, they have the power to exempt them.

If they are moving away, presumably a continuation of benefits would not necessarily be an incentive to continue drug use; in that case, it could be an incentive to continue away from drug use, right? So I am not sure there is really disagreement there.

And I would think, Mr. Chairman, that we ought to really—and the legislation I think does this—stimulate inquiry into the long-term TANF recipient, because the data may differ. Although we tend to stereotype, the majority of people move on and off of TANF within 1 year.

But there is a substantial number that we have always worried about, and you surely have people who are long-term recipients, and for them, drug abuse may be the more serious problem. Is that possible?

Ms. YOUNG. That is the information that came from Utah, which had a welfare reform that targeted alcohol- and drug-using parents prior to the Federal legislation. And they found—and they had a no exemption policy. Everyone was required to participate in some sort of work activity; they could define work activity more broadly than most States have defined work activity. But they found, after the initial wave of persons were able to get jobs, they had a higher concentration of alcohol and drug problems than what they had in their population at the beginning of their welfare reform initiative.

Mr. LEVIN. So as the States move with some success to reduce the roles, the likelihood is there will be more long-term people who are on the rolls than short-term—that is almost by definition, but I think it is beyond that—and the drug abuse problems within that population may be more serious, and therefore we need to focus on the relationship of drug abuse in that population, right?

Ms. YOUNG. That is correct.

Mr. LEVIN. And are we doing enough of that research? Time is running, so what should we do to focus in on that population?

Ms. YOUNG. There are a handful of States that have used their, I believe, substance abuse money to do a good, methodologically sound study of the TANF population, using a screening inventory that can assess both alcohol and drug problems, psychological problems, social family relationships, legal problems.

One of those States is Florida, which is in its final planning stages, so that they will have methodologically reliable data about the TANF population and the addiction severity in the TANF population. We are hopeful they will be able to expand that to their child welfare population also.

Mr. LEVIN. Also, the $3 billion program that was passed has a focus on the longer term recipient, and I don't remember offhand the breadth we gave to the States in terms of applying funds or problems that relate to drug abuse. They cannot use any of the moneys directly for prevention or for a treatment program, but—you can use TANF, but not the $3 billion.

Mr. ZILL. Representative, I did want to say——

Mr. LEVIN. I think what we are doing is kind of zeroing in. It is kind of helpful to focus in on what the issue is all about.

We haven't touched foster care in my questions, but on the TANF population——

Mr. ZILL [continuing]. Some of the long-term recipients, it is not a question of drug abuse; it is a question of low skills, related job skills. And some of the people who are on welfare, who have drug-abuse problems, in fact, have quite decent skills; the problem is, they have a drug-abuse problem. So I think there is a higher incidence, but it is not the case for all long-term recipients.

Mr. LEVIN. And the last thing I want to do is stereotype any segment of TANF recipients, but it may be there is a greater incidence of drug abuse among those who are on TANF longer term—there may be some correlation; and if there is a correlation, it means, as they become a larger proportion of TANF recipients, there has to be more attention given to the drug abuse issue.

Thank you.

Chairman SHAW. Just to add to that, very briefly, a lot of these people got in the fix they are in because of the drug abuse, so it is a question of, they got in the program because they were poor and they were poor because of drug abuse and particularly when you get into crack cocaine that preys on the poor so terribly and is so immediately addictive, almost is a foregone conclusion in itself, once they get into that.

Ms. YOUNG. Chairman Shaw, I don't believe we have evidence that would necessarily support that because drug abuse is so interrelated to other issues—related to unemployment, to less than a high school education, to the age of the person, and to marital status. So you are looking at something that is interrelated, and I don't believe there is evidence that would say the receipt of welfare was something that was a precursor or that less than a high school education was a precursor to drug abuse; those things are all mixed in together. But there are higher rates among the unemployed.

Chairman SHAW. What I was saying is, once somebody gets into that spiral—whether they are receiving TANF or not, once they get into the spiral, their ability to take care of themselves and work is greatly diminished, so that the drug itself, the use of the drug itself, almost dictates the person is going to go into a life of poverty.

Ms. YOUNG. For all of us, yes.

Chairman SHAW. I was trying to establish a chicken-and-egg situation. It isn't that people receiving benefits are more likely to fall into drugs, as much as it is people using drugs are likely to fall into a situation where they need the aid.

Mr. LEVIN. And I think I might say, the result of that is, it has implications for whether it is 15 to 20 percent, for how that group moves off of welfare into work. I think it has implications for the programs that are necessary.

Chairman SHAW. Back into the situation you were talking about, and that is, once we get down to the hardcore population, it is going to be tough to be showing the successes we are showing now in the early returns.

Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman.

Ms. Young, Dr. Young, I have a canned question here pointed out by staff that I want to ask you; then I want to ask you one of my own. You described a highly fragmented Federal effort to combat substance abuse. Would a block grant of these programs help, where the Federal Government ends all or most of the current programs, provides money in a single stream to States, and removes current fundamental Federal mandates and restrictions that accompany these funds?

Ms. YOUNG. In fact, I think a lot of the States have passed on that block grant notion to their local regions and their counties, and it has been up to the counties to put the pieces together.

I think the Federal Government could do a lot in order to make it easier for the locals to determine what their own needs are and being able to address those needs. I am not an expert on public financing of big social programs, so I would not want to say that that would be the way to go; however, I do believe there are things Congress could do to make it easier for the locals to be able to put those pieces together.

A treatment center that operates in south central Los Angeles has over 40 funding streams coming into its agency; the administrative nightmare for 40 funding streams is enormous. I am not saying we need another funding stream by any means, but we certainly need to be able to put that together at a local level that makes much more sense.

Mr. COLLINS. OK. Now for my question.

In all of these studies where you concentrated on the area of welfare, welfare recipients, and drug abuse among those recipients, was there any part of these studies that focused beyond demand and looked at supply? Maybe in the area where there was more concentration by the local government on the enforcement—not on the use of drugs, but on those who are trafficking in and selling drugs? Where you might have had a shorter supply, a higher cost for the demand, do you have anything like that that shows whether there may be some variance of usage versus the——

Ms. YOUNG. Dr. Reuter does.

Mr. REUTER. Yes, I do. Supply——

Mr. COLLINS. What is your full name? We have got a place for you too.

Mr. REUTER. There are no studies really for any population that relate the intensity of enforcement to drug use, whether it is participation rates or frequency of abuse among those who do use.

First of all, it is very hard to get good measures of the intensity of enforcement, and you have to do it in a way that allows you to match that data against the way data are collected on demand. There aren't any studies that do that, whether for welfare or for anything else.

Mr. COLLINS. I go back to the point Mr. Rangel made. Oftentimes, these people who get trapped in this type of lifestyle, their best friend is the drug dealer, and I think we should concentrate too not only on trying to help those who have been—who have gotten addicted to this problem, but that best friend who keeps them addicted, who is making money out of the system; and I just wondered if there was any type of study that indicated whether there

might be less use in an area where you have stronger enforcement of the supplier?

Mr. REUTER. Congressman, I agree that is a very reasonable hypothesis. There is no evidence that bears on it, but nothing that contradicts it.

Mr. COLLINS. Have you attempted to do anything like that?

Mr. REUTER. Have I attempted? No. It is simply a data problem. It is not conceptually difficult; it is just that there aren't the data.

Mr. COLLINS. I think it would be an area to look at, rather than always trying to look at how we can spend money on those who have been trapped. That is a necessary evil, but the worst of the evils are the ones who are supplying it. By God, they are the ones we ought to set our sights on in trying to get them off the streets and out of the way and shorten the supply, run the price up, and maybe we would have a positive effect on those attempting to use by pricing it out of the market.

I don't care if you give them welfare or work; if they have a problem, they are going to spend whatever funds they get on that problem. So—that is enough.

Thank you, Mr. Chairman.

Mr. ZILL. There is a consistent body of evidence from the delinquency area, which does not speak to drug suppliers, per se, but speaks to bad friends. These kinds of behaviors, including drug use, are often linked to being tied into a group of peers who are users, and so there is——

Mr. COLLINS. I am not talking about peers, I am talking about the guy Mr. Rangel was talking about who becomes their best friend, because they will keep them addicted and supplied. That is not a best friend at all.

Mr. REUTER. There is the notion that there are two separate groups: One is a set of people who sell, and the other is a set of people who buy. In fact there is a population of frequent users of drugs that moves across that boundary; a lot of people who are drug users are frequent drug sellers. It is fairly hard to find someone who is an impoverished, frequent user of cocaine who is not also at times a seller.

Whether locking them up does good for them, or anyone else, is a reasonable question; but I think the notion that you go after the suppliers, suggesting there is a different population, is probably not in fact very helpful.

Mr. COLLINS. I think you are wrong.

Mr. REUTER. I am simply saying, analytically, it is not very helpful. It is not a policy statement.

Mr. COLLINS. Get out in the real world.

Chairman SHAW. Mr. Coyne.

Mr. COYNE. I yield to Mr. Rangel.

Chairman SHAW. Mr. Rangel.

Mr. RANGEL. Thank you.

Dr. Zill, was it your opinion that exempting addicted welfare recipients from the 5-year limit would encourage drug dependency?

Mr. ZILL. Continue drug dependency.

Mr. RANGEL. And what do you base that on?

Mr. ZILL. Well, as I stated in my testimony, what seems to be a key in identifying that minority of cases where there is successful

drug treatment is some kind of a motivational change within the person, and often you have success after a set of failures; and having some strong sense of motivation that if I get off this habit, I can change my life in a positive way, that countering that with, if you stay dependent, you are going to continue to get effortless funds—admittedly, they are not very generous kinds of funds, but you will get supported by the Government—I think is an incentive in the wrong direction.

I am not saying this is going to create miracles. I don't think it is going to create miracles, but I think it is a bad policy to make an exemption for people who are drug abusers.

Mr. RANGEL. Would it follow that if the limit was 4 years or 3 years or 2 years, that that would be an incentive to speed and encourage people to be——

Mr. ZILL. I believe that TANF should provide drug treatment programs, but I think they should be in parallel with employment training and preparation, because I don't think you should have treatment first and then employment. I think you should have the two together.

Mr. RANGEL. I agree with that, but don't get me confused. If cutting it off in 5 years is an incentive for a person to get off of drugs, research would suggest that cutting it off in 2 or 3 or 4 years would be a greater incentive.

Mr. ZILL. I don't think the time limit is the important thing——

Mr. RANGEL. It is important enough for you to suggest that a person not be exempted in 5 years. I agree with you that time is important politically, but it is certainly not important in terms of trying to help a person. A person that can go to work in 1 day, that should be the time limit.

Mr. ZILL. If there is a good job waiting for them.

Mr. RANGEL. Fine. You talk about those with no skills. If there are no skills and no jobs, you couldn't possibly support just cutting them off in 5 years, could you? We have a 20-percent safety net; you would recommend that they fall in that group, wouldn't you?

Mr. ZILL. Perhaps.

Mr. RANGEL. I don't have any other questions.

Mr. ZILL. I do feel there is also a very bad aspect to this from the point of all those people who need help who are not drug abusers, that when TANF is known as a program that supports drug abuse, it paints the other people with a bad brush.

Mr. RANGEL. I was under the impression, and I haven't had your training, that these people who are drug abusers are sick people, the same way as those who abuse alcohol; but you are saying we should not treat them that way. It would be unfair to them. In other words, you are subsidizing the sickness by giving treatment.

Mr. ZILL. If we had a treatment like immunization, you get this injection and you will no longer be a drug abuser——

Mr. RANGEL. We don't have that.

Mr. ZILL. We are talking about a behavior that is subject to motivational things for which we don't have a 100-percent solution; in fact, as was just stated, we have about a 33-percent solution.

Mr. RANGEL. But reduction in treatment for alcoholics and addicts, in your opinion, should encourage people to get better faster.

Mr. ZILL. Well, I think you understand——

Mr. RANGEL. I do understand.

Mr. ZILL. And I do think we have to be humane, but at the same time have a program that is effective.

Mr. RANGEL. I understand.

Chairman SHAW. Mr. English.

Mr. ENGLISH. No questions.

Chairman SHAW. Well, I would like to thank this panel. I think you have given us very good information and insight. Obviously, in some of these areas, there is room for disagreement, and reasonable people can disagree; but I think that in the long run, I found a lot of agreement among the witnesses, and I appreciate your testimony.

The final panel, and I want to announce to the Subcommittee and to the testifying people, the House is going back in at 5 o'clock and they are expecting at least one vote at that time. Without in any way shortchanging the final panel or the Members' ability to question, if we finish by 5 o'clock, that is fine. If we don't, we would simply recess until such time that we can come back and continue the hearing.

Gale—is it Slater or Slaughter?

Ms. SALER. Saler.

Chairman SHAW. Saler—deputy executive director at Second Genesis in Bethesda; Judy Ogletree, former welfare recipient, receptionist at Second Genesis in Bethesda; Dave Batty, executive director of Teen Challenge, Inc., in Brooklyn, New York; Sally Satel—Dr. Sally Satel, the Oasis Clinic in Washington, DC, and a lecturer at Yale University School of Medicine; and Mitchell Pearlstein, Ph.D.—president of Center of the American Experiment in Minneapolis, Minnesota.

Ms. Saler.

**STATEMENT OF GALE SALER, M.ED., CPC, CRC–MAC, DEPUTY EXECUTIVE DIRECTOR, SECOND GENESIS, INC.; ACCOMPANIED BY JUDY OGLETREE, GRADUATE AND RECEPTIONIST, SECOND GENESIS, INC.**

Ms. SALER. Thank you, Mr. Chairman. I want to thank you for inviting Judy Ogletree and myself to appear before your Subcommittee. I am deputy executive director of Second Genesis, a not-for-profit corporation providing therapeutic services in Maryland, Virginia, and the District of Columbia. I am also, by training, both a vocational rehabilitation counselor and an addictions professional.

Therapeutic community programs provide substance abuse services using the disease model of addiction and incorporating the principles of positive peer support with professional substance abuse treatment. Our goal is to provide to individuals, families, and communities the tools necessary to live safe, healthy, self-sufficient lives, free of drugs, crimes, violence, and exploitation. Many of the clients referred to therapeutic communities have significant occupational and educational deficiencies resulting from their years of substance abuse.

Most of our clients need habilitation, not rehabilitation, because they never developed adequate social or coping skills. Interacting within the healthy environment of the therapeutic community is a

vital part of treatment for our clients, and an important part of our job is to help the folks we see identify a value to being clean, sober, and self-sufficient and to recognize that, maybe for the first time, they have something to lose if they decide to use drugs in the future.

It is important to know that successful treatment in the therapeutic community requires employment and a job or career path appropriate to the education and skill level of the individual. Locally, we have been very lucky in this regard and worked very hard at establishing corporate partnerships, and I would recommend that the Subcommittee talk to some of the corporate partners who have worked with substance abuse treatment.

I have included details in my written testimony of the process by which therapeutic communities move clients simultaneously into recovery and into the work force, and I think they address some of what I know have been Mr. Rangel's long-held concerns about making sure that happens. It is useful to recognize that these processes—recovery and return to the work force—can be made to work together, supporting the goal of the safe, healthy, self-sufficient individual.

What is essential for us to recognize is, this type of comprehensive plan requires immense coordination of services, ranging from treatment to health care, to children's services, to education, to vocational counseling, to housing, to child care, and so on. It is also essential it be recognized, this is a process that does not happen overnight or over 1 week or even over 1 month. We are teaching essential life skills to folks, many of whom who do not have role models for what we are teaching.

One of the programs operated by Second Genesis is designed to provide treatment to women and their children up to age 10. That is where Judy received her treatment, and this is a program that allows a family to remain in residence and receive treatment together, mother and children. For approximately 6 months, with 3 to 6 months of aftercare and access to services for up to 2 years. This program is one of the 50-plus programs nationwide currently funded by Federal Center for Substance Abuse treatment dollars and for which funding will be running out next year.

I invite you or any of your staff to come visit that program; it is only a few miles away, off Pennsylvania Avenue. There you will see the best of recovery and the best of welfare reform—women helping women, women helping children, children helping children, and families finding the proverbial bootstraps they need to return to their communities as contributing members.

Some of you will ask, Does this really work. The answer for me is simple. Clinically, I know treatment works. I also know that as with most other diseases, treatment works best if you follow and complete the prescribed treatment plan.

From January 1992 through December 1994, Second Genesis participated in a national Institute for Drug Abuse-funded study comparing standard and enhanced treatment protocols to which clients were randomly assigned by an outside source. The longitudinal results of this study clearly indicate the effectiveness of the therapeutic community for improving psychological functioning,

post-treatment employment, and reducing substance abuse and criminal activity.

