



Framework and Policy Tools for Improving Linkages Between Alcohol and Drug Services, Child Welfare Services and Dependency Courts

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Background

In 2000, Children and Family Futures (CFF), a California-based public policy firm, was contracted by the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration to develop “*Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Drug Services with Child Welfare*”—TAP 27 in the Treatment Assistance Protocols (TAP) Series. The TAP was published by CSAT in April of 2002 and is one of the most frequently requested resources of the National Center on Substance Abuse and Child Welfare (NCSACW). It provides descriptions of seven sites from around the nation that have implemented promising programs that link alcohol and drug services, child welfare services, and the dependency court.

The TAP has made several important contributions to fields that work with children and families receiving substance abuse and child welfare services. It proposed a ten-element framework for assessing the components of collaborative efforts to address the substance abuse issue among families in the child welfare and dependency court* systems. The ten-element framework identifies linkages for improving systems and sustaining practice and policy reforms. The ten-element framework incorporated prior work conducted by CFF¹ as well as five major reports that had been published on the issue between 1998 and 1999.² More recently, the elements have been revised from input from the NCSACW consortium members, including the:

- American Public Human Services Association
- Child Welfare League of America
- National Association of State Alcohol and Drug Abuse Directors
- National Council of Juvenile and Family Court Judges
- National Indian Child Welfare Association

The TAP has been useful to many states and communities. However, the opportunity to work with many sites where progress has been made led us to introduce several revisions to the basic framework and policy tools. Many of these revisions were introduced in various formats and conference presentations over the past few years. There are two fundamental changes in our approach:

1. The integration of the perspective of the dependency court in each of the elements of the framework, emphasizing the three core systems *as trilateral partners*: substance abuse, child welfare and dependency courts (previously a single element of the framework was “working with the courts”).
2. The separation of linkages with community groups and family supportive systems as a distinct area of practice and policy, differentiated from the element in the framework that supports work with critical community agencies and formal support systems such as

* Dependency court in this paper refers to those courts that have jurisdiction in cases of child abuse and/or neglect and include both the judicial officers and the attorneys who represent parents, children, social workers and the State in court processes.

mental health, domestic violence, primary health, income support and employment-related agencies.

The Elements of System Linkages

These elements were originally developed by Children and Family Futures as a framework, combining the five domains of action highlighted by Department of Health and Human Services in its 1999 Report to Congress, *Blending Perspectives and Building Common Ground*,³ and the framework that had been used in CFF's prior work for the Child Welfare League of America. As we began this revision to the framework, we were joined by staff from the National Council of Juvenile and Family Court Judges in specifying the specific roles of the judiciary and attorneys in implementing plans in each of the areas. The ten major elements of the instrument are:

- **Underlying Values and Principles of Collaborative Relationships**
- **Daily Practice–Client Screening and Assessment**
- **Daily Practice–Client Engagement and Retention in Care**
- **Daily Practice–Services to Children of Substance Abusers**
- **Joint Accountability and Shared Outcomes**
- **Information Sharing and Data Systems**
- **Training and Staff Development**
- **Budgeting and Program Sustainability**
- **Working with Related Agencies**
- **Working with the Community and Supporting Families**

Why are these elements so important to a partnership between substance abuse, child welfare and the dependency court systems?

1. *Underlying values* should be addressed in developing collaborations because the partners are very likely to come to the table with different perspectives and assumptions about their agency's or the court's values and mission and mandates. Unless these differences are addressed, the partners will be unable to reach agreement on issues.
2. **Daily practice and protocols in the areas of AOD screening and assessment** should be addressed by the collaborative, since it is in these first contacts with the client that agencies must begin the process of determining what kind of substance abuse problem—if any—these parents have, and what mode of treatment can best respond to the problem, and what information needs to be communicated among workers and attorneys. Legal advocates for parents play a pivotal role in the process by either encouraging or discouraging their client from seeking services and being forthright during the evaluation.
3. **Daily practice in engaging and retaining parents** should be addressed by the collaborative as the Adoption and Safe Families Act (ASFA) and children's developmental needs demand the best possible efforts to keep clients on track in meeting their parental goals while balancing the many obstacles often confronting chemically-dependent parents and their children. There are discrete roles and responsibilities that can

be exercised by judicial officers to enhance retention in care among parents. Again, parents' attorneys play a crucial role in the messages they give to their clients about engaging in substance abuse and other services. Agency attorneys are also positioned to inform the court and community about available resources and gaps in services.