The Center for Substance Abuse Research at the University of Maryland conducted an independent followup, which found, in part, that 79 percent of those who completed their treatment program were drug free 2 years later, 65 percent of those who completed their program had no further involvement with the criminal justice system, and 85 percent of those who completed their program were employed at the time of followup.

These statistics are impressive for two reasons. They confirm lifestyle changes in the majority of clients who complete treatment, and they demonstrate the importance of completion of treatment for positive outcomes.

Welfare reform has already moved many Americans off public assistance, but the States report that that first wave was the easiest to employ. Greater challenges will be faced in making many of those who remain employable; among those are our addicted populations.

Recovery from substance abuse is not just about people getting clean and sober; it is about empowering people to make healthy choices because they have been given the opportunity to succeed.

Judy is one such person.

Ms. OGLETREE. Hi, I am Judy, and I am one of the graduates of Second Genesis. I am glad to be here today, Mr. Chairman.

I am here today on behalf of myself and a lot of working mothers with children that were hooked on crack cocaine. Today, I can proudly say that I am no longer hooked on crack cocaine. I am working full time, I am a mother to my two kids today.

I was in the justice system as a criminal. I am no longer a criminal. I am working full time at Second Genesis as a receptionist. I have my kids back in my life because they were placed in the foster care system. They are currently living with me in a transitional house. Also, I will have full custody of them, as of January.

As of November, I will be off of the welfare system for good, and basically, that is what the welfare reform has done for me today. The help of the welfare reform and the people in my life, such as Second Genesis, if they had not given me a second chance at life, I don't think I would have made it out there alone. As I said, I can proudly thank Second Genesis and people in my life, such as the welfare system, for giving me and my children the assistance that I needed.

I had a child that was born with a disability as a result of me using—for 14 years on drugs and alcohol; but today my child is getting the special help that she needs to get through this state—through the proper people, through Second Genesis. They taught me how to become a loving parent, how to care for my child that needed that special attention; and today I can say, she is going into a regular pre-K schooling class, along with my son, who is doing very well. He is also registered in a Head Start Program.

So I can proudly say today that welfare reform does work for mothers that are single parents with children, or even for those who aren't single, but it does work. And the whole thing about it is, you have to want to change; and it came to a point in my life where I wanted to change; I wanted that change in my life, for my-

self and my children. They deserve a parent in their lives—and today I can say they have a parent in their lives that is a very good role model for them.

I get up every morning at 4 o'clock in the morning to be to work on time, I come home by 8 o'clock at night and they are still fed, they are still clothed, and they are still bathed; and so today I can proudly say that I am a hard-working citizen and a mother today.

[The prepared statement follows:]

**Statement of Gale Saler, M.Ed., CPC, CRC–MAC, Deputy Executive Director, Second Genesis, Inc.; Accompanied by Judy Ogletree, Graduate and Receptionist, Second Genesis, Inc.**

Mr. Chairman:

My name is Gale Saler. I am the Deputy Executive Director of Second Genesis, Inc., a not-for-profit corporation providing therapeutic community services in Maryland, Virginia, and the District of Columbia. I would like to thank the Chairman for inviting Judy Ogletree and me to appear before the House Ways and Means Subcommittee on Human Resources today to discuss the challenges welfare reform is placing on state governments, private industry, and welfare recipients.

The response to welfare reform has differed among the states. In Maryland, the State Assembly has recognized the need to prepare recipients to become financially independent by supporting substance abuse treatment as an important step.

Second Genesis operates five (5) therapeutic communities in the Washington, D.C., metropolitan area. Four of our communities serve a mixed male/female adult population. Our program in Upper Marlboro, Maryland, is a women's and children's program designed to provide therapeutic community services for women who have minor children under the age of 10. Our therapeutic community programs provide substance abuse services in a residential setting using the disease model of addiction by incorporating the principles of positive peer support and professional substance abuse treatment.

Typically, clients referred to therapeutic communities have significant occupational and educational deficiencies resulting from years of substance abuse. They are considered hard core, and in general they are considered dangerous. Therapeutic communities are designed to provide a whole range of services while the clients are in residential treatment. Most of our clients need "habilitation," not rehabilitation, because they never developed adequate social or coping skills. Interacting socially within a healthy community environment is a vital part of treatment for our clients.

*The Client*

Our typical clients are young (20s to 30s) and present several similar characteristics upon admission. Primary among these characteristics is a predictable pattern of substance abuse that has resulted in increasing . During the course of the substance use other life goals have been sabotaged or severely delayed.

Frequently the client has no work history or a sketchy work history that includes several minimum wage jobs with few if any benefits. The client lacks competitive skills and has educational skills that are inadequate to compete for vocational training or career track positions. As a result of these deficiencies, our clients lack goal setting and planning skills that are appropriate or reasonable given their education and skill level.

The client often has a skewed or distorted definition of success with inflated and unrealistic expectations due to media and cultural influences. This distorted image is usually created to mask the lack of a positive life vision.

Personally, the client lacks self-esteem which results in a poor self-image and a poor interview performance. The client usually has at least one "high maintenance" child whose needs frequently conflict with job demands. Generally, there is a family history of welfare dependency, and frequently there is involvement with the criminal justice system.

Substance abuse treatment alone is not sufficient for a client with these problems to stay clean and sober, much less succeed in finding meaningful employment.

A client who appears for treatment with these severe developmental and social skill deficiencies feels he or she has little to lose by using alcohol or drugs. Helping a client reach his or her developmental potential is a key to encouraging the client work toward a future free from alcohol and drugs.

An important part of our job is making the clients feel that there is a value to staying clean and sober—that maybe for the first time in their life they have something to lose if they choose to use alcohol or drugs in the future. The idea of making

healthy choices by avoiding the risk of losing a good job, a good relationship, or a comfortable home is truly a new concept for most of our clients. The role of the therapeutic community is to put interventions in place for vocational training, educational services, social skill building, conflict resolution and anger management, and housing placement assistance that will support their success in recovery from substance abuse.

Therapeutic community treatment involves multiple phases and multiple types of interventions. Although different clients may follow slightly different treatment paths (based upon their developmental needs), all clients go through the following phases: stabilization, orientation, identification of a need to make changes, external pressure to change, discovery of skills (empowerment), and orchestrated success.

Successful treatment requires employment in a job or career that is appropriate to the education and skill level of the client. In developing the pathway to successful employment in thhe primary steps include:

*Work Adjustment Training*

Work adjustment training teaches accepted employment practices in a sheltered therapeutic environment by assigning jobs within the residence. Early in treatment, job assignments are designed to enhance strengths and foster self esteem. As treatment progresses, assignments are designed to address clinical and behavioral weaknesses and teach frustration tolerance. During this phase, the client is challenged to face those situations that could cause an employee to quit, lash out at co-workers, or be insubordinate to a supervisor. The best therapy is the use of actual situations that have caused the crisis, studying the reactions of the client, and discussing the alternatives the client could have chosen. This therapeutic model empowers the client to use other alternatives to relieve a crisis.

The client begins to develop work skills by understanding the need to pay attention to detail, the need to complete a task, taking pride in workmanship, and accepting responsibility and accountability. Most employment situations are hierarchical in that most employees have supervisory, supervised, and peer relationships with other staff. The client learns to understand the appropriate role he or she plays in each relationship. The client also learns about employee rights, on-the-job advancement, and standard grievance procedures.

Our goal is to create a client who will be a responsible, proud employee who understands his or her appropriate role within an organization and is not fearful of being held responsible or accountable for tasks that are assigned during the course of employment.

*Vocational Preparation*

Vocational services begin when the client has experienced clinical and experiential success in the treatment and recovery program. Vocational services are earned by the client by demonstrating pre-vocational skills, including a realistic desire to succeed. The vocational counseling services include assessment, guidance, planning, resume and interview preparation, and other related job-seeking skills.

*Activities of Daily Living*

Activities of daily living include groups with themes such as "appropriate behavior on the job," "peer relationships and socializing on the job," "negative behavior," and "entitlement." Each group member learns the appropriate role in the workplace by role playing situations and discussing alternative methods of resolving conflict.

Relapse prevention plays an important role for the client in understanding the triggers and impulses that can lead to a return to substance use. The client learns to avoid triggers and how to use his or her recovery program to avoid situations that can lead to relapse.

The client learns to prepare a personal budget, how to use a bank, and how to live within a budget. The client also learns to develop a healthy social network of friends and hobbies to replace friends who may still be alcohol-or drug-involved or hobbies that may be criminally related. The therapeutic community exposes the client to recreational and social alternatives that will create an environment supportive of continued recovery.

Vocational counseling is essential throughout the process of making the client ready to seek employment. Developing behaviors and skills that are consistent with successfully finding employment prepares the client for the challenges of locating the right job and independent living.

*Setting a Goal*

The client learns to set a realistic goal that is obtainable given the resources, education, and training available. He or she must then determine if reaching the goal

will create an income adequate to meet basic needs. The client then is asked to determine what step and sacrifices will be necessary to reach the goal and if he or she is prepared to make the sacrifices necessary to achieve the goal.

*The Employment Plan*

The client prepares a plan to achieve the employment goal that he or she has selected. The plan must include specific objectives for vocational preparation, unmet educational needs, planning for child care and family needs, safe housing, and coping with relapse triggers. The plan also needs to have alternative choices for each objective if circumstances or mistakes require the plan to be altered. The client learns the need to remain focused on the objectives of the plan to reach the goal of selected employment.

*Carrying out the Plan*

The client develops a job search strategy that includes developing a resume, identifying references (personal and professional), and learning how to locate the most likely sources of employment prospects. The client learns how to assess a job offer by weighing the pros and cons, benefits, and other employment options. At the time the client accepts a position, he or she learns to clarify any unsettled questions with the prospective employer and establish a mutually agreeable starting date. The vocational counselor prepares the client for the first day on the new job when a new employee's desire to succeed may create stress for the employee (and everyone else). The client then begins to activate the budget plan beginning with the first paycheck.

*Moving Out*

During the move out phase the client lives within the budget he or she has created, setting aside funds for housing, food, child care, transportation, legal fees (if any), utilities, social needs, and savings. While the client is still in residence in the treatment program the client places the funds in a bank where they are reserved until such time as he or she has located a safe place to live, convenient to his or her employment, that is within the budget the client developed based upon his or her income.

*Aftercare*

The first goal of anyone in recovery is to stay clean and sober. All other goals and objectives are dependent on their being able to maintain sobriety. Aftercare smoothes the transition for the client from the safety of the therapeutic community to the hazards of the real world and all the relapse triggers associated with returning to the community. After the client is discharged from residential treatment he or she continues to return to the program for outpatient aftercare to address issues that occur after the client leaves treatment and begins to move toward independent living.

*Does Treatment Work?*

From January 1993 through December 1994, Second Genesis participated in the D.C. Initiative, providing residential therapeutic community services in a "standard" and an "enhanced" treatment protocol. The longitudinal results from the D.C. Initiative clearly indicate the effectiveness of therapeutic community treatment for improving psychological functioning, post-treatment employment, and reducing substance abuse and criminal activity. Outpatient aftercare was a significant contributing factor to the success of clients who completed both the residential and outpatient treatment components.

It should be noted that in addition to the having the developmental needs most frequently seen in the population on public assistance, two-thirds of the population that participated in the D.C. Initiative also had a pattern of involvement with the criminal justice system. The Center for Substance Abuse Research (cesar) of the University of Maryland has conducted follow-up studies on clients who participated in the therapeutic community service of the D.C. Initiative. A summary of its findings includes the following:

- Seventy-nine percent (79%) of the persons who completed the program reported they were drug-free more than two years after leaving treatment. Thirty-one percent (31%) of the persons who did not complete the program were drug-free after two years. The 79 percent figure was confirmed by drug tests taken three days prior to the follow-up interview.
- Sixty-five percent (65%) of the persons who completed the program reported no further involvement with the criminal justice system after treatment. Only 42 percent of the persons who did not complete the program reported no further criminal involvement.

• Eighty-five percent (85%) of the persons who completed the program reported being employed at the time of the follow-up interview. Only 61 percent of the persons who did not complete the program reported employment at the time of the interview.

These statistics are impressive for two reasons: they confirm the life-style changes in the majority of clients who completed treatment, and they demonstrate the importance of completion of treatment for positive outcome.

A reduction in involvement with the criminal justice system at the time of the follow-up interviews was significant. These findings support the importance of treatment completion in the reduction of criminal activity and drug use in a sample that was heavily involved in criminal activity prior to treatment.

The findings by CESAR of the clients who participated in the D.C. Initiative support the concept that substance abuse treatment, if it is to be successful, must also accomplish significant life-style changes, incorporate developmental needs into the treatment milieu and prepare the client for independent, drug-free living. (See Attached Table).

*Summary*

Welfare reform has moved millions of Americans off public assistance. Up until this time, the persons who have successfully moved from public assistance have been those who were easiest to employ or who had alternative support during the transition to self-sufficiency. Greater challenges will be faced in providing services to make others employable and self-sufficient. Recovery from substance abuse is not just about people getting clean and sober, it is about people empowered to make healthy choices because they have been given the opportunity to succeed in life through recovery.

Attachments:

D.C.I. Statistics, CESAR, University of Maryland, 1997

Therapeutic Communities of America, Memorandum from Linda R. Wolf Jones to Gale Saler, *TCA Perspective on Welfare, Work and Drug Treatment*

Second Genesis graduates of treatment in the D.C. Initiative used drugs less frequently and had fewer arrests than non-graduates.

| | Completed Inpatient & Outpatient at Second Genesis % | Completed Neither % |
|---|---|---|
| *Used Drugs Post Dicharge (Self-Reports):* | | |
| Alcohol | 18 | 43 |
| Marijuana | 7 | 23 |
| Cocaine | 16 | 55 |
| Crack | 15 | 52 |
| Heroin | 8 | 11 |
| *Positive Urine Test Results:* | | |
| Alcohol | 6 | 10 |
| Marijuana | 7 | 10 |
| Cocaine/Crack | 18 | 49 |
| Heroin | 12 | 6 |
| Arrested 6 Months Post Discharge | 9 | 28 |

Source: Center for Substance Abuse Research (CESAR), University of Maryland, College Park, Md.

THERAPEUTIC COMMUNITIES OF AMERICA
1612 CONNECTICUT AVENUE, N.W., SUITE 4–B
WASHINGTON, DC 20009
*October 17, 1997*

TO: Gale Saler
FROM: Linda R. Wolf Jones

Re: TCA Perspective on Welfare, Work and Drug Treatment

Therapeutic Communities of America (TCA) supports public policies that move women from welfare to work, but cautions that women with substance abuse problems will not generally be able to succeed in making the transition unless their substance abuse is addressed through intervention and treatment.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193) limited the receipt of welfare benefits to no more than five years. Substance-abusing welfare recipients will need treatment in order to achieve and maintain self-sufficiency. However, the legislation did not address or add capacity to the substance abuse treatment system. Individuals with dysfunctional life histories and severe substance abuse problems frequently require long term residential treatement in order to achieve a drug free, self-sufficient life style; The number of such treatment slots is very limited (estimated at no more than 15,000–20,000 nationwide, depending on the definition of "long term") and needs to be expanded. We suggest that additional funding must be made available specifically for the creation of long term residential treatment slots and the expansion of treatment capacity.

We are also disturbed by the fact that the Balanced Budget Act of 1997 (P.L. 105–33) recognizes that individuals who require substance abuse treatment for employment are (and should be) a target population for the use of welfare-to-work funds, but that substance abuse treatment is not specifically listed as one of the allowable activites as work experience programs, on-the-job training, and readiness, placement and post-employment services. For those with severe substance abuse problems, treatment is a prerequisite to succeeding at a job. It may be that the list of allowable activities can be interpreted as including provision of substance abuse treatment, but States are not likely to make such an interpretation if not specifically told that they can do so. Substance abuse treatment should be clearly identified as an allowable activity (i.e., an activity meant to move individuals into, and keep them in, unsubsidized employment) in the current law and any future legislation.

Chairman SHAW. Thank you.

Mr. Batty.

## STATEMENT OF DAVE BATTY, EXECUTIVE DIRECTOR, TEEN CHALLENGE, INC., BROOKLYN, NEW YORK

Mr. BATTY. Chairman Shaw, I am pleased to be here on behalf of Teen Challenge. I am Dave Batty, and I work with Teen Challenge in Brooklyn, New York.

For the past 39 years, Teen Challenge has worked not just with teens, but also with adults and families affected by drugs and alcohol in 130 centers across the Nation. We are privately funded by businesses, individuals, and churches, and we seek to work with inner-city gangs, substance abusers and their families, teen runaways, those who have been sexually abused, and also persons with HIV–AIDS.