4. **Daily practice in services to children** should be addressed by the collaborative as treating the parents alone ignores the effects of AOD problems on the children. Substance abuse services provided to families in the child welfare system should be provided in a family systems approach. When residential care is warranted, keeping parents and their children together whenever appropriate should be a priority. If the cycle cannot be interrupted in a family where caretakers are substance abusing or addicted, there is the risk that without effective intervention a new generation may repeat the same pattern in which they were raised. Advocates for children have a role in ensuring that the special needs of children of substance abusers are addressed in prevention and intervention programs. Agency attorneys can act as a liaison between the agency, community and media to advocate for improved services to increase family recovery and child protection.
5. **Joint accountability and shared outcomes** should be addressed by the collaborative because jointly developed outcomes can guide the work of the collaborative and are critical to demonstrate that the collaborative has achieved interagency agreement on desired results. Without such an agreement, each of the partners is likely to continue measuring its own progress as it always has, using only the outcomes that the agency is accustomed to.
6. **Shared information systems** should be addressed by the collaborative because these are the prerequisites for joint accountability. Joint information systems, which form the basis of communicating across systems, must be used to track progress toward joint goals and to determine whether joint outcomes are achieved. Without the effective communication and sharing of information the partnership will have no guideposts to gauge its programs' effectiveness.
7. **Budgeting and program sustainability** should be addressed by the collaborative, since tapping the full range of funding resources available to a state or community is the only way to develop multi-year stability for innovative approaches.
8. **Training and staff development** should be addressed by the collaborative because without cross-training efforts at all levels – policy, administrative, management and line-level staff, conventional practice will deepen the division between key players in the system.
9. **Working with other agencies** should be considered **by the collaborative**, because many parents with AOD problems also require assistance from services other than substance abuse and child welfare to address the multiple, complex issues impeding the functioning of families affected by alcohol- and drug-related problems. In particular, mental health,

domestic violence, primary health, housing, and employment-related services are needed partners.

10. ***Working with the Community*** and supporting families should be addressed by the collaborative. Community roles in child welfare reform and in substance abuse have been shown to be great resources with the ability to mobilize community members and community-based organizations. These community based organizations and support systems have served as a “front line” of child protective services that functions as child and substance abuse prevention as well as providing on-going supports after “formal” services have ended.

The TAP also introduced a developmental Matrix of Progress in Building Linkages Among Alcohol and Drug Agencies, Child Welfare Services, and the Dependency Court. The Matrix of Progress is a tool for assessing collaboration across systems, specifically the identification of benchmarks for improving system linkages, which are fundamental to improving outcomes and long-term well-being for families with substance use disorders involved in the child welfare and dependency court system. The Matrix of Progress identifies fundamentals for improved practice, good practice, and best practice for each of the 10 key elements (See Appendix 1).

The monograph also provided number of new tools for improving resources⁴ and, in particular, introduced two inter-related policy tools that were developed and piloted with the County Alcohol and Drug Program Administrators Association of California and the Children’s Committee of the County Welfare Directors Association of California. The policy tools are intended to assist states and communities in their collaborative efforts and include (See Appendix 2):

- ❖ **Collaborative Values Inventory (CVI)** – a questionnaire that serves as a neutral, anonymous way of assessing how much a group shares ideas about the values that underlie their work. It is intended to bring to the surface issues that may not be raised if the collaborative begins its work together without clarifying the underlying values that its members bring to their work.
- ❖ **Collaborative Capacity Instrument (CCI)** – a self-assessment tool with questions designed to elicit discussion among and within child welfare, substance abuse, dependency courts and community agencies about their progress in addressing specific issues and to prioritize their most urgent program and policy plans.

These tools are available on the Children and Family Futures website (www.cffutures.org) for use by states and communities.

This paper explains the framework and highlights the strengths and challenges in developing a collaborative approach to the issues of familial substance use disorders among the child welfare and dependency court populations. Child welfare administrators, supervisors and workers, as well as substance abuse administrators and clinicians have specific roles and responsibilities in establishing and implementing collaborative programs. This paper spotlights the roles and

responsibilities of the dependency courts—judicial officers and attorneys—in developing and sustaining collaborative approaches to improve outcomes for these children and families. Finally, we include synopses of the program sites that we visited in the Spring of 2000 that are further described in the TAP.