Teen Challenge does extensive prevention training in community settings. We also have long-term residential help for those who have serious addictions. Teen Challenge provides over 3,100 beds in their residential programs. As I have worked with Teen Chal-

lenge since 1968, I have seen the success of this in leading people to a lifestyle that is free from addictions.

When I received the invitation to testify before this Subcommittee, I was told of your interest in hearing about organizations that have success in getting people off welfare and off drugs.

In a survey of the women in our Brooklyn Teen Challenge, I found 80 percent had been on welfare before coming to Teen Challenge. These ladies had been on welfare from 2 to 15 years. All had been using drugs while on welfare. Many had used their welfare checks to buy drugs. Seventy percent were working, and most of these were being paid under the table while they were on welfare. They used this money to support their drug habit. Eighty percent had been in at least one other drug treatment program before coming to Teen Challenge.

Now, some of these ladies had started on welfare because of a family crisis, but most came to believe the Government owed them this money. It is clear that those who come to Teen Challenge are not shining examples of the success of welfare. I would like to share with you the examples of three women who have graduated from Teen Challenge and are now working.

One 1991 graduate has been employed as a clerk typist at the same job for 4 years. A 1990 graduate has been working at the same job in the Bronx for 6 years as a social worker. Another lady, who is HIV positive, is working very effectively as staff for Teen Challenge in Brooklyn. She said, If I had not gone through Teen Challenge, I would be out there on the streets getting everything I possibly could from the Government.

So how does Teen Challenge help these welfare recipients to so dramatically change their lifestyle? The drug prevention work that Teen Challenge offers is faith based. We tell them they need to change their whole way of living. They need more than drug rehabilitation; they need life transformation.

We believe the key to long-term change is to place high priority on the spiritual component of their life. Establishing a personal relationship with God is the key to finding a path to freedom from addictions. This personal relationship with God provides the desire and the power to change their way of living.

In Teen Challenge, the residents attend classes dealing with anger, attitudes, self-image, temptation, obedience to those in authority, just to name a few of the issues. Getting them physically off their drug addiction usually only takes a few weeks, but developing a whole new way of living with a new sense of personal responsibility—that is why the Teen Challenge residential program is 1 year long.

In 1975 the Federal Department of Health, Education and Welfare funded a study of the graduates of Teen Challenge to determine the effectiveness of this approach to help drug addicts. Under the leadership of Dr. Catherine Hess, the former Assistant Chief of the Cancer Control Program of the U.S. Public Health Service, this study looked at those who had been out of the program for 7 years. This study showed that 70 percent of Teen Challenge graduates were living drug-free lives, abstaining from all narcotics, alcohol, and marijuana. Seventy-five percent indicated their current status as "employed"; 87 percent of the graduates did not require addi-

tional drug treatment after leaving Teen Challenge; 72 percent had continued their education after completing Teen Challenge.

A 1994 study by Dr. Roger Thompson, head of the Criminal Justice Department at the University of Tennessee at Chattanooga, found similar results in looking at graduates who have been out of the program from 2 to 15 years.

Teen Challenge has the proven cure for the drug epidemic. We work with both males and females with a significant student population in Hispanics and Afro-Americans. The help Teen Challenge offers cannot be forced on people; they must want to change. However, we have found that many of those who come to Teen Challenge had given up all hope of ever changing. They didn't see any way out until someone told them about Teen Challenge.

In conclusion, faith-based programs offer a high degree of success in helping drug addicts kick their addiction for good and establish a whole new lifestyle. Those who are using and abusing the welfare system can be helped through an approach that gives primary focus to meeting the spiritual needs of the person, in addition to their life-controlling problems. There is a great need for the Federal Government to find appropriate ways to partner with faith-based programs which are proving to be so successful in treating those with drug addictions.

[The prepared statement follows:]

**Statement of Dave Batty, Executive Director, Teen Challenge, Inc., Brooklyn, New York**

INTRODUCTION

I am Dave Batty, the executive director of Teen Challenge in Brooklyn, New York. I am pleased to be here to testify on behalf of Teen Challenge.

For the past 39 years the Teen Challenge organization has been working with youth, adults and families affected by drugs, alcohol and other life-controlling problems. In 130 centers across the nation which are privately funded by donations from individuals, businesses and churches, we seek to work with inner-city gangs substance abusers and their families teen runaways those who have been sexually abused and persons with HIV/AIDS

Teen Challenge does extensive prevention training in schools, churches and other community settings. Long term residential help is also provided to those with serious addictions. Teen Challenge provides over 3,100 beds in their residential programs.

As I have worked with Teen Challenge since 1968, first as a volunteer and then as a full time staff, I have seen the success of this program in leading people to a lifestyle free from addictions.

When I received the invitation to testify before this sub-committee, I was told of your interest in hearing from organizations which are having success in getting people off welfare and life-controlling problems that got them on welfare.

I conducted a survey of the women in our Brooklyn Teen Challenge and found that

- had been on welfare before coming to Teen Challenge
- an additional 10% were receiving food stamps
- these ladies had been on welfare from 2 to 15 years
- many had used their welfare checks to buy drugs
- 70% were working and paid off the books while on welfare and used this money to support their drug habit
- 80% had been in at least one other drug treatment program before coming to Teen Challenge

Some of these ladies had started on welfare because of a family crisis. Most came to believe the government owed them this money.

It is clear that those who come to Teen Challenge are not shining examples of the success of welfare in its goal to help those in legitimate need and help them move to become part of a productive work force in our nation.

I talked with three who have graduated from Teen Challenge and are now working.

1. One lady graduated in 1991 and has been employed as a clerk/typist at the same job for 4 years.

2. Another lady graduated in 1990 and has been working at the same job in the Bronx for 6 years as a social worker.

3. Another lady who is HIV+ is working very effectively as a staff at Teen Challenge in Brooklyn, NY. She said, "If I had not gone through Teen Challenge I would be out there on the streets getting everything I possibly could from the government." So how does Teen Challenge help these welfare recipients to so dramatically change their lifestyle? The drug intervention work that Teen Challenge offers is faith-based. At Teen Challenge we treat more than their drug addiction. We tell them they need to change their whole way of living. They need more than drug rehabilitation, they need life-transformation.

The key to the success of Teen Challenge is its holistic approach. We believe the key to long term change of those in Teen Challenge is to place key priority on the spiritual component of their life. Establishing a personal relationship with God is foundational to finding the path to freedom from addictions. This personal relationship with God provides the desire and the power to change their way of living.

In Teen Challenge the residents attend class daily where the focus is not drug education, but life education. Classes deal with anger, attitudes, self-images, temptation, personal work habits, obedience to those in authority, dealing with failure, just to name a few. In each class the focus is on personal application of life principles, not just content mastery.

Getting them physically off their drug addiction usually takes only a few weeks at the longest. But developing a whole new way of living, with new attitudes, new habits, a new sense of personal responsibility—that's why the Teen Challenge residential program is one year long.

In 1975 the Federal Department of Health, Education & Welfare funded a study of the graduates of Teen Challenge to determine the effectiveness of this approach to help drug addicts. Under the leadership of Dr. Catherine Hess, M.D., the former assistant chief of the Cancer Control Program of the U.S. Public Health Service, this study looked at those who had been out of the program for 7 years. This study showed:

- 70% of Teen Challenge graduates were living drug-free lives, abstaining from all narcotics, alcohol, and marijuana
- 75% indicated their current status as employed
- 87% of the graduates did not require additional drug treatment after leaving Teen Challenge
- 72% had continued their education after completing Teen Challenge
- 90% had been arrested before entering the program. Only 30% had been arrested in the seven years following their graduation

For more information on this research project, see NIDA SERVICES RESEARCH REPORT: AN EVALUATION OF THE TEEN CHALLENGE TREATMENT PROGRAM (DHEW Publication No. ADM. 77–425 Printed in 1977) and Research Summary by Dr. Catherine Hess. Both of these resources are available from Teen Challenge National Training & Resource Center, PO Box 1015, Springfield, MO 65801.

A 1994 study under the leadership of Dr. Roger Thompson, Head of the Criminal Justice Department of at the University of Tennessee at Chattanooga found similar results in looking at graduates who had been out of the program from 2 to 15 years.

- 67% of Teen Challenge graduates were living drug-free lives, abstaining from all narcotics, alcohol, and marijuana
- 72% indicated their current status as employed
- 88% of the graduates did not require additional drug treatment after leaving Teen Challenge
- 60% had continued their education after completing Teen Challenge

A complete report on this research is available from Teen Challenge National Training & Resource Center, PO Box 1015, Springfield, MO 6580l.

Teen Challenge has the proven cure for the drug epidemic. We work with both males and females, with significant student populations of Hispanics and Afro-Americans. Let me caution you—the help Teen Challenge offers cannot be forced on people. They must want to change. However, we have found that many of those who come to Teen Challenge had given up hope of ever changing. They didn't see any way out, until someone told them about Teen Challenge.

In conclusion, faith-based programs offer a high degree of success in helping drug addicts kick their addiction and establish a whole new lifestyle. Those who are using and abusing the welfare system can be helped through an approach that gives pri-

mary focus to meeting the spiritual needs of the person in addition to their life-controlling problems.

There is a great need for the federal government to find appropriate ways to partner with faith-based programs which are proving to be so successful in treating those with drug addictions.

---

Chairman SHAW. Thank you, Mr. Batty.

Dr. Satel.

**STATEMENT OF SALLY L. SATEL, M.D., PSYCHIATRIST, OASIS CLINIC; AND LECTURER, YALE UNIVERSITY SCHOOL OF MEDICINE**

Dr. SATEL. Mr. Chairman, thank you for inviting me. I work as a psychiatrist at a drug treatment clinic here in the District of Columbia, and I think my primary qualification for appearing today is that I have worked with so many patients whose recovery, in my view, was actually undermined by the welfare payments that they received.

What happened was that welfare, as a safety net, cushioned people from the painful consequences of their addiction; and that is not good in the long run, because it is the very fact that consequences are painful that is the major impetus to recovery. In addition to this, of course, the cash payments were regularly used to purchase drugs.

Obviously, there is a lot of talk about sending drug-abusing welfare clients to treatment, but I am not so sure that will be enough. And the reason is, attendance in programs is so low, and these programs have few means to keep the patients in. They have little leverage to keep patients involved, to reward attendance, to reward clean urines, sanction poor compliance.

So my suggestion is this: Use the welfare system as a leverage and harness the incentive power of, say, cash benefits to combat addiction by keeping people in treatment.

There is a drug clinic, for example, in Baltimore that is doing something like this; the monetary incentives they use come from a special research fund, but you can imagine they might be welfare benefits. In this clinic, patients who are struggling with heroin and cocaine get redeemable vouchers when they submit a clean urine and attend job training. Attendance at the training is way up.

Now, this approach can be adapted by clinics that are treating welfare recipients, so that the benefits themselves become the incentives for sustained attendance and ultimately recovery. But right now, conventional treatment programs don't have leverage to keep patients coming back. In fact, they have a very mixed record in treating patients and helping them to be drug free.

If you look at the second—the figure on the second page of my testimony—you see huge dropout rates from outpatient treatment, which is the most common form of treatment. About 1 in 10 complete 52 weeks, and, at minimum, 1 year is considered adequate duration of treatment. That is a minimum.

When patients do finish, as others today have said, they can do extremely well; but dropout is the rule, and then relapse becomes the rule. And that is why I am skeptical that treatment, as usual,

is the way to go, is the easy answer for drug-abusing welfare recipients. The alternative, as I mentioned before, would be to merge the functions of welfare, which is economic support, with the functions of drug treatment, which is recovery.

Create an active arrangement where the person can, for example, earn back payments, managed by a third party, possibly the treatment program itself, when the patient complies with the treatment. This would entail clean urine, counseling, job training, or supportive employment.

I will just mention briefly a few programs that are trying this. They are not using welfare payments. One of them, however, is using SSI payments.

Harborview is a clinic in Seattle. It works with substance abusers who also have mental illness. This is a clinic where patients are asked to sign over their SSI payments. And the clinic keeps their bank account and acts as their representative payee. Rent and other basics are taken care off, and the patients earn back whatever is left over; they earn back those discretionary funds through their compliance with treatment. Ultimately, they can get control of their bank account if compliant with the program.

The results show that after entering this payee program, compared to before, attendance and treatment are up, hospitalizations for drug-related complications are down, and jail time is way down.

Another program I will tell you about briefly is a clinic run by the University of Texas working with pregnant cocaine users; they receive payments, again, for attending clinics and keeping prenatal visits. And those women who received the payments attended far more clinic visits, had cleaner urines, in fact, were cocaine free when the babies were born, and their babies were less likely to be premature.

Finally, at the University of Alabama, addicts are given standard treatment, plus an opportunity to participate in supervised work as a positive reward for abstinence. If you have a dirty urine that day, you can't work. If you can't work, you don't get paid that day. If you get two clean urines, you can work again.

And the researchers there have found again, higher attendance at treatment and greater drug abstinence among the individuals participating in the incentive program.

So, of course, I am in favor of treatment for drug-abusing recipients who can't quit drugs on their own, but you have to keep in mind four things. Drug treatment really only works when people complete it. Dropout rates are high. You can keep patients in treatment longer with incentives and sanctions, and it would be a good idea to use the naturally occurring welfare benefits to provide these incentives.

I think this is a wonderful opportunity to take a system that for many, has induced dependence and use it to help shape their autonomy.

Thank you very much.

[The prepared statement follows:]

**Statement of Sally L. Satel, M.D., Psychiatrist, Oasis Clinic; and Lecturer, Yale University School of Medicine**

Mr. Chairman and Members of the Committee:

Thank you for inviting me. My primary qualification for appearing here today is that I treat many addicted patients whose progress in therapy is undermined by the welfare payments they receive. This safety net is well-intentioned but, unfortunately, it cushions the painful consequences of addiction. And it is the very fact that consequences are painful that provides the major impetus to recovery. Also, of course, cash welfare payments are regularly used to buy drugs. This unwitting sabotage can be redressed, I am confident, to help patients lead healthier lives, be better parents and contribute to society.

• I am skeptical, however, that such gains can be achieved through standard treatment which gives patients only modest incentives to fully comply, let alone become drug-free.

• The welfare system, however, provides an excellent opportunity to wield carrot and stick for the purposes of drug rehabilitation.

• We can use the incentives of the welfare benefits themselves as leverage to change behavior.

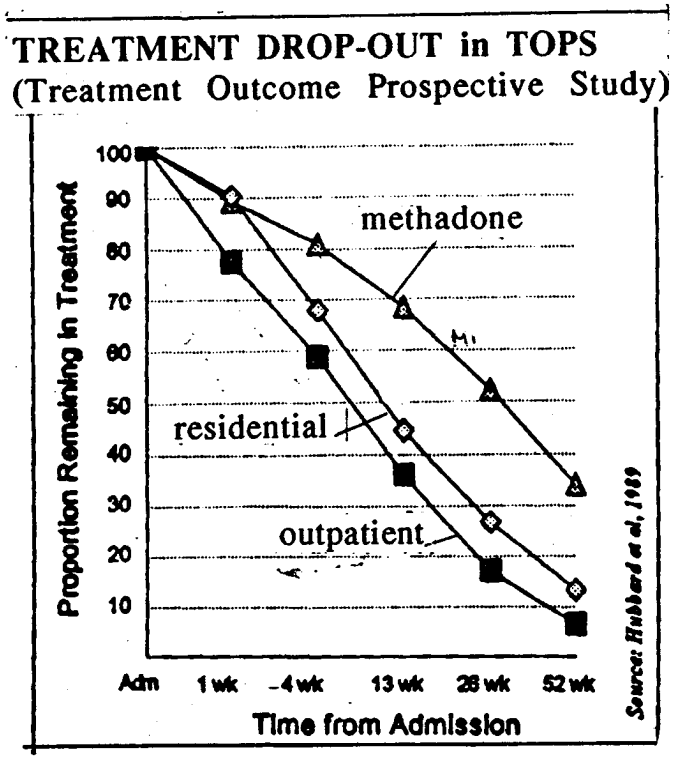
One model takes place in a Baltimore clinic where addicted patients get redeemable vouchers when they submit a clean urine screen or attend job training sessions. This kind of behavioral approach could be adapted so that welfare benefits themselves become incentives to recovery.

• Although welfare was meant for a different purpose—to support for mothers with children—we shouldn't be reluctant to use it to help them combat addiction.

BACKGROUND

Review of Treatment Effectiveness:

Although the signature of the Center for Substance Abuse Treatment is "treatment works," data show, more accurately, that treatment can work but that drop out is high and relapse to drugs like heroin and cocaine is the rule. For example, after 52 weeks, about 10% of patients remained enrolled in standard drug-free outpatient treatment (see figure and Hubbard RL et al.: "Drug Abuse Treatment";, U. No. Carolina Press, 1989).




The good news, however, is that treatment almost always saves money—in this sense, it "works," ("Socio-economic Evaluations of Addictions Treatment", President's Commission on Model State Drug Laws, Dec. 1993). In the year after treatment, costs associated with enforcement and criminal justice and drug-related hospitalizations reliably decline by 25–60% with figure here treatment while employment goes up by about 10%. That means every dollar invested in treatment yields four to seven in social savings. In addition, improvement increases the longer a patient stays in treatment beyond a critical period of at least 90 days.

A recent state-wide survey from California (California Drug and Alcohol Treatment Assessment, CALDATA) reported cost-benefit ratio of $1:7. This year, the Department of Health and Human Services produced an analysis that focused on the welfare recipients in the CALDATA study. To my knowledge, this is the only large scale evaluation of the effects of treatment on a welfare population. According to the January 1997 report, "Alcohol and Other Drug Treatment for Parents and Welfare Recipients—Outcomes, Costs and Benefits": (1) crime fell by 54 to 67% between the year before and the year after treatment (including arrests and engaging in one or more illicit activities such as drug dealing and shoplifting); (2) hospitalization dropped by 58%;(3) cocaine use went down about 40% and heroin 14%; and (4) cost benefit ratio for welfare recipients was 1:2.5.

Thus, CALDATA presents a socioeconomic analysis that, despite its shortcomings, shows that treatment for recipients—even if it doesn't work in the sense of stopping drug use completely—is certainly worth it as a social investment.

Women with Children Least Likely to Benefit: Women are less likely to enter drug treatment than men, a fact often ascribed to their lower likelihood of criminal justice involvement (a common mechanism of referral to treatment). Some may be fearful that they will lose their children if they come to the attention of doctors and other authorities. Also, women are more likely to suffer clinical depression or distress associated with domestic violence. Thus, with her poor prognosis for employment, limited options and feelings of demoralization, many drug abusing welfare re-

cipients make the classic "rational economic decision" to depend on public assistance.

One of the major conclusions of the policy book "When Drug Addicts Have Children: Reorienting Child Welfare's Response" (Ed. D. J. Besharov, Child Welfare League of America, AEI Press 1994) is "assume that parental addiction to crack and other drugs will not be cured ... even the best programs report that, in most cases, they can break the pattern of crack usage only temporarily." Outpatient care—by far the most common mode of treatment—is passive. The patient may show up to the clinic one day or she may not, she gives a clean urine or not ... and there's little leverage the program can wield to increase her participation.

What about residential treatment? Traditional treatment ranges from outpatient clinic visits to long term (12–24 months) residential treatment. Residential is a form of treatment often discussed as an option for TANF mothers (Jon Morgenstern MD, consultant to State of New Jersey). It is epitomized by New York City's Phoenix House programs which seek to transform destructive patterns of thinking, feeling and behavior that predispose to drug abuse. Through community living and cooperating with others, structured tasks, expectations and rules, patients learn self-discipline and responsibility; they are thus less resistant to authority and supervision (attitudes essential for success in the workplace). Teen Challenge, also residential, fosters recovery through religious conversion.

This is an ambitious program of change, yet data show that patients who complete it do extremely well. Among graduates of Phoenix House (the most extensively studied of all residential programs) 90% are still working and law abiding five to seven years later; 70% are completely drug free. The problem is, however, that drop out rates are high: 30% within the first six weeks, about half make it through the first year at Phoenix House and only about 15–20% finish.

Opportunity to assess residential treatment for mother and children: Unfortunately, there is little quality data on the effectiveness of mother-and-child residential treatment programs compared to less expensive options. Nor are there data on the optimal length of stay.

Residential treatment has advantages for women reluctant to seek help out of fear their children will be taken away. Pregnant women, in particular, may worry about arrest if they come to the attention of doctors or other authorities. It also side-steps the no-children-allowed rule. Currently, if a woman is lucky enough to find a scarce residential bed, chances are children are not allowed or the limit is one child only. Understandably, many women don't want to leave other children behind with relatives or foster care. Lastly, residential care solves housing and day care problems, the former representing a major source of disorganization in the lives of welfare mothers and their children.

Despite its advantages, there are two big problems with mother-and-child residential treatment. The first is cost; $30,000 per family minimum. Second, even if states were willing to spend the money, it would take several years to build this infrastructure. States need a more immediate solution.

## CONTINGENCY MANAGEMENT—LEVERAGE AS A SOLUTION

Treatment can be very helpful if the patient completes it so how do we improve retention? The bold answer: coercion. Several ways to "coerce" patients into substance abuse treatment are (1) through criminal court-order; (2) threat of loss of child custody through protective services and, (3) suspension of welfare support unless the woman agrees to treatment. But can patients who are forced into treatment benefit? Yes. Counterintuitive as this may seem, data reliably show that outcomes for coerced patients are as good or better than traditional voluntary patients. Drug abusers may be court-ordered to treatment by the criminal justice system or, more rarely, committed by a civil judge because of severe mental or physical debilitation due to severe addiction (Institute of Medicine: Treating Drug Problems, 1990).

What is CM? Using rewards and punishment to shape behavior is hardly new. For children and adults, respectively, contingency management (CM) arrangements take the form of "if you do X (eat spinach), you can get Y (dessert)" and/or "if you don't do A (show up for work on time), something aversive will occur (you won't get paid)."

Research on CM: A large body of research shows that this can be applied in treating drug abusers. One of the earliest studies concerned deteriorated skid row alcoholic volunteers. Ten were randomly chosen to be eligible for housing, medical care, clothing, employment services if their blood alcohol levels were below a minimum level. The other ten could obtain these services from the Salvation Army as usual. The volunteers who were rewarded for not drinking, had far better outcomes in

terms of maintaining sobriety and employment (Miller PM: Arch Gen Psychiatry, 32:915–18, 1975).

More recent studies on CM use vouchers redeemable for goods. The bulk of controlled research on this subject has been conducted by psychologists Steve Higgins of the University of Vermont and Ken Silverman of John Hopkins University. Their work consistently demonstrates that patients who abuse cocaine or heroin substantially reduce or cease drug use and remain in treatment longer when given vouchers for each negative urine submitted. Silverman and colleagues also conducted a small pilot project which showed that unemployed heroin users on methadone had significantly increased attendance at job skills training when they were given vouchers based on attendance.

Regarding work itself as a treatment intervention makes good sense. In many ways, it is the ideal therapy for hard-to-serve welfare recipients by instilling and rewarding discipline, responsibility, and cooperation with authority and colleagues.

CM Drawback: A problem with CM is the tendency to resume drug use, albeit at a lower level than before treatment, when the reward contract is withdrawn. This may be due, in part, to the short duration of the research projects. Three to six months is not enough time to enable the person to learn new skills, secure a job and attain the measure of personal growth needed to live drug-free. Another problem is the cost of the vouchers; in these studies the "rewards" were written into the grant budget but real-world treatment can't provide monetary incentives. Yet these two obstacles to CM could be remedied by using TANF payments as the contingencies. Once the recipient is transitioned to the workplace, the employer could continue to drug test former recipients—who now have something to lose—as a condition of employment.

How Should CM work? Psychiatrist Thomas J. Crowley of the University of Colorado recommends:

- make the consequences very clear: Written agreements or contracts should spell out what kinds of violations (missed appointments, dirty urines, etc) will trigger what kinds of sanctions.
- make consequences incremental, immediate and highly predictable. Rewards and sanctions are more effective when they are experienced frequently. Sanctions need not be harsh if they are administered predictably and with immediacy. An Urban Institute analysis of the Washington DC drug court shows that immediate sanctions like a few days in jail after the first positive urine can have a beneficial effect on drug use compared to the absence of predictable sanctions.

## TANF As a Vehicle for Rehabilitation

Not all drug abusing TANF recipients require treatment, let alone residential care with its long length of stay and expense. Some recipients will respond to less aggressive forms of intervention, starting with urine testing.

Urine Testing Alone: Some drug abusers simply respond to the consequences of positive urines (Urban Institute report on Washington DC Pre-Trail Services). One woman, now completely abstinent, told me that she wanted to get a job as a truck driver explicitly because "they'll take my urine regularly and it'll help me control myself." Women who need more help to keep urines clean can enroll on their own in treatment-as-usual and/or Narcotics Anonymous.

It is important to realize that not everyone who uses drugs has a raging habit. Some people can even use crack and cocaine in a sporadic manner. Often my patients have dirty urines because "I just had some money that day" or "I ran into a friend who had cocaine last week" or "I got mad at my boyfriend and I figured what the hell." These are examples of deliberate use. And deliberate use means the ability to abstain if the consequences are meaningful.

Another patient, a young man whose urines were often positive for tranquilizers, heroin and cocaine, started turning in clean urines. His explanation? "I got arrested two months ago and my probation officer checks my urine weekly." He says I'm going to jail if I give him a positive. I'm telling you, getting arrested was the best thing that ever happened to me."

Free Standing CM: If urines remain positive, then all cash and redeemable benefits should be handled by a responsible payee. It is important that drug abusing recipients do not have direct access to cash (perhaps not even food stamps since they can be traded for cash). Not only is this cash used to purchase drugs (recall Rosa Cunningham—the welfare matriarch portrayed by Washington Post reporter Leon Dash), it is also siphoned away from the valid recipients—the children.

Also, cash itself can be a powerful trigger for drug craving, especially cocaine. I have literally never met a drug using patient who did not use all or part of a benefit check (welfare check, veterans benefits, SSI income) to buy drugs. What's more,

when asked, patients readily admit this, many conceeding they'd be better off if the money were direct-deposited into a bank and there was a limit imposed on withdrawals.

Using contingency management, women can earn back their welfare payments, perhaps on a semi-weekly basis, by producing clean urines. If recipients are engaged in job training or employment, their welfare payments can be earned back for each day worked. However, if their urine is dirty, they should not be allowed to work that day.

This model is employed by Dr. Jesse Milby at the University of Alabama at Birmingham School of Medicine where addicts are provided standard treatment plus housing and opportunity for supervised work as positive rewards for abstinence. A comparison group received standard treatment only. Dirty urines prevented subjects in the first group from working that day and they had to move back to a homeless shelter. However, if they produced two consecutive clean urines, they could return to the house and job. Results showed that the housing-job contingency group had a significantly higher abstinence rate than comparison patients.

If the these or other forms of intervention are insufficient, the recipient should enter formal treatment. If she refuses, child custody becomes an issue (and a potential leverage to compliance).

Formal Treatment with CM: Treatment could range from weekly counseling and self-help like AA to day-long intensive outpatient visits with supervised workshop employment or job training. An arrangement could be developed wherein expenses for housing and other basics are taken care of by case manager via electronic transfer/direct deposit and patients "earn back" the remaining cash by complying with treatment and submitting clean urines. The key feature is that the welfare payment becomes the leverage to compliance.

Vignette #1: Psychiatrist Andrew Shaner of the West Los Angeles VA Medical Center has started a cash incentive program for cocaine-addicted schizophrenics attending an outpatient clinic. In cooperation with the regional social security authority, monetary rewards will be drawn from the patients' own SSI disability checks. Dr. Shaner sought to initiate this CM procedure after he observed a strong temporal relationship between the receipt of monthly benefit checks and the use of cocaine and increase in psychotic symptoms in over 100 patients. (A Shaner, et. al.: New England Journal of Medicine. 333:777–783, 1995.)

Vignette #2: Johns Hopkins University researchers use redeemable voucher contingencies (up to $10/day) to keep pregnant addicts—a notoriously hard-to-retain population—in outpatient day-long treatment. The study lasted thirty seven days, during which there was high drop out (roughly 60% at the end of 30 days) but the women who received financial incentives for each day attended during the first week had between 5 and 20% higher attendance over the course of the project (Svikis DS: Drug and Alcohol Dependence. 48:33–41, 1997).

Vignette #3: At Harborview Medical Center in Seattle, Dr. Richard K. Ries directs a clinic for mentally ill substance abusers. The most disabled patients are asked to sign over their SSI check to the outpatient clinic which then acts as their "representative payee" and manages their bank accounts. Rent and other basics are covered by the payee and the patient is allowed to "earn back" discretionary funds through compliance with treatment. Ultimately he gets control of the bank account when he has demonstrated the ability to manage money responsibly (Am J Addiction, in press). Even though these patients were the sickest in his clinic, after signing over their funds they were significantly more likely to attend treatment sessions than their healthier counterparts and as likely to participate in job training sessions and to stay out of the hospital and jail.

Coordination with the Criminal Justice System: According to a recent survey of state welfare and state alcohol and drug officials by the Legal Action Center (Making Welfare Reform Work, Sept. 1997), 19% of AFDC women in treatment are there as a condition of parole or probation and another 21% percent had felony convictions. Conceivably, the welfare system could coordinate with the criminal justice system to impose rewards and sanctions on recipient offenders based on their compliance with care.

Today, there are almost 200 drug courts nationwide. Non-violent drug-related offenders are diverted to drug court treatment programs. These programs have heavy judicial involvement and are explicitly built around a graded sanctions schedule (e.g., one dirty urine, 1 night in jail; the second dirty urine, 3 nights in jail and so on) but the ability to use the welfare cash benefit as a reward would likely enhance the therapeutic leverage. A new GAO report on drug courts (July 1997—GAO/GGD–97–106) documents mean retention rates of 71% compared with anemic rates of 10–20% mentioned earlier. This impressive result is due to the combination of coercion and graduated sanctions.

KEY POINTS

• Drop out from treatment is very high. Simply prescribing more treatment-as-usual—while far better than nothing at all—may not be good enough for many.

• States should capitalize on the proven virtues of leverage to enhance retention in treatment and to shape behavior directly. Locales that adopt innovations are social laboratories and should be encouraged to evaluate their work rigorously.

• Some advocates will criticize manipulation of benefits as intrusive and coercive, but from a clinical standpoint coercion is a valid intervention. If anything, it would irresponsible not to apply the accumulated research and experience showing the value of incentives.

• Welfare reform provides an excellent opportunity to transform the perverse reward of public entitlements into constructive incentives that promote recovery and autonomy using the very same, naturally occurring benefits that the system now offers.

For too long the security of welfare benefits—just knowing they were there, no matter what—has actually facilitated a dual dependence: on the system itself, and on drugs. Facing real consequences for using drugs is often a turning point for the addict, putting her on the arduous path to recovery. At the same time, real rewards for "playing by the rules" help develop responsible citizenship.

Chairman SHAW. Thank you.

Dr. Pearlstein.

## STATEMENT OF MITCHELL B. PEARLSTEIN, PH.D., PRESIDENT, CENTER OF THE AMERICAN EXPERIMENT, MINNEAPOLIS, MINNESOTA

Mr. PEARLSTEIN. Mr. Chairman, thank you very much—Members of the Subcommittee, particularly since I am the last speaker to attend this afternoon, I would like to speak more personally than perhaps it would be usual in such a circumstance.

Chairman SHAW. Dr. Satel, would you move that microphone over?

Mr. PEARLSTEIN. As I was saying, I would like to speak quite personally in the few moments that I have.

I come at this question from several perspectives. As you perhaps have seen in the written statement, I run a think tank, a conservative, free-market think tank in Minneapolis. My wife is a social worker who runs homeless programs—excuse me—out of a Lutheran church in Minneapolis. And we have just adopted a little girl, Nicole, who is now 6½ years old, who was born drug positive.

In the formal statement that you have, I do discuss the connection—my interpretation of the connection between welfare and drugs and adoption. What I would like to do exclusively in the next 3 or 4 minutes is to emphasize one point, and that is that we must rescue children faster. Translated—and this is terrifically sensitive and terrifically tough—that means terminating parental rights in many instances faster.

Let me tell you about Nicole. We have had her since last November 22, which brings new meaning to that date, let me tell you; and we will officially adopt her on November 21. My wife and I have known her since birth. Diane is actually her godmother. She was born marijuana positive; her birth mother had done crack earlier in the pregnancy. The first time I met her, she was about 6 weeks old. She was shaking. It was right around Easter. I am not trained

in this area, but it was clear to me that this child had a drug problem.

She was adopted once before, you should know. We believe, by the way, that we are her sixteenth placement. But Nicole was put in preadoptive placement the first time in March 1995. She was given back to Hennepin County 1 year later because she was too much for that first couple to handle.

I would ask you to think hard about what it means to have 16 placements and you are not yet 6 years old.