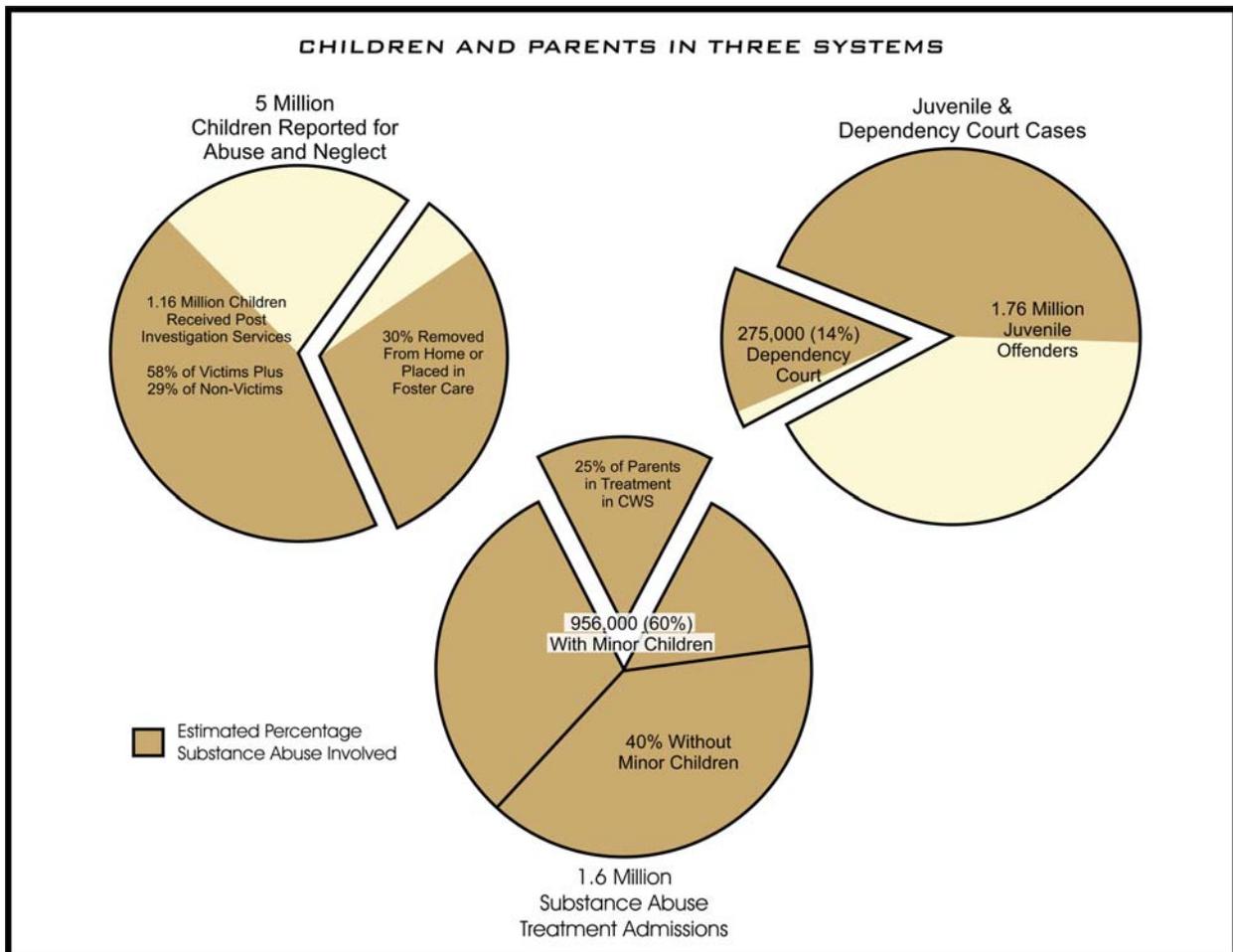
Rationale for a Trilateral Relationship

There are families involved in substance abuse treatment and child welfare services who do not come to the attention of the dependency courts. However, for those families in which child protection and custody issues prevail, the dependency courts play a critical role in overseeing compliance with the law, adjudicating the case and ensuring the safety, permanency and well-being of children. A critical part of the context of this problem is the magnitude of the child abuse and neglect reports which are the entry points to the CWS system and the extent of overlap between these families with the other core systems—substance abuse and the dependency court. The overlap between the systems is substantial as indicated by the following national estimates.