It was medically confirmed, I am afraid, just last month that she had been sexually abused. She has been diagnosed suffering from ADHD, attention deficit and hyperactivity disorder. She has also been diagnosed as suffering from reactive attachment disorder, which translated means she doesn't trust any grownups terrifically well.

When my wife and I were going through our training in Hennepin County 1 year ago, a social worker matter of factly said that just about 98, 99 percent of children who have spent extended periods in foster care have been sexually abused. I said at the time, I could not believe that. Perhaps I was wrong.

How is my daughter doing? Well, all things considered, I think pretty well, though I am the first person—and my wife is the first person—to tell you that raising a child like Nicole is not easy. Raising any child is not easy. But a child with this kind of background, and sometimes you need to know I look in her face, particularly after we have been fighting, and I think perhaps what this child has gone through, and I just dissolve away in love for her.

Let me tell you about another little girl that we have been foster parents to that we tried to adopt and could not. Her name is Annie, not her real name, but for today's purposes it is Annie. She is 7½ years old. We haven't seen her in 4 years. We used to be her unofficial foster parents. She has been in foster care in Ohio for 4 years this month with very little time away from that situation. Her father, her biological father, credibly claims to have fathered 14 children. Annie and her younger sister have just—just been taken away from him; parental rights were just terminated earlier this month. All the other children had either been taken away from him or he had abandoned them or they had died on his watch.

I ask the question, What in the world took 4 years? Why did it take 4 years before these children were freed for a better life?

The final point, at American experiment we are beginning a major project that will, we hope, significantly increase the number of children adopted in Minnesota homes by loving Minnesota families. And I was in a meeting recently with our adoption lawyer, who also was involved in the center; and it had been a particularly difficult day with Nicole. My wife and I were there, and I said glibly, in a dark way, We want to have this project so other parents could have this great joy that we are having this afternoon—not a statement I am terrifically proud of.

And she called me up short, and she said, No, what you want to do with this project is make certain there are many more children rescued far quicker than has been the case with Nicole, so they are not so terribly damaged by the time they are adopted.

Thank you very much.

[The prepared statement follows:]

**Statement of Mitchell B. Pearlstein, Ph.D., President, Center of the American Experiment, Minneapolis, Minnesota**

Mr. Chairman and Members of the Committee, my name is Mitchell B. Pearlstein and I've been asked to appear today in two roles: both as an analyst and as an adoptive father.

As founder and president of Center of the American Experiment—a conservative and free-market public policy institute in Minneapolis—I have spent the last nearly 8 years thinking hard, writing frequently, and hosting many public programs about education, fatherlessness, adoption, welfare, drugs and suchlike. Which is to say, I've spent a lot of time thinking about endangered children. By saying this, I don't mean to suggest that I've hit upon reams of good answers. Neither do I mean to suggest that I consider myself a scholar in these broad areas in the narrow sense of the term. While I hold a doctorate in educational administration from the University of Minnesota, run a "think tank," and have held other public policy jobs in and out of government, I'm more comfortable viewing myself as a reasonably well-versed generalist rather than as a specialist when it comes to many of the questions before you today.

Yet having allowed that, I do recognize that I bring an important perspective to the table by virtue of being an adoptive father of a little girl, Nicole, now six and a-half, who has suffered an extraordinarily tough start in life. And in a not dissimilar vein, my testimony this afternoon is contoured by the fact that my wife, Diane McGowan, is a social worker and the executive director of Our Saviour's Housing, a church-based, tough-loving program for homeless and formerly homeless men, women and children in Minneapolis.

In other words, Mr. Chairman, and at the risk of presumption, I just may be the only conservative think tank president in the United States who has recently adopted a special needs child (whom, Im sorry to say, tested positive at birth for illegal drugs) and whose wife, moreover, works daily and intimately with homeless and other very troubled clients. It is from these vantage points that I would like to speak this afternoon. I also have, you should know, three adult stepsons from my wife's first marriage.

Before proceeding, though, might I ask a favor of all who may come upon this statement? Testifying before a congressional Committee, and then having that testimony published in the Congressional Record, is anything but a private act. I decided, however, to write as personally and openly as I have because of the stakes involved: In bluntest terms, thousands of boys and girls need to be rescued, not only from the chemical and other abuses of their parents, but also from a child-welfare system that, for a variety of reasons, is capable of rescuing only some of them. Which is to say, while I very much hope that what I have to say is attended to, I also would hope that my family's privacy—particularly that of my daughter—might be respected to the greatest extent possible.

Let me begin by talking about Nicole and how my wife and I have come to adopt her. (Technically, our adoption will not be official until November 21, though I assure you I have viewed Nicole as our daughter in every loving and permanent sense of that word ever since she came to live with us on November 22, 1996.)

My wife, Im proud to say, is the kind of social worker who often brings her work home with her. This was the case when, over Easter weekend in 1991, she and I were asked by Nicoles birth mother to provide emergency respite care for her 6-week-old baby. While I am not professionally trained in the effects of drugs on infants, I must tell you it was immediately clear to me that Nicole had been exposed, as she cried to the point of near-tremors almost constantly. I did later learn that she had been born marijuana positive and that her birth mother had smoked crack earlier in her pregnancy.

My wife and I stayed in reasonably close contact with Nicole over the next several years even though she wound up spending most of that time in various out-of-home placements. Diane, in fact, had become Nicoles godmother in the spring of 1992. We stayed in direct contact until March 1995 when Nicole was put in her first pre-adoptive placement. I'll return to this matter in a moment, but first I need to fill in some blanks about her birth mother.

Doris (not her real name), voluntarily gave up parental rights to Nicole either in late 1994 or early 1995. Nicole was her fifth child—and the fifth boy or girl whom she had either given up on her own or who had been taken away by the state. As for Nicoles birth father, he has never been involved in her life beyond conception. A drug dealer by trade, Ive recently been informed that he is serving a life term

in prison for murder. Doris doesnt recall his last name, and almost needless to say, they were not married.

Without rationalizing away Doris morally and otherwise unacceptable decision to do drugs during her pregnancy with Nicole, I have no hesitation in acknowledging the coarseness and unfairness of Doris own life. Her parents were chemically dependent. She has suffered all manner of abuse. She has been diagnosed with a serious mental illness. Early in her pregnancy with Nicole she was set afire when a drug deal went bad, leaving her in the burn unit of Hennepin County Hospital for several weeks, where she received prescribed drugs—and later also did illegal drugs.

Given this prologue, Im not opposed to giving Doris a measure of credit for recognizing that she was not capable of raising Nicole and, in light, forfeiting her parental rights. But the fact remains, the little girl who was to become my daughter had been condemned to a simply dreadful start.

The best my wife and I can figure, we are Nicole's 16th placement. Yes, many of these were short, emergency stints when, for example, Doris went off on one binge or another and her boyfriend (not Nicole's biological father) couldnt cope alone. But several placements were of much longer duration. These included 2 years with a foster family before her first pre-adoptive placement, in March 1995, and then 8 months in that same foster home when, after exactly a dozen months, the pre-adoptive family gave Nicole back to Hennepin County because she was too much for them to handle.

Ladies and gentlemen, I would ask you to think hard about what it means to live in 16 different places—which is not necessarily to say homes—before you are 6 years old. I also would ask you to consider a few other things about Nicole.

It was recently confirmed medically that she had been sexually abused, quite likely more than once. She also has been diagnosed as suffering ADHD (attention deficit and hyperactivity disorder). Im well aware of the fact that diagnosing ADHD is more art than science, and that the term has been known to be used profligately. But let me assure you, this is not the case here.

When Diane and I were going through Hennepin County-sponsored, pre-adoptive training last year, several instructors reported—I'm tempted to say almost as a matter of fact—that most children who are veterans of the foster care system tend to wind up (1) having been sexually abused; and (2) suffering from ADHD. In fact, one instructor estimated that upward of 98 or 99 percent of all such children are sexually assaulted. I immediately objected, arguing that hardly any social phenomenon is known to occur so frequently, and that at any rate, I just couldnt imagine the problem being so pervasive. Perhaps I was wrong.

How is Nicole doing now? In many ways, better than what one might imagine. But for all the progress she has made, for all the medical and psychological care she is receiving, and for all the love she is now bathed in, there remains, deep in her, a flood of anger and distrust. Yet who can blame her for harboring such poison?

More briefly now, let me say something about another little girl my wife and I have tried to adopt in the past, Annie (not her real name). Annie is now seven and a-half, not that we have seen her for 4 years, as she has been in foster care in Ohio almost all that time.

Annie is the daughter of two of my wife's clients, Meg and Johnny (again not their real names), and as with Nicole, we have known her since birth. Both Diane and I are Annie's godparents, and we also were her frequent, if unofficial, foster parents in the early nineties. (One reason we were "unofficial" is that Annie is part American Indian while Diane and I are not, and the Federal Indian Child Welfare Act didn't take kindly to our care giving. But I digress.)

In the fall of 1993, Johnny and Meg (who have never been married) moved to Ohio and quickly proceeded to do things that led child-protection officials there to rightly place their young daughter in protective custody. She has remained in foster care in Ohio ever since. In part, this is the case because Johnny's parental rights to Annie, and to her younger sister Gloria, were terminated only in the last few weeks. In Johnny, it needs to be noted, we are talking about a man who credibly claims to have fathered 14 children, with all 14 now having been taken from him by government, or abandoned by him, or found dead on his watch. As for Meg, she voluntarily gave up rights to the two girls a couple of years ago once she concluded she could not care for them. She may have AIDS.

What did Johnny and Meg actually do to justify having Annie taken from them on a number of occasions in Minnesota and Ohio? On generous days I'm willing to concede that they have tried to love her, and Gloria, as best as they know how. But the fact remains, their ability to raise their daughters successfully was severely compromised by drugs, alcohol, mental illness, frequent arrests, unemployment, and so forth. Annie, for example, tested positive for crack at birth. She tested positive for cocaine again later on, likely by way of secondhand smoke. The fact that she

wound up being required to repeat kindergarten may or may not have been incidental.

Question: Why in the world, given all this, were Johnny's parental rights terminated less than a month ago? Why were his two girls kept in limbo so outrageously long?

Another key question, given the subject of today's hearing, is whether any of the birth parents I've been talking about were ever afforded the chance to participate in a drug rehabilitation program while they were on welfare? Doris, Johnny, and Meg, as one might expect, have received a combination of benefits, including AFDC, SSI, and General Assistance.

The short answer is that yes, each has been provided multiple opportunities to get straight, not that any of the three has ever stuck with any treatment program. (I don't have a clue about what second, third and fourth chances might have been extended to Nicole's birth father by taxpayers before he was imprisoned, perhaps for a last time.) Some surely will argue that none of these programs were exactly right or fitting or sufficiently funded. But the larger truth is that neither Doris, nor Johnny, nor Meg has ever found it within themselves to keep clean, either for themselves or for their children.

So much for stories and comments drawn from my personal life. What do I conclude from all of this in terms of policy and in terms of our culture itself? Permit me to quickly expand on three points having to do with (1) the Muzak-quality of drug and alcohol abuse in the United States; (2) the importance of faith-based programs in combating such excesses; and (3) the need, in many instances, of terminating parental rights much faster so that supremely at-risk children can be adopted—and, thereby, physically and emotionally saved—much more successfully.

We have all seen data and heard stories about the hard toll exacted personally, socially, and financially by chemical excesses and addictions. The dollar amounts, for example, no matter how rigorously or casually calculated, are always labeled immense, accurately so, I'm sure.

But for present purposes, I have no interest in citing numbers, never mind how huge and telling they may be, as I'm sure others who are better equipped either have or will do so. Instead, I want to argue that regardless of how big a problem we may think excessive drinking and illicit drug use are, they are almost certainly larger still—be our focus the nexus with welfare or not.

This is the case, I would contend, because the very implicitness of boozing and narcotizing in so much that is melancholy and broken all around us has made our reactions more muted than sharp. Alcoholism? Drug abuse? Sure they're problems. Big ones. But my sense is that are sensed by most people, most of the time, more as background noise than as sirens. Drugs and too much drink are downplayed precisely because they are embedded in the landscape.

Now, needless to say, sirens do blare for individuals and families racked at any moment by insobriety. But the broader point to be made is that drug and alcohol abuse routinely grabs holds of us in the same way that Muzak does—meaning not vividly at all.

Back in the early eighties I served on the staff of former Minnesota Gov. Al Quie. I still remember how he would talk about how drugs and/or alcohol had been at each and every scene, so to speak, whenever he returned to the office following meetings of state pardons board. I have few doubts that much the same can be said about the overwhelming majority of child neglect and abuse cases. Yet still—exempting for hearings like this, and at the risk of an overdone metaphor—the nation routinely seems to be in a haze, numbed to the pervasiveness and destructiveness of drugs.

What might this suggest? One thing is that we need plenty of treatment avenues. But it's precisely in areas such as this that policy deliberations suffer from excessive confidence in the efficacy of "programs."

Almost always running through such public conversations is the presumption that if only enough dollars are "invested," results would be excellent. But on closer consideration, almost everyone knows this is not the way either the world works or recovery works, as just about everyone knows of men and women who have "graduated" any number of times from treatment programs—only to go tumbling off an identical number of wagons. Recall Doris, Johnny, and Meg and their repeated failure to take advantage of the public dollars invested in them.

Ungrounded confidence in the effectiveness of treatment programs—especially secular ones—is but the flip side to the half-obliviousness that surrounds chemical dependency in the first place. The most important question about healing we can ask has little to do with whether we are really "committed" as a society to helping drug addicts and alcoholics. The short answer to that one is yes, as witness all the money

we spend every year, as well as the many job and other protections now afforded to chemically dependent individuals.

The key question, rather, has to do with what kinds of treatment programs we should more earnestly seek to create and replicate. The answer, I would suggest, is spiritually driven ones. The kinds, frequently, without a lot of formally credentialed therapists on staff. The kinds, quite frankly, which give orthodox secularists and many governmental grant makers the willies. But the kinds of programs which friends such as Bob Woodson of the National Center for Neighborhood Enterprise, and Marvin Olasky of the University of Texas—as well as friends and colleagues doing great things in Minnesota—have convinced me are most adept at performing near miracles in turning very troubled lives around.

Nonetheless, it would be fraudulent if I let it go at that; if I suggested that enough "near miracles" could be assured for those who seriously harm their children if only right treatments were divined and backed. We know this is not possible. And it's for this reason that I've come to reluctantly conclude that we must terminate the rights of unfit parents more frequently, and more quickly, than we generally do. Putting matters directly, we need to find the fortitude to speed up the process by which parental rights are ended when it is demonstrably clear that children are being ruined.

Suffice it to say, I'm well aware of the implications of what I've just said. As someone who runs a conservative think tank, I am not enthused about urging government to become more energetic in investigating families. But after several years of thinking things through, I'm more convinced than ever that we must fundamentally reorient the child-protection system in favor of vulnerable children.

This is the case insofar as prevailing law and ideology in child-protection circles since the early eighties—emphasizing the rigid pursuit of "family preservation" even when there is barely a shred of a viable family to reconstruct—have been a disaster. We all know the resulting numbers, starting with the fact that almost 2,000 infants and young children in the United States die from neglect and abuse by parents and care givers every year, with upward of half of them dying after they and their families enter the child-protection system.

If I do say so, and not with a little surprise, I've discovered that most of my counterparts on the right also have come to agree that we need to terminate parental rights faster. This is a remarkable development given the strong and intuitive opposition of most conservatives to further extending government's reach into the life of families.

I just cited the almost 2,000 infants and young children who die at the hands of their parents and care givers every year. Another very sad, in this instance, Minnesota-based fact is this: The number of American-born children adopted by nonrelatives in my state fell from more than 2,500 in 1970 to less than 500 in 1995—even though the number of children removed from their biological homes, at least temporarily and for a host of reasons, exploded across the country during this span. As with anything so complex, there are several reasons for this drastic decline in adoptions, including the aforementioned emphasis on family preservation and, particularly in Minnesota, a disproportionate emphasis on the racial matching of adoptive parents and children. But quite obviously, if as a society we seek, for good cause, to increase the rate of terminations of parental rights, we are obliged to find ways of increasing the rate of adoptions.

This is not the time or place to detail exactly how this might be done. For no other reason, this is the case because adoption—as is true with just about every issue addressed in this statement—is principally a state and local matter, not a Washington one. It's also not necessary to dwell on the intricacies of adoption because we already have identified the most important step in increasing their likelihood: Ratcheting up terminations of parental rights so that more children are freed for new lives. But having said that, let me conclude this way:

Nearly a year into the process, I'm not the same romantic I once was about adoption, at least when it comes to children, like Nicole, who have been victimized horribly. There is no getting around the fact that boys and girls who are exposed to drugs in utero and afterward, who bounce from placement to placement, who are sexually abused, and who suffer any number of other assaults to body and spirit, are not necessarily easy children to raise.