- ❖ Substance Abuse Treatment
 - 1.6 million adult admissions to public system⁵
 - 478,000 of these admissions (30%) are women⁶
 - 955,900 of persons admitted to treatment (60%) have minor children⁷
 - 239,000 parents (25% of the 955,900) have child welfare case⁸
 - 83,650 parents (35% of the 239,000) in treatment had parental rights terminated⁹
- ❖ Child Welfare Services
 - 2.7 million referrals regarding 5 million children reported for abuse/neglect in 2001¹⁰
 - 1.789 million reports resulted in a further investigation – 67% of referrals¹¹
 - 573,000 substantiated or indicated – 32% of investigations¹²
 - 903,000 child victims – consisting of 57% neglect; 19% physical abuse; 10% sexual abuse; 14% other¹³
 - 275,000 (30% of child victims) entered foster care in FY 2001¹⁴
 - One- to two-thirds of families in child welfare services are affected by substance use disorders¹⁵
- ❖ Dependency Court
 - Total number of dependency cases filed -unknown
 - 275,000 children court involved due to placement in foster care¹⁶
 - Children not removed for whom a petition alleging parental abuse or neglect has been filed - unknown¹⁷
 - 90,000 children subject of dependency cases out of 1.75 million juvenile dependency cases*.¹⁸
 - 60,000 estimated to involve families with substance use disorders¹⁹

* Each case represents a new referral to juvenile court for one or more offenses. A youth may be involved in more than one case in a year. The *Juvenile Court Statistics* series does not provide a count of individual juveniles brought before juvenile courts.

The graphic shown below illustrates how each system interacts with the other for some percentage of its total population. While the overlapping population is extensive, none of the three systems has a specific mandate to differentially address the portion of families with substance use disorders.



One component adding to the complexity of this issue is the fact that each of the systems also have a significant group of cases who do not interact with the other two systems. Another way to view the systems is shown below; the systems are not Venn diagrams of overlapping populations. Rather, each system interacts with the other for some percentage of its total population. However, none of the three systems has a specific mandate to differentially address the portion of families with substance use disorders.

Challenges to Collaboration

Given the intersecting population of children within the child welfare and court systems whose parents are challenged by substance abuse, it is important to engage all three systems—the courts, child welfare, and treatment providers—in planning for systemic change. Challenges in building successful collaboration between the substance abuse and child welfare systems have

been noted in several publications (see the summary of the Five National Reports in the endnotes). Including the court system in the collaborative team can also raise issues that should be addressed. Collaboration calls upon judges, attorneys, child welfare professionals and substance abuse treatment providers to rethink their roles and responsibilities and to focus in a different way upon the needs of families and children.

The challenges inherent in building and maintaining a successful collaboration among all three partners often stem from a general lack of information and understanding about one another's roles and responsibilities. Child welfare systems often are frustrated by the lack of appropriate services immediately available from treatment providers. Treatment providers may not understand the various roles and responsibilities of child welfare workers. And both systems are often not well trained to work within the dependency court arena, which can be intimidating to other professionals as well as bewildering to families.

Developing new policies to support improved practice requires all three systems to work in a collaborative method, which places new responsibilities upon each system's professionals. In a collaborative setting, judges, attorneys, child welfare professionals and treatment providers must move beyond their traditional roles, begin to look at the system as a whole, and focus on the needs of children and families in a holistic way. By rising above daily practice issues and making the best interests of abused and neglected children the primary level of focus, all three partners can plan for effective systemic change. This change can include development of treatment and support service options that best meet the needs of dependent children and their families within their communities.

This policy focus can guide planning for change in court and agency practice which is centered on children and families taking into consideration the importance of a child's needs, including a child's sense of time, developmental needs, sense of well-being, and other critical developmental issues. A holistic approach to assessing and revising policy can ensure that appropriate and immediately accessible substance abuse services will be available to parents and those mental health needs of children and parents will be met.

Collaboration among all three systems presents certain barriers that must be overcome. There is a shifting role for professionals as they develop and implement a new way of communicating with one another on policy issues. Differences in practice among stakeholders, from courtroom to courtroom, from agency to agency, and from provider to provider must be recognized and addressed. Difficult collaborative issues arise in reallocating resources or identifying new sources of support and these issues must also be addressed by all three systems. If adequate numbers of caseworkers, judicial officers, and attorneys, and appropriate treatment services are not available, it is the responsibility of policy stakeholders to identify gaps and find new or redirected resources to meet the needs of children and families within their communities.