Beyond dealing with behavioral problems fed by anger, distrust, and perhaps neurological damage, adoptive parents are called on to collaborate on an ongoing basis with a seeming platoon of social workers, therapists, pediatricians, lawyers and other professionals. Often, my wife and I wonder how people without the flexibility we're fortunate to have in our work lives can ever do justice to a child like Nicole. Sometimes, in truth, we wonder if we're doing her justice, given our professional obligations as well as our (advancing middle) age.

But at the same time, we very much recognize that grownups are not afforded the sacred opportunity every day to save a child, and that little girls like Nicole largely have run out of good chances for a decent life by the time they start school or by the time their first tooth falls out.

Which is just one more way, Mr. Chairman and Members of the Committee, of making the case that children in drug-poisoned situations must be rescued quicker, so that new wounds are not allowed to pile on, day after day and year after year.

---

Chairman SHAW. Thank you, Doctor.

Mr. McCrery.

Mr. MCCRERY. Let me start with Ms. Ogletree. I am going to ask you a few questions.

I am just curious about, because they relate to some other considerations that we go through in looking at the welfare system and welfare reform that is in place, and some problems that may come up, first of all, How old are your children? You have two children.

Ms. OGLETREE. I have a set of twins that are 3, 3 years old.

Mr. MCCRERY. Three years old?

Ms. OGLETREE. Yes.

Mr. MCCRERY. Why do you have to get up at 4 o'clock in the morning? And why do you not get home until 8 o'clock at night?

Ms. OGLETREE. For one, I am dedicated as an employee, where I live at; making a change in my life is becoming responsible as a parent, OK? And for me, at this stage in my recovery, I would go to any means, any length to be a responsible parent to my kids and show them that I am a good role model and, today, that I am somebody.

So—that means for me to get up at 4 o'clock every morning, get to work, be on time, and to be comfortable on my job so when I start, I am ready to work, then that is what it takes.

Mr. MCCRERY. So do you live that far away from your work? Is that——

Ms. OGLETREE. It is a commute. It is about a 1-hour commute, an hour and a half in the morning. So the commute is very long, but I am willing to do that.

Mr. MCCRERY. And where do your kids go when you leave?

Ms. OGLETREE. My kids go to the babysitter. And the babysitter, in turn, puts them on the bus to go to school in the morning.

Mr. MCCRERY. OK. And what about in the evening? What happens to your children in the evening?

Ms. OGLETREE. OK. When I come home from work, they are at the babysitter's. She takes them off the bus. One goes in the morning, and one goes in the afternoon. So one is usually with her in the afternoon. While the one is in school, the other one is coming off the bus. So it is, you know, difficult for her, too. So——

Mr. MCCRERY. Now, I thought I heard you say that you are in a transitional home; is that not correct?

Ms. OGLETREE. Yes, I am.

Mr. MCCRERY. That is correct?

Ms. OGLETREE. Yes, it is.

Mr. MCCRERY. So, is the babysitter provided by the transitional home——

Ms. OGLETREE. Transitional home——

Mr. MCCRERY [continuing]. Or provided by——

Ms. OGLETREE. No, the babysitter is not provided by the transitional home. The babysitter is in a program that works with drugs and alcohol. And she was willing to work with me, as long as I was doing what was expected of myself as far as my recovery. And you don't find too many people like that, so I guess I could say I was fortunate.

Mr. MCCRERY. Yes. So are you paying the babysitter?

Ms. OGLETREE. Yes, sir. I am paying them out of my pocket, yes.

Mr. MCCRERY. So when you are out of the transitional home, what are your plans? Are you going to be able to afford a place to live and a babysitter? Are you going to try to find a place closer to your work, or what is your plan?

Ms. OGLETREE. Well, my plan is by—well, I have up to 2 years in my transitional house; and within that time, I have plans to transitional out into a regular setting where I can afford my own place, get the experience on my job that I need to transitional out into a regular apartment, affordable housing, that I can afford and affordable day care for my kids.

Mr. MCCRERY. OK. Well, good luck.

Ms. OGLETREE. Thank you.

Mr. MCCRERY. Thank you very much for your testimony.

Mr. Batty, how is your program funded?

Mr. BATTY. It is privately funded.

Mr. MCCRERY. What does that mean?

Mr. BATTY. Individual contributions, businesses and churches provide the bulk of that support, as opposed to a government subsidy.

Mr. MCCRERY. OK.

Dr. Satel, you have testified that you think we ought to link welfare payments—I presume you mean TANF payments, cash welfare payments——

Dr. SATEL. Right.

Mr. MCCRERY [continuing]. For compliance with treatment programs.

Dr. SATEL. Yes.

Mr. MCCRERY. And then you mentioned that some other places are linking things such as SSI payments on a voluntary basis. The folks in treatment voluntarily give their SSI payments over to the treatment center?

Dr. SATEL. Right.

Mr. MCCRERY. And they give them back if they are successful. So, would you recommend tying some other entitlement programs to compliance with treatment programs, like SSI benefits or food stamps or——

Dr. SATEL. Yes. We had an interesting model for this called DA&A, drug abuse and alcoholism. Until 1995 the Social Security Administration considered addiction to be a disease, and addicts were given benefits just like everyone else who was disabled. There was a lot of trouble with the DA&A Program. As you remember, few people went to treatment; a lot of that money ended up subsidizing addiction. There was a linkage formed between SSA and treatment programs but that legislation was reversed about 1 year

after it went into effect. Nevertheless, that was a model for making benefits contingent upon compliance with treatment.

Here, I am talking about a much more—I guess I could say a more micromanaged form of that, ideally at the level of the treatment program. A colleague of mine has been collaborating with the State of New Jersey trying to help the State to come up with some creative ideas. For example, for compliance with work requirements and treatment if the person needed it, the State could give them improved housing vouchers. And also food stamps are important to control, because if the person is actively using drugs, again they are converted into cash and sold and used to buy drugs.

Mr. MCCRERY. OK. Thank you. Thank you all for your testimony.

Chairman SHAW. Thank you, Mr. McCrery.

I might add that the States can do that with the TANF payments if—if they can.

Mr. Levin.

Mr. LEVIN. Just quickly, so others can join in, the States have the discretion. So let me ask you, how do you, with TANF, how—let's say that, with drug addicts, there is kind of an up and down—not off in a straight line.

So let's say for a few months, the person hasn't used drugs. And then the person does for 1 month, the fourth month, and has two children. How do you—you have to link these two creatively, don't you? I mean you can't just——

Dr. SATEL. Right.

Mr. LEVIN [continuing]. Have a mechanical linkage.

Dr. SATEL. In the written testimony, I went into that a little bit. If a recipient started to deteriorate badly, you would give her the—you could give people a lot of choices; but one choice could be residential care—obviously, a person can't be maintained as an outpatient if she is heavily using drugs. Her children aren't safe; she is using.

I wouldn't stop the clock either; I agree with Mr. Zill on that. One of my key points here is that the reason why people drop out of treatment at such high rates and why compliance with treatment is so poor is because there are no consequences. Ultimately, if they violate every rule and expectation associated with welfare or with the treatment program, I suppose they could run out of safety nets. If they did land on the street and if they did—as Professor Reuter was saying earlier, they would likely resort to crime, but we have something called drug courts which are wonderful innovations. And they take people who have been arrested for drug crimes, misdemeanors, or felonies. There is one in the District of Columbia, and it is a diversionary program where offenders are sent to treatment instead of jail. And there are very, very clear consequences for not keeping up with the treatment program, ultimately ending up with the person having to fulfill a jail sentence. Not that many people have to do that. And if they comply with the treatment and finish it, then their offense gets expunged at the end.

In fact, if I could just add, the District of Columbia drug court did a very interesting demonstration project a few years ago where they had one cohort in treatment and another just getting sanctions. These people were told, if your urine is dirty, you are going

to go to jail for a night. If it is dirty the second time, 2 nights and so on, progressively.

And the group with just the sanctions were told, If you think you need some treatment, go to AA, get it on your own, but we are just looking at the urines. And this is what is going to happen to you if your urines are positive, so you know up front.

That group did better than the group in treatment. And that has a lot to do with the unaccountable way that particular treatment program worked. And it is very similar, unfortunately, to the average treatment program out there.

Mr. LEVIN. OK. I think others should question.

Thank you.

Chairman SHAW. Mr. Coyne.

Mr. COYNE. I have no questions.

Chairman SHAW. Mr. Rangel.

Mr. RANGEL. I have none.

Chairman SHAW. I would like to make an observation here with regard to Ms. Ogletree and Ms. Saler and going back to what Charlie Rangel was saying and then, Mr. Batty, from your standpoint, it appears here that there is a common thread. If somebody is getting into a job or looking or training for a job, the cure rate is much better. Or if it is a spiritual awakening, it is much better.

I think what we are doing, where Charlie was talking about—put me in jail, so what; my family name, so what—I think it is more a question of self-worth, self-dignity, and feeling good about yourself and having some expectations of yourself than other people having expectations of you.

Ms. Saler, you used a statistic, you put the two back to back, and I may have missed them, but did you say—what is the correlation between people who find a job and those that are successful in the completion of your program?

Ms. SALER. With the—in the study that was done, what was important was that those who completed treatment at the time that the independent followup was done, 85 percent of them were employed. One of the connections that we were able to make in this is that we were able to actually see people who had made lifestyle changes that supported their recovery, and the converse of that, their completed treatment supported making those changes.

So what we spend a lot of time with internally in treatment is looking daily, weekly, quarterly at a minimum, for an overall picture, who is not staying in treatment. When are they leaving? What can we do differently? What needs to be done better? What is missing for this group at this time? And spending a lot of time. And I would say that many of my colleagues in the field do the same thing, looking at what it is we can do.

And knowing the consequences is important. I would just mention in regard to part of that, just a few weeks ago, we sponsored a conference for women in Maryland who are in treatment; 150 women from around the State of Maryland came. And the theme of the conference was "Welfare Reform: What Does It Mean to You." And officials from the State of Maryland, folks in recovery, all came together and presented two women who are going through the process in varieties of programs around the State, what it is

that all of this meant and how it impacted them. And if they didn't think it was real, they had better get with it pretty quickly.

And it was very interesting to—Judy was there and a lot of other women. And they both felt they had the information they needed. They also felt empowered because it was very clear to them what the State was willing to do to help them, what the treatment programs were willing to do to help them, and what was expected of them. And I would throw that out as one other type of thing that is going on. And it is a tool in working with folks that are going through this.

Frequently, just sitting down and giving folks the information and letting them know what the consequences are and making sure we follow through on the consequences are really important.

Chairman SHAW. Ms. Ogletree, let me ask you a question. If you had come out of the program and just gone home and received benefits and not gone to work, would it have been harder for you to stay clean?

Ms. OGLETREE. Yes, it would have. When I first came out of the program, I wasn't working; I was unemployed. And I did receive benefits for 2 months after I left treatment. I then got a job at Second Genesis as a receptionist. I was still looking for employment.

And I had some of the job skills. And it was just more incentive to want to get off welfare reform, welfare system with the reform going on and everything like that. And I knew I always had it in me to go back to work and be the responsible adult that I should be.

So after treatment, I did stay on welfare for 2 months.

Chairman SHAW. I appreciate all of your testimony today. I think it is——

Mr. MCCRERY. Mr. Chairman.

Chairman SHAW. Yes.

Mr. MCCRERY. If you would allow me.

Chairman SHAW. Surely. Go ahead.

Mr. MCCRERY. I would like to ask Ms. Saler a question. How many employees do you have?

Ms. SALER. At Second Genesis?

Mr. MCCRERY. Yes.

Ms. SALER. Approximately 110 right now.

Mr. MCCRERY. And how many of those are women with small children; do you know, offhand?

Ms. SALER. One-third.

Mr. MCCRERY. One-third?

Ms. SALER. That would be a rough guess, one-third to one-half.

Mr. MCCRERY. I gather you don't provide any child care for your employees?

Ms. SALER. We have at our women and children's program, we have it onsite, but no, we don't, we—it is a problem. It is an issue for us for bringing—we do hire a lot of single mothers, working mothers, and that is an issue. It continues to be an issue. And it—and as we return more and more women to the workforce, child care is becoming a major issue.

I will sit—and when I get into talking about people getting back to work at vocations, I'll say there is vocational counseling, child

care, skills training and child care, and housing and child care; and how are we going to handle it?

Mr. MCCRERY. Have you looked at providing onsite child care for your employees?

Ms. SALER. Yes, we have.

Mr. MCCRERY. And what is the obstacle?

Ms. SALER. Cost.

Mr. MCCRERY. Cost.

Chairman SHAW. Is liability a part of that? I hear that also.

Ms. SALER. We have actually at our women's and children's program, we already have children onsite, and that has not been an issue. I am less worried about the liability.

One of the issues becomes, in the current climate, getting the funding for treatment. We work—we do work with public dollars, and what we are getting paid for treatment is far below what the private for-profit sector is paid on average in our—most of our regular programs we get paid about $55 a day. The women and children's program, we get about $125 a day to work with the entire family. So——

Mr. MCCRERY. Your total funding comes from public sources?

Ms. SALER. Public and private. We work—we do work on contract with the States and the local jurisdictions, and then we—we do some work with private insurance companies, employee assistance programs, things like that.

Chairman SHAW. Again, I want to thank this panel.

Mr. Pearlstein, good luck with your daughter and your coming adoption.

Mr. PEARLSTEIN. Thank you very much.

Chairman SHAW. And we are adjourned.

[Whereupon, at 5:15 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

**Statement of Child Welfare League of America, Inc.**

The Child Welfare League of America (CWLA) welcomes this opportunity to submit testimony. We commend the subcommittee for its efforts to examine the links between substance abuse and child abuse and neglect. Our comments focus on substance abuse as a factor in the placement of children into foster care, and highlight the need for and examples of interventions that keep children safe and help families recover.

CWLA's 900-member public and private agencies across the country work everyday to improve conditions for children and families at risk and in crisis. Serving over 2.5 million children and their families each year, CWLA member agencies provide a wide array of services including child protective services, family preservation, family support, adoption, family foster care, treatment foster care, residential group care, adolescent pregnancy prevention, child day care, emergency shelter care, substance abuse treatment, independent living, and youth development.

NEED FOR PROTECTION AND CARE INCREASES

• In 1996, an estimated 3,126,000 children were reported to child protective services agencies as alleged victims of child maltreatment.[1] From 1987 to 1996, the total number of children reported abused or neglected increased 45%.[2] The number of reports substantiated has increased by approximately 14% over the same period.

• In 1996, nearly one million children were confirmed victims of child maltreatment.[3]

• Last year, an estimated 1,046 children, or three children per day, died as a result of child abuse and neglect; 82% of the victims are under the age of five, and 42% are less than one year old at the time of their death.[4]

• When child protective services determines that a child cannot be safely cared for at home the child is removed to a safer place. Preliminary estimates indicate that 502,000 children in the U.S. lived in out-of-home care—family foster care, kinship care, or residential care—at the end of 1996.[5]

SUBSTANCE ABUSE HIGHLY INVOLVED IN ABUSE AND NEGLECT REPORTS

The use of drugs and abuse of alcohol among families is a pervasive and disturbing trend that continues to have a devastating impact on the safety and well-being of children. Although it is difficult to quantify a causal relationship between alcohol and other drug (AOD) use and child maltreatment, experts agree there is a high correlation between parental chemical dependency and child abuse and neglect.

• Nearly eighty percent of states report that parental substance abuse is one of the top two problems exhibited by families reported for maltreatment.[6]

• Drug testing of families with abused and neglected children in the District of Columbia Family Court in 1995 revealed that two in three parents tested positive for cocaine and one in seven tested positive for heroin and other opiates.[7]

Identifying family members who are chemically involved and assessing how AOD use affects their ability to provide a safe, nurturing living environment are critical steps in determining risk of maltreatment for children. Once substance abusing caregivers are identified, child welfare professionals struggle to find and provide appropriate treatment. Even if treatment services are available, the timeframes for effective treatment may exceed timeframes to achieve permanency for children. A wait for residential AOD treatment for women with children may be close to 10 months in some parts of the country.

CWLA'S 1997 AOD SURVEY REVEALS GREAT NEED, FEW RESOURCES

In 1997, CWLA surveyed state public child welfare agencies in order to obtain a baseline measure of the types of policies, programs and data collection efforts in

---

[1] National Committee for the Prevention of Child Abuse (NCPCA). Current Trends in Child Abuse Reporting and Fatalities: NCPCA's 1996 Annual Fifty State Survey, Chicago, IL: NCPCA Publications.