Some challenges faced by all three systems result from the high rates of change and turnover in each of the systems. Judges are often required to rotate. Child welfare agencies in many jurisdictions are encountering high rates of turnover. Substance abuse treatment providers encounter similar challenges in retaining staff.

There are also ethical considerations to be noted in building collaboration with judicial officers and attorneys, which should be addressed early on in the collaborative process. Thinking beyond traditional judicial, legal, child welfare and service provider roles requires development of new ways of thinking, bringing a sense of cooperation to the table, and a willingness to “think outside the box.”

Clearly, judicial officers and attorneys bring major strengths to the effort as well as challenges posed by their participation in the planning and implementation of cross-system initiatives including:

Strengths

- ❖ The ability to convene stakeholders to address policy considerations in improving practice;
- ❖ The ability to outreach to the community for support;
- ❖ The ability to hold stakeholders, clients, and themselves accountable;
- ❖ The ability to join with stakeholders in looking holistically at the system and, along with stakeholders, identify challenges, as well as plan for and implement meaningful changes in practice;
- ❖ Ability to reach out to lawmakers and funding bodies (county commissioners) for support of new practices developed through collaboration; and,
- ❖ The advocacy role of attorneys.

Challenges

- ❖ Judicial officers often act independently, which creates challenges to implementing changes across courts;
- ❖ Some jurisdictions rotate judicial officers, as well as attorneys, which poses challenges to the continuity of the collaborative effort;
- ❖ The adversarial nature of the legal system and relationships among the various advocates within the dependency court system, including attorneys who represent children, parents, social workers and the state, poses challenges to incorporating a collaborative vision in working with these families; and,
- ❖ The legal mandates of the dependency court require more hearings and a higher judicial workload than other areas of the judiciary.

Roles and Responsibilities

It is clear that some challenges faced by all three systems result from the high rates of change and turnover in each of the systems. Judges are often required to rotate. Child welfare agencies in many jurisdictions are encountering high rates of turnover. Substance abuse treatment providers encounter similar challenges in retaining staff. A fundamental prerequisite to screening, assessment and case planning is the need to address joint training of staff. Sufficient time for staff to be familiar with the roles, responsibilities, nomenclature, values and practices in the other

fields is a basic requirement for addressing the complex issues of families with substance abuse and child abuse/neglect.

While there are ethical considerations to be noted in building collaboration with judicial officers and attorneys, which should be addressed early on in the collaborative process, thinking beyond traditional judicial, legal, child welfare and service provider roles require development of new ways of thinking, bringing a sense of cooperation to the table, and a willingness to “think outside the box.” Understanding the roles and responsibilities of the staff members in each of the systems is imperative to building effective teams.

Alcohol and Drug Services Systems – have a primary responsibility to address substance use disorders, guiding the client to sobriety and recovery. They also have a legal mandate to report suspected child abuse or neglect.

- **Counselors** – have a primary role to help the client break through denial, envision a positive life without substance dependency or abuse, understand the impact and damage the condition brings to life goals and relationships with children, family, friends, employment, etc. The counselor is coach, critic, and cheerleader. To achieve and cement sobriety and promote continued recovery, the treatment must include the safety of the child and the healing of the entire family.
- **Supervisors** – have a primary role to provide perspective to the case management, ensuring that program protocols are followed, client needs are fully identified, clinical interventions are appropriate, all service and community resources are tapped and counselor experiences or values are not inappropriately biasing the service plan and interventions. Supervisors provide oversight so the above is provided on a timely basis.
- **Administrators** – have a primary role to provide appropriate policies, protocols and adequately trained staff to meet the system responsibilities.

Child Welfare Systems – have a primary responsibility to ensure the safety and well-being of the child, which includes addressing the child’s need for a permanent and loving home within twelve months of case opening for children placed in out of home care. The system is also charged with the legal responsibility to make reasonable efforts to reunify the family.

- **Caseworkers** – after conducting an investigation to assess child safety and risk, casework includes providing a nurturing environment for the child while understanding and identifying the needs of the child and of the neglectful or abusive parent or caregiver. Reasonable efforts to reunify require the caseworker to be coach, critic and cheerleader to support, heal and train the parent so he or she has the capability of caring for the child.
- **Supervisors** – have a primary role to provide perspective to the case management, ensuring that program protocols are followed, child and family needs are fully identified, clinical interventions are appropriate, all service and community resources are tapped and

caseworker experiences or values are not inappropriately biasing the service plan and interventions. Supervisors provide oversight so the above is provided on a timely basis.

- **Administrators** – have a primary role to provide appropriate policies, protocols and adequately trained staff to meet the system responsibilities.

Dependency Court Systems – have jurisdiction in cases of child abuse and/or neglect and include both the judicial officers and the attorneys who represent parents, children, social workers and the State in court processes.

There are several critical roles of the dependency courts in addressing substance abuse issues among families in child welfare services. In addition to substance abuse issues, judges and attorneys are also being asked to assume new roles in their work with families who are affected by domestic violence and mental health issues. This comes at a time of evolution in the overall role of the courts and of judges' roles in addressing a variety of societal problems through court-based interventions. The evolution of court-based "therapeutic intervention" is in its infancy, and there is a need for judges, attorneys, other service providers and the larger community to understand the different roles that courts are being asked to play in these arenas. These changes include the shifting role of dependency court judges from a base of power and authority to shared responsibility among partners focused on therapeutic as well justice-related goals. In the area of substance abuse and dependency courts, the roles of judicial officers include:

Leadership. Judges can tap into the power structure of the community and have a unique role of guiding change and working with stakeholders to reallocate and identify new resources.

Public Awareness. Judicial officers hold positions of respect in the community and can gain public awareness and support for additional resources as they are often in the community spotlight.

Convener. Judges can bring together diverse groups to develop a common vision and to implement jointly-held goals.

There are specific roles for the attorneys who represent parents, children, social services and the State in the dependency court that influence the nature of their collaborative efforts. As stated by the Youth Law Center:

“In dependency cases involving issues of substance abuse, attorneys play a critical role in enforcing their clients' rights to services and to family integrity. Representing clients in these cases requires expertise not usually acquired in the general practice of law. Prior to accepting these complex cases, attorneys must have sufficient background information, knowledge, and skill to practice competently in this area.”²⁰

According to the Youth Law Center, legal advocacy skills that attorneys can provide include:

- ❖ Interpretation of federal, state and local statutes, regulations and standards;
 - ❖ Lobbying and speaking to legislatures, boards, and commissions;
 - ❖ Development of relationships with experts from various disciplines (psychology, tribal, etc.) to obtain expert advice when necessary;
 - ❖ Investigation and development of a complete history of the case, including all other court involvement and involvement of other agencies (delinquency court, domestic violence court, family/divorce court, mental health agencies);
 - ❖ Ensure that witness attend hearings; and,
 - ❖ Inform the court about available community services.
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- **Dependency Court Judges** – have the primary role of making judicial decisions that lead to permanency for children who are in the child welfare system. They follow a set of procedures and timetables that are specified in the Adoption and Safe Families Act, presiding over a series of hearings throughout the child welfare case. They will also examine whether the child welfare agency has made reasonable efforts to provide the services needed (including treatment services), first to prevent removal, and then to achieve reunification.

 - **Parents’ Attorneys**—have a primary role as advocate for their client, which includes protecting the legal rights of the parent. In addition, parents’ attorneys play a crucial role in understanding the client’s wishes regarding parenting, encouraging the client’s engagement in substance abuse and other services, and advocating for reasonable efforts to provide these services to their clients. Through their advocacy attorneys ask the court to hold other stakeholders responsible. Attorneys must be familiar with services that address the most common problems faced by families with substance use disorders and should advocate for development of services not routinely available in their community. They must be able to present evidence on the reasonableness or unreasonableness of the agency efforts and on alternative efforts that could have been made. Further, they should be prepared to obtain court orders for specific services, including visitation when appropriate.²¹

 - **Children’s Attorneys**—have a primary role as advocates for the best interest of the child in the case. This includes advocating for appropriate services, ensuring permanency and fostering the child’s long-term well-being. Representing children in dependency court poses special challenges and particularly when the child is old enough to express an opinion regarding their status. There are differences of opinion regarding this situation. One position is that the attorney should advocate for the child’s best interests, regardless of what the child says. The other is that the attorney should represent the child as one would represent any other client and advocate for the position the child expresses.²²