[2] 2 NCPCA, 1996.

[3] 3 NCPCA, 1996.

[4] 4 NCPCA, 1996.

[5] Tatara, T., American Public Welfare Association. Research Notes. (1997, March).

[6] 6 NCPCA, 1996.

[7] Newmark, L. (November 15, 1995)."Parental drug testing in child abuse and neglect cases: Major findings." Presented at the 46th Annual Meeting of the American Society of Criminology. Washington, DC: The Urban Institute.

place to support chemically involved families, with a special emphasis on children and youths in out-of-home care. Survey respondents estimated that:

- 67% of parents involved with the child welfare system need AOD treatment;
- Child welfare agencies could only provide services for 31% of those parents in need;
- Less than half of all states report that training on recognizing and dealing with AOD problems is available for foster parents;
- Only 9 states (of 47 states responding) provide similar training for kinship care providers yet 30 percent of all children currently in out-of-home care are in kinship care living with a relative;
- 83% could not provide the number of youth in out-of-home care whose parents are chemically dependent;
- Only 11% believe that children and parents with AOD problems can be treated in a timely manner (less than 1 month);
- 42% rely on school-based education drug prevention programs as the only form of prevention services available for youth in out-of-home care;
- 94% could not provide the number of youth in out-of-home care known to abuse AOD themselves.

### EFFECTIVE TREATMENT EXISTS; SUPPLY AND ACCESS REMAIN VERY LIMITED

Treatment is a cost-effective strategy for intervening to stop the cycle of destruction and despair that substance abuse inflicts on children and families. Programs providing comprehensive services and attending to the continuing treatment needs of women are most beneficial. The U.S. Department of Health and Human Services' Center for Substance Abuse Treatment recently reported on women's outcomes for their grantees providing comprehensive programs targeted to post-partum women and their infants.[8]

Of the women in treatment:

- 95% reported uncomplicated, drug-free births;
- 81% were referred by the criminal justice system and had no new charges following treatment;
- 75% who successfully completed treatment remained drug-free; and
- 40% eliminated or reduced their dependence on welfare.

Of their children:

- 65% were returned from foster care; and
- 84% who participated in treatment with their mothers improved their school performance.

As noted earlier, such interventions are in short supply. In general, traditional substance abuse treatment services have been tailored to male addicts not to women. Very few substance abuse treatment programs provide child care or adequate alternatives for women who seek treatment, creating a significant barrier for women who need help. A 1993 survey of drug treatment programs in five cities found that most accept pregnant women (83% of outpatient and 70% of residential programs), but only 20% both accept pregnant women and provide child care. In three of the five cities surveyed, no residential programs accepted pregnant women and provided child care.[9]

The most effective and responsive solution to the chemical dependency/child abuse dynamic is preventing the problem in the first place. We must educate the public on the devastating health consequences of AOD abuse and the emotional and physical hazards of growing up in a chemically involved household. We must develop better means to identify and provide a continuum of treatment and support services to chemically involved families. Without additional prevention and treatment resources, the child welfare system will continue to wage a war against substance abuse that it cannot win.

We again applaud the efforts of this subcommittee to investigate the difficult and complex links between substance abuse and child abuse and neglect. We look forward to continuing to work with you to help children stay safe.

---

[8] 8 U.S. Department of Health and Human Services, Center for Substance Abuse Treatment. (1995). Study of grantees administered by the Women's and Children's Branch. Rockville, MD: author.

[9] Breitbart, V, Chavkin, W, and Wise, PH (1994). Accessibility of drug treatment for pregnant women: A survey of programs in five cities. American Journal of Public Health, 84(10), 1658–1661.

**Statement of Ray Soucek, Haymarket Center, Chicago, Illinois**

Mr. Chairman, I am writing on behalf of Haymarket Center, a comprehensive drug treatment center located on the West side of Chicago, in reference to your Subcommittee's recent hearing on Substance Abuse in Welfare Families. Established in 1975, Haymarket is the third largest substance abuse treatment center in the State of Illinois, providing services to more than 13,000 people annually. Our organization is deeply concerned with the effect of welfare reform on recipients with drug and alcohol abuse problems.

The link between substance abuse and welfare recipients is significant. A study conducted by Aid to Families with Dependent Children (AFDC) of drug and alcohol use among adult recipients found that between 15–20% of welfare recipients have drug and alcohol problems. Another study conducted by researchers at the National Institute on Alcohol Abuse and Alcoholism (NIAAA) based on data from the 1992 National Longitudinal Alcohol Epidemiologic Survey, estimated that 17.9% of welfare recipients are dependent on alcohol and drugs, compared to 8.9% of non-recipients. Put simply, welfare recipients report a higher rate of drug and alcohol abuse than non-recipients do.

Mr. Chairman, it is our belief that States must address the issue of dependency in order to prepare more welfare recipients to enter the workforce. With the new Welfare-to-Work stipulations, States must pay for the effects of substance abuse regardless of whether they pay for treatment. Ignoring the problem will result in States having an estimated 20% of their workforce with a major job-readiness impediment, causing heavy financial burden for the State. The new welfare law mandates that work participation rates amongst recipients rise from 25–50% between 1997 and 2002, with States receiving fines for non-compliance. An even more expensive consequence having to take over when untreated alcohol and drug abuse problems prevent recipients from leaving welfare within the designated time limit.

There are two subgroups within the welfare population that pose significant challenges to Welfare-to-Work self-sufficiency efforts: abusers with co-occurring disorders, and substance abusing welfare mothers.

*What is the effect of co-occurring disorders on diagnosis and treatment?*

Co-occurring disorders are a common problem among all people with substance abuse disorders. It is estimated that half of all people with substance abuse problems have co-occurring disorders, involving psychiatric as well as substance abuse disorders. Often one problem can be considered primary and the other secondary, but more often, the patient is disabled by both disorders and requires integrated treatment. These people often fall victim to inadequate or ineffective treatment services, and lack of insurance coverage for their problems.

According to M. Susan Ridgeley, J.D., M.S.W., Associate Professor, Department of Mental Health and Law policy at the University of Florida, there are numerous aspects of co-occurring disorders that make the problem more debilitating to the patient and the system:

- Patients often suffer from more severe psychiatric symptomatology
- High rates of relapse and rehospitalization
- Worse course in treatment of the psychiatric disorder
- More admissions to emergency rooms and noncompliance with treatment interventions
- Increased acting out suicidal and criminal behavior
- Less able to carry out activities needed to manage their lives

Mr. Chairman, this last characteristic common to patients with co-occurring disorders is especially significant to the self-sufficiency goals of the Welfare-to-Work program, and in reducing the incidence of drug abuse among welfare recipients. With increased pressure from the new laws to get welfare recipients into the workforce, less time is likely to be spent getting to the root of the problem. Co-occurring patients are expensive to the system because they often are not properly diagnosed. The solution is providing incentives for physicians and counselors to make diagnosis and treatment for co-occurring disorders the ônormö rather than the exception.

*Why do dependent welfare mothers often not receive treatment?*

According to a September 1997 study produced by the Legal Action Center (LAC), titled Making Welfare Reform Work: Tools for Confronting Drug and Alcohol Problems Among Welfare Recipients, there are many common barriers to treatment for women with children. And according to the Department of Health and Human Serv-

ices, in 1991 it was estimated that 5.6 million mothers with children living at home had used drugs during the past six months. The LAC study said these women face unique obstacles in receiving treatment, including:

1. Stigma: Studies have discussed the multitude of self-deprecating feelings women with substance abuse problems have experienced. According to the LAC, "these emotions can lead to an immobilizing sense of depression and isolation and ultimately prevent women from asking for help."

2. Lack of Child Care: A 1996 survey in Substance Abuse Report reported that few substance abuse treatment centers provide child care, often acting as a deterrent for welfare mothers from seeking treatment, according to William Walden, Commissioner of the New Jersey Department of Human Services. Ther to meet increased demand for child care services. The problem of lack of quality child care for all welfare recipients is compounded for those with substance abuse problems. Before welfare mothers need quality child care while they are working, they need quality child care while in treatment, making centers that do provide child care and clinical child services more appealing.

3. Fear of Losing Custody of Their Children: Since many States take punitive action against mothers with drug problems, women often are afraid to admit their addiction and seek treatment.

4. Fear of Prosecution: In State v. Whitner the South Carolina Supreme Court ruled that women can be held criminally liable for their actions during pregnancy. The fear of prosecution by those welfare mothers who use drugs while pregnant coincides with fear of losing custody of children.

5. Victims of Violence: Women with substance abuse problems have high rates of being victimized by violence, a problem that affects their recovery from addiction.

6. Safe Housing: Drug-free safe housing is important for many recovering women. However, safe housing has become more and more difficult to obtain due to The Housing Opportunity Extension Act of 1996, which permits authorities to deny housing to former drug and alcohol abusers due to the potential threat they pose to other residents.

Mr. Chairman, States must overcome these barriers by identifying welfare mothers with substance abuse problems and providing them with proper treatment. It is clear that the consequences for ignoring the problems are severe. Child welfare and foster care costs are increasing dramatically. Alcohol and drug abuse are among the top factors for children entering welfare and foster care. According to a 1994 GAO study, almost 80% of young children who entered foster care in 1991 in California, New York, and Pennsylvania, had at least one parent with a drug or alcohol addiction. The cost of placing a child in the welfare or foster care system is 2 to 16 times more than the cost of individual federally funded drug treatment. According to a LAC study, "Providing alcohol and drug treatment prevention services for [welfare] families could protect children, reduce welfare caseloads, and produce significant savings for the federal and state governments."

The reformed welfare system must recognize the needs of recipients wif recipients are expected to achieve self-sufficiency and job-readiness. Investments in treatment, especially for those with co-occurring disorders and welfare mothers, will be much more cost effective for the system and beneficial to recipients in the long run.

---

**Statement of Gwen Rubinstein, M.P.H., Deputy Director of National Policy, Legal Action Center, Washington, DC**

Welfare reform, now unfolding, presents states with many opportunities and challenges. It will not be long before we know whether this experiment will succeed in its key mission of moving many Americans from welfare to work.

Reform of the child welfare and foster care systems will also be enacted soon. That initiative will present a set of new challenges to states, which are already grappling with many other complex reform initiatives inside and outside of the welfare system.

We commend the Subcommittee on Human Resources of the House Committee on Ways and Means for calling this hearing, and we appreciate the opportunity to provide written testimony for the record. Alcoholism and drug dependence often are major barriers to self-sufficiency for welfare recipients, and we welcome discussion of how our national policy can confront thisproblem humanely, productively, and cost-effectively.

The Legal Action Center is a law and policy organization focusing on alcohol, drug, and HIV/AIDS issues. The Center also represents the National Coalition of

State Alcohol and Drug Treatment and Prevention Associations, a coalition of 34 state treatment and prevention associations in 30 states around the country. These associations represent providers on the front lines of treatment and prevention who daily confront the dramatic need to maintain and strengthen services for individuals and families with drug and alcohol problems.

A key component to the success of both of these reforms, we believe, is the adoption of a balanced and comprehensive approach to addressing alcohol and drug problems among all Americans, but particularly low-income Americans. If reforms are to succeed, they must make a steadfast commitment to identifying children and adults who have or are on the brink of an alcohol or drug problem and providing them appropriate alcohol and drug treatment and prevention services.

The Legal Action Center recently completed a major study for the Annie E. Casey Foundation entitled "Making Welfare Reform Work: Tools for Confronting Alcohol and Drug Problems Among Welfare Recipients" (copy attached). This statement incorporates some of our study's leading findings and recommendations. We request that the entire study be included in the record.

## ALCOHOLISM, DRUG DEPENDENCE, AND WELFARE

Several national studies have attempted to determine how many welfare recipients have alcohol and drug problems; all have concluded that between 15 and 20 percent of welfare recipients do.[1] This could translate nationally into between 400,000 and 800,000 adult welfare recipients needing treatment to move into recovery, off welfare, and into jobs.

Few states, however, know the prevalence of alcoholism and drug dependence in their welfare caseloads. Earlier this year, the Legal Action Center surveyed state welfare officials and state alcohol and drug officials to gauge their knowledge and plans concerning welfare reform and addiction. Our report found that only five states had any data on the number of welfare recipients with drug or alcohol problems.[2]

This lack of information will undoubtedly hamper state and local planning and reduce the likelihood that alcohol and drug problems will be confronted with enough thought to be handled most effectively.

## ALCOHOLISM, DRUG DEPENDENCE, AND CHILD WELFARE

Abuse and neglect associated with parental alcohol and drug abuse are among the most common reasons for entering the child welfare system, and drug-and alcohol-related foster care placements have been increasing. Almost 80 percent of young children who entered foster care in 1991 in California, New York, and Pennsylvania had at least one parent who was abusing drugs or alcohol, compared to 52 percent in 1986.[3]

In Washington State, 41 percent of infants placed in out-of-home care in 1995 were born to 1mothers who abused alcohol or other drugs during their pregnancy.[4] In New York, crack cocaine alone was blamed for a three-fold increase in the city's child abuse and neglect cases in the late 1980s.[5]

Out-of-home placements for children whose parents have alcohol or drug problems have contributed to skyrocketing foster care costs. Federal expenditures on foster care increased 300 percent between 1986 and 1991—from $637 million to more than $2.2 billion.[6] In Illinois, the added medical and related costs of caring for 2,500 cocaine-affected infants in child welfare custody were $60 million in 1991.[7]

---

[1] Entities that have published studies include: Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services: National Center on Addiction and Substance Abuse at Columbia University; and National Institute of Alcohol Abuse and Alcoholism, National Institutes of Health.

[2] Those States included Kansas, which reported that 20 to 50 percent of its caseload would fail a drug test, North Carolina, which said 35 percent of its welfare clients were at risk for alcohol or drug problems, and Oregon, which estimated that 50 to 60 percent of its welfare caseload was alcohol or drug related.

[3] General Accounting office, *Foster Care: Parental Drug Abuse Has Alarming Impact on Young Children*, 1994, p. 7.

[4] Washington State Department of Social and health Services, "Chemical Dependence Among DHS Clinets: A Departmental problem," October 31, 1996, p. 10.

[5] Brandeis University, institute for Health Policy, *Substance Abuse: The Nation's Number One Health Problem—Key Indicators for Policy*, 1993.

[6] *Ibid.*

[7] Child Welfare League of America, "Through the Eyes of a Child: A National Agenda for Addressing Chemical Dependency," (Working Draft), 1992, p. 27.

Providing adequate alcohol and drug treatment and prevention services for these families would protect children, reduce child welfare caseloads, and produce significant savings for the federal and state government. Foster care costs in 1994 ranged from $4,800 per year for placement in family foster care to $36,500 per year for placement in group care.[8] This is two to 16 times more than the cost per person for federally funded drug treatment.[9]

Yet legislation passed in House this spring and in the Senate over the weekend to speed up adoption of children in foster care virtually ignores the relationship between addiction and child welfare. In fact, the Senate version of the bill, at the last moment, lost three important provisions to address that issue: a General Accounting Office study to explore the relationship between child welfare placement and alcoholism and drug dependence, allowance for foster care funding (under Title IV–E of the Social Security Act) to help pay for residential treatment in the case of children being reunited with a parent in treatment, and a new priority in the Substance Abuse Block Grant for parents in families involved in the child welfare system.

These problems can be overcome, but not if they are ignored. In a recent study of 475 New York child welfare cases that received a range of preventive services (including alcohol and drug treatment), 98 percent of the families avoided foster care placement, domestic violence decreased in 93 percent of the families, child physical and sexual abuse decreased in 100 percent of the families, and 48 percent of the families sustained abstinence from alcohol and drugs.[10]

## TREATMENT IS EFFECTIVE BUT UNDERFUNDED

Empirical research has shown that after alcohol and drug treatment, women reduce their reliance on welfare and increase their employment.[11] [12] We believe these findings support public policy that promotes treatment for welfare recipients with alcohol and drug problems as a way of helping them find and keep jobs and leave the welfare rolls. (I have attached a copy of the National Treatment Improvement Evaluation Study and ask that it be included in the record.)

Individual recovery stories also demonstrate the effectiveness of treatment:

• CD is a 38-year-old woman who has been in recovery for two years, since she entered residential treatment at Project Return in New York City for crack abuse. She has three children—ages 12, 7, and 6 years old—who had been in kinship foster care with her mother while CD was abusing drugs. After treatment, CD was reunited with all of her children. CD is a former welfare recipient who has been employed for nearly one year as a nurse's assistant.

• SS is a 38-year-old white woman who had lost custody of her three children due to her long history of substance abuse when she entered Par Village in St. Petersburg, Florida, for treatment. Her drug use included crack cocaine, alcohol, and heroin. Between 1992 and 1994, SS participated in treatment and was able to regain custody of her children one by one. She has worked diligently to develop and practice her recovery and vocational skills. After treatment, SS established a home for her and her children and enrolled in St. Petersburg Junior College, where she continues her studies and is employed by the Work Study Program. SS and her children are very involved in the worship and activities at their church in Clearwater, Florida, and she is an active participant in 12-step programs throughout Pinellas County.

These success stories are occurring all over America, yet publicly funded treatment programs such as Project Return or PAR Village are not always readily available in many communities. Waiting lists are common, and the most difficult treatment to find in virtually any community is a residential program for women and children.

The main source of federal funding for alcohol and drug treatment, the Substance Abuse Prevention and Treatment Block Grant, has been stagnant. It will be allocated $1.36 billion in FY 98, the same as in FY 97. According to our study, only nine states plan to increase their own appropriations for alcohol and drug treatment for welfare families.

---

[8] U.S. House of Representatives, *1996 Green Book: Background Materials and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, 1996, pp. 714–724.

[9] Substance Abuse and Mental health Services Administration, FY 98 Budget Justification.

[10] National Development and Research Institutes, "Preventive Services Outcome Assessment: A Survey of Contracted Agencies, Preliminary Results," March 1995.

[11] Dean R. Gerstein, et. al, "Alcohol and Other Drug Treatment for Patents and Welfare Recipients: Outcomes, Costs, and Benefits," January 1997, p. 29.

[12] Center for Substance Abuse Treatment, "The National Treatment Improvement Evaluation Study—The President Effects of Substance Abuse Treatment, One Year Later," September 1996, p. 11.

Drug and alcohol treatment services are also not well covered under state Medicaid plans because they are optional. And reimbursement is expressly disallowed for all Medicaid-covered services provided to recipients between 22 and 64 years of age in residential treatment facilities classified as Institutions for Mental Diseases (IMDs).[13]

Finally, about 20 states are likely to deny cash welfare and food stamps to individuals with drug felony convictions, thus reducing funds that have been available for alcohol and drug treatment. Cash welfare and food stamps have helped to pay for room and board in residential alcohol and drug treatment programs for women with children. But the new federal welfare law prohibits giving these benefits to individuals with drug felony convictions, unless states "opt out."

Treatment programs serving women are, predictably, concerned about these trends. Our study found that most expect welfare reform to decrease their revenue but increase their caseload.

## POLICY RECOMMENDATIONS

The Legal Action Center submits the following policy recommendations to the Subcommittee for addressing alcohol and drug problems among welfare recipients and families involved in the child welfare system:

*Identify Welfare Recipients and Families Involved in the Child Welfare System Who Have Alcohol and Drug Problems.*

The first step in breaking the cycle that keeps addicted people and later generations dependent on welfare or involved with the child welfare system is identifying, easily and cost-effectively, welfare recipients who have alcohol and drug problems.

• Conduct Screening and Refer Welfare Recipients and Families Involved with the Child Welfare System Identified as Having Alcohol or Drug Problems for Treatment; Penalize Only Those With Alcohol and Drug Problems Who Refuse to Enter Available Treatment.

Many short and simple screening tools—both written and verbal—are available for identifying individuals with drug and alcohol problems. They can easily be integrated into the existing welfare intake process, as some states and localities (such as New York, Oregon, and Utah) have already done, or child welfare intake process (as Sacramento County has done). Those identified as having alcohol and drug problems can then be referred for further clinical assessment and appropriate treatment, if needed.

• Reject Drug Testing as a Method of Identifying Individuals With Alcohol and Drug Problems.

Limited resources should not be invested in drug testing because it yields little useful information at too high a cost.f screening and assessment described above is far more effective at a fraction of the cost.

• Train Welfare and Child Welfare Caseworkers to Administer Screening Protocols and Refer Clients for Services.

The knowledge and skills of welfare and child welfare caseworkers are of critical importance in helping welfare recipients overcome both their short-and long-term barriers to working, including alcohol and drug problems. If caseworkers are in as much denial as their clients are about these problems, even the most well-designed state initiative is doomed to fail.

*Promote and Encourage Treatment and Recovery Among Welfare Recipients.*

Helping individuals who are dependent both on welfare and alcohol and drugs enter treatment and overcome their addiction is an effective way to move them from welfare to work and reduce child abuse and neglect.

• Provide Treatment to Welfare Recipients Whose Addiction Prevents Them from Working, and Encourage Their Participation in Treatment by Not Counting Time Spent in Treatment Toward Their Time Limit on Welfare.

Ideally, welfare recipients identified as having alcohol and drug problems should have ready access to treatment. National, state, and local policies should make every effort to increase the availability of treatment for welfare recipients needing it, particularly treatment designed for women with children, and make it more attractive by exempting individuals in treatment from the welfare time limits.

• Draw on All Possible Sources of Treatment Funding.

---

[13] The IMD exclusion, originally drafted to prevent funding of large mental hospitals, has been extended to include even cost-efficient substance abuse treatment programs. IMDs are facilities with more than 16 treatment beds.

The new welfare reform and adoption reform laws provide no new funding for alcohol and drug treatment. But treatment can still be funded by increasing federal appropriations for the Substance Abuse Block Grant, state allocation of welfare savings to treatment, state transfer of welfare money to the Social Services Block Grant, and Federal or state expansion of Medicaid reimbursement for treatment.

• Define Appropriate Work Components of Treatment as a Work or Community Service Under the Welfare Law, and Ensure that Work and Treatment Are Coordinated.

Some work activities (as defined in the new welfare law) are integral parts of some alcohol and drug treatment programs. Counting them as work—whether by contracting with treatment programs to provide them or coordinating treatment with other work activities—will ensure that states have more welfare recipients to count toward their minimum work participation rates (so they will avoid penalties) and that welfare recipients striving toward recovery will gain work experience within the suoportive context of their treatment program.

• Eliminate the Felony Drug Conviction Ban.

The federal government should eliminate the welfare law's ban on welfare and food stamps for individuals convicted of drug felonies. The drug felony conviction ban shrinks available treatment resources, strips the criminal justice system of resources it needs for mandatory drug and alcohol treatment, and shreds the safety net for individuals who have been in recovery, worked, and paid taxes, and their families.

*Promote Prevention and Early Intervention for Welfare Recipients and Their Children.*

Addiction and welfare can both be inter-generational; effective prevention and intervention can break the cycle for many families forever.

• Integrate Prevention and Early Intervention Services into Welfare Reform.

Preventing parents and children on welfare from developing alcohol and drug problems—or intervening early in the process—can keep families together, maintain safe environments for children, and help more families make a successful transition from welfare to work. All of these would decrease welfare and child welfare caseloads and save states money. The benefits to individuals, families, and communities would be great.

• Draw On All Available Sources of Prevention Funding.

Prevention activities can be funded both inside and outside of the new welfare law and at the national, state, and local levels. Key federal sources of funding that should be increased include the Substance Abuse Block Grant and programs under the Center for Substance Abuse Prevention and Safe and Drug-Free Schools and Communities Act.

## CONCLUSION

Many welfare recipients have alcohol and drug problems. Their children (and many adult welfare recipients) are themselves at high risk for becoming dependent on or abusing alcohol or drugs. To succeed, welfare reform must confront this problem in a balanced and effective way that includes alcohol and drug treatment and prevention services.

Many families involved in the child welfare system also have alcohol and drug problems, putting both children and parents at risk. The child welfare system must confront this problem in a balanced and effective way that includes alcohol and drug treatment and prevention services.

Adopting a reasoned and comprehensive approach can simultaneously meet the goals of welfare reform, reduce alcohol and drug addiction and abuse, and improve the lives of our children, families, and communities.

**Statement of William D. McColl, Director of Government Relations; on Behalf of National Association of Alcoholism and Drug Abuse Counselors, Arlington, Virginia**

On behalf of the National Association of Alcoholism and Drug Abuse Counselors (NAADAC), please accept the following comments regarding protecting children from the prevalence and impact of substance abuse on families receiving welfare. NAADAC, with more than 18,000 members, is the largest national organization representing the interests of alcoholism and drug abuse treatment and prevention professionals across the United States.

Research has clearly shown that children are highly affected by alcoholism and drug addiction within the family. Families on welfare face additional pressures from joblessness and poverty. Nevertheless, these issues are not insoluble. NAADAC reiterates three fundamental principles to deal with alcoholism and drug addiction, applicable not only to welfare, but also to society at large. First, alcoholism and other drug dependency must be addressed primarily as a public health problem. Second, access to appropriate care, delivered by credentialed professionals, must be provided to persons dependent on alcohol and other drugs. Finally, public and private funding must be significantly increased and policies improved to provide adequate levels of care for persons dependent on alcohol and other drugs.

By following these fundamental principles, our nation can begin to reduce the tremendous burden faced by victims of the diseases of alcoholism and drug addiction. Treating these diseases will result in safer children, restored families and inproved communities. NAADAC adds the following specific program solutions below, designed to enhance the nation's ability to help those children caught in the difficult position of being on welfare with one or more parents who have the disease of alcoholism or drug addiction.

TREATMENT MUST BE A FUNDAMENTAL PART OF FEDERAL AND STATE WELFARE PROGRAMS—WELFARE

In 1996, Congress fundamentally changed the federal welfare law to require that states move people from public assistance to work. As states begin to implement the new welfare requirements, the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) supports policies and legislation which acknowledge the vital role of alcohol and drug treatment in helping individuals who are addicted to alcohol and other drugs to find employment and achieve self-sufficiency.

State policymakers must be made aware that treatment positively affects the ability of this population to move into employment. According to one recent study, 5.2% of adults in Aid to Families With Dependent Children (AFDC) households are so severely impaired by alcoholism and/or drug addiction problems that they are unable to participate in immediate employment or training activities.[1] This group must receive treatment if they are to become capable of work. An additional 11.2% of AFDC adults are somewhat impaired and may require alcoholism and drug addiction treatment concurrent with work or training activities.[2]

Alcoholism and drug addiction treatment is capable of cost-effectively moving clients from the ranks of the unemployment to work. The National Treatment Improvement Evaluation Study showed that people who complete treatment increased the rate of past year employment by 18.7% while decreasing income received from welfare programs by 10.7%.2 In addition state governments will save significant public funds by reducing the medical costs that result from this disease, helping people to live independently from welfare and public assistance, reducing the number of crimes committed by people who are addicted, and lowering the cost of incarceration.[3]

Much of the funding of the welfare system is in block grant form which allows each state a substantial opportunity to decide how they will spend their funds. NAADAC recommends that states place a portion of welfare funding into alcohol and drug treatment to help ensure success in moving people into jobs. State treat-

[1] Gerstein, Dean R. et. al., U.S. Department of Health and Human Services, Office of the Assistance Secretary for Planning and Evaluation, Alcohol and Other Drug Treatment for Parents and Welfare Recipients: Outcomes, Costs and Benefits, January 1997.

[2] Ibid.

[3] Center for Substance Abuse Treatment, National Treatment Improvement Evaluation Study, September 1996.

ment agencies and treatment advocates must educate state legislatures, executives, policy makers, and welfare agencies to ensure that those most responsible for implementing welfare requirements clearly understand the need for treatment.

## CHANGES TO THE 1996 WELFARE LAW

NAADAC urges one significant change to the 1996 welfare reform law. The law currently makes any individual convicted of a drug-related felony ineligible for food stamps and Temporary Assistance to Needy Families (TANF), previously AFDC. This provision unnecessarily sanctions people who are suffering from the diseases of alcoholism and drug addiction. The loss of food stamps and TANF reduces families' total allotments by the amount of funding which would have gone to the ineligible person. This may jeopardize an entire family's well-being because benefits support entire families, not just the individuals who use them. Children are particularly vulnerable to these reductions. Moreover, many treatment providers use TANF and food stamp benefits to help support the costs of room and board associated with residential treatment. Loss of access to even this meager funding source may cause a patient to lose treatment opportunities.

Patients who complete treatment require stability and continuing care to ensure a successful transition to drug free life. There is no provision for restoration of benefits in the new welfare law upon an individuals entrance into recovery. Consequently the stability that this source of funding could bring to people in recovery is lost. We urge Congress to repeal this lifetime ban. Short of repeal, Congress should take steps to mitigate possible damage from this provision by exempting persons who are seeking treatment, have completed treatment, are pregnant, or who are otherwise disabled. NAADAC notes that states are currently allowed to opt out of this provision. They should do so.

## DRUG TESTING AND THE WELFARE LAW

The welfare law now allows states to require that welfare recipients be tested for drug use and to apply sanctions for positive tests. NAADAC again reiterates its position that "the purpose of drug testing must be rehabilitative and not punitive."[4] We are concerned that blanket drug testing programs will be accomplished at high cost to the state without leading to effective treatment people addicted to drugs. Testing will not effectively address the alcohol and prescription pharmaceutical addiction problems of welfare recipients, and will not, by itself, adequately identify people who are addicted to those illegal drugs which are most commonly tested. To correctly identify persons addicted to drugs, state welfare agencies must professionally assess and screen recipients in addition to, or in place of, drug testing. Upon positively identifying an individual who is suffering from alcoholism or drug addiction, agencies must provide access to an adequate level of alcohol and drug addiction treatment from licensed or certified alcohol and drug treatment counselors.

## CONCLUSION

In summation, the best way to help people who are on welfare and who suffer from alcoholism or addiction to drugs is to provide them with treatment. Treatment is the most cost-efficient and effective means of ensuring that welfare recipients suffering from these diseases are able to move from dependence on cash assistance to employment and self-sufficiency. NAADAC supports efforts to reform the welfare law to ensure that persons who are suffering from the diseases of alcoholism and drug addiction do not suffer from discrimination.[5] In particular, provisions barring persons convicted of drug-related felonies from receiving food stamps and TANF are onerous and make treatment inaccessible to those who are most in need of this service. Finally, NAADAC encourages states to make every effort to ensure that drug testing is rehabilitative and not punitive. If drug testing is used, states should provide adequate access and funding for treatment by certified and licensed counselors.

---

[4] Ibid.

[5] NAADAC, Position Statement, Drug Testing, March 1996. NAADAC, Position Statement, Drug Screens, April 15, 1987.

**Statement of Hon. Jim Ramstad, a Representative in Congress from the State of Minnesota**

Mr. Chairman, thank you for calling this hearing to discuss the impacts of substance abuse on families receiving welfare. I would also like to thank you for inviting Dr. Mitch Pearlstein, my friend from the Center of the American Experiment in Minnesota, to testify today.

I know many of the people speaking today will explain that alcoholism and drug addition are painful, destructive occurrences with staggering public costs. We all know addictions cause health care costs to rise and contribute to the overwhelming amount of crime, violence and domestic abuse in our nation today.

Despite these facts, I couldn't agree more with Dr. Pearlstein's assessment that this nation "seems to be in a haze, numbed to the pervasiveness and destructiveness of drugs." That's why this hearing, to shed light on the devastation all drugs can create, is so important.

The most important costs, of course, are the personal costs. Alcoholism and drug addiction permeate all races and all income levels. They afflict both the abuser and his/her family—most dramatically, the children. Dr. Pearlstein gives an emotional personal account of how it has affected his family, especially his adopted daughter.

As one who has been sober for 16 years, I know treatment works. I also realize that many factors affect treatment success, and just like chemotherapy and radiation for cancer victims, traditional treatment programs cannot have a 100% success rate.

We should look at alternative programs, as Dr. Pearlstein suggests in his testimony. Frankly, I believe we should consider anything that will effectively help a person fight addictive tendencies. I am glad to learn through today's witnesses about the kinds of treatment programs that are working across this nation so we can try to replicate them for others.

And for those who won't or can't fight addiction, Mr. Pearlstein is absolutely correct—we must remove the children from their care and get the children into a stable, loving and nurturing family as soon as possible.

Certainly, any welfare/foster care system that keeps just one child in harms way or away from a loving family just one day longer than necessary needs improvement. Unfortunately, more than one child is severely neglected by our system every year. Dr. Pearlstein tells of 2,000 infants and young children in the U.S. who die from neglect and abuse by parents and caregivers every year. We also know that over 500,000 children linger in our foster care system awaiting adoption.

Because alcoholism and drug addition are so pervasive and destructive and can most greatly harm the most vulnerable in our society—our children—I would like to thank you again, Mr. Chairman, for calling this hearing. I look forward to the testimony of today's witnesses and learning more about ways we can fight addiction and improve the lives of America's children and families.

○