 - **Social Services’ Attorneys**—primary have a role to advocate for the social worker and to present the legal position of the social services department in the case. n, they help develop policies, protocols (i.e. confidentiality) and oversee the best interests of the child

and family. They have an obligation to share agency records with attorneys for the private parties involved and have a policy role as they assist in developing protocols (i.e., confidentiality) and agency policy as they oversee the best interests of the child and family. The agency attorney's ethical obligations include a responsibility to the general public and to the welfare of the child whom the agency is attempting to assist.²³ In carrying out that responsibility, they can act as a liaison between the agency and the community and media to advocate for improved child protection in the community.²⁴

They also play a pivotal role in bringing to the court's attention those cases in which reasonable efforts need not be made or should be terminated. There are differences across jurisdictions regarding the office that brings cases to court and files charges in the court petitions regarding child custody issues. In some jurisdictions the attorney for the child welfare agency fulfills that role. In others there is a separate attorney who acts on behalf of the people of the State to file petitions for removal and other actions that are brought before the court. All attorneys have a role to play in their respective communities and offices to educate community members about the needs of clients.

Brief Synopsis of the Sites and Program Models

The seven sites included in the TAP were involved in a wide variety of reforms during the Spring of 2000, with none of them working simultaneously on all ten framework elements. These seven sites were chosen because they exemplified "promising practices" addressing specific barriers. Some of the sites were well advanced in their implementation and were making revisions of their model that amount to a second-phase innovation, others were well along in implementation phases, while others were in the early implementation stages of program development. The following are short descriptions of the program models, which are more fully described in the TAP using the 10 point framework described above and will include several appendices of pertinent program forms and procedures developed by the sites.

The State of Connecticut

Project SAFE (Substance Abuse Family Evaluation) began in Connecticut in 1995, after a governor-requested extensive review of the Department of Children and Families (DCF). The review found the impact of substance abuse as a contributing factor in many cases and that DCF was not systematically screening for substance abuse. Initially, the primary purpose was to produce an evaluation and systematic response to families' substance abuse needs for decision-making concerning the removal of children from their parents' custody and for evidence in court hearings. Workers and policy leaders wanted a "clinical tool" that they could rely upon for screening and assessing their client's substance abuse problems and for monitoring prognosis for family reunification.

DCF, which handles child welfare, children's mental health, juvenile justice and adolescent substance abuse treatment programs in Connecticut, instituted a substance abuse screening questionnaire to be used by child welfare workers system wide. The screening tool was developed to cast a wide net in order to "screen in" parents and potential caregivers for further

assessment. To provide the assessment of substance abuse conditions, DCF entered into a services contract with a nonprofit organization, Advanced Behavioral Health, Inc. (ABH). ABH is a state-wide consortium of non-profit behavioral health agencies. The initial DCF contract involved drug testing, substance abuse assessment, and outpatient treatment for DCF-referred biological parents and caregivers from abuse and neglect investigations and/or on-going services. At-risk “Healthy Families” program participants and those being considered for subsidized guardianships were added later. By November 1999, over 23,000 unduplicated referrals were made from DCF to substance abuse services under this contractual arrangement.

The DCF-ABH contract is a fee-for-service arrangement, where providers are paid by service units rendered for drug testing, evaluation, individual, group, family, intensive outpatient and partial hospital services. There were arrangements made through the state Medicaid system for providers to be in the ABH network to maximize funding. DCF clients who needed other intensive levels of care are provided services through the existing publicly-funded treatment system managed by the Department of Mental Health and Addiction Services (DMHAS).

The Connecticut “model” has evolved developmentally. The initial phase focused on assuring immediate access to substance abuse evaluations for DCF parents. Subsequently, substance abuse intervention was arranged by hiring addiction counselors to work in the DCF regional offices. Phase I lasted from approximately 1995 to 1999. An emerging Phase II is evolving into a wider emphasis upon client engagement, retention, and receipt of supportive services required for successful treatment outcome. Both the lessons learned during the first phase and the imperatives of implementing ASFA, have led to these shifts in philosophy and operations.

By mid-1999, DCF recognized the need to form a closer relationship with the state’s DMHAS, as it is the major state agency for managing adult behavioral-health issues, including services for persons with AOD problems. A primary goal in seeking to improve the linkage between the two state agencies was to better tap existing AOD assessment and treatment resources-both funding and expertise-through the publicly-funded AOD service network. The Commissioners of DCF and DMHAS, together with their Deputy Commissioners of Addiction Services and Child Welfare, met on several occasions to develop a joint approach. The Commissioners agreed upon “15 Guideposts” for their working relationship and the development of cross-department strategies.

A formal second phase of the project began with the Guideposts. A working group was convened in 1999 by the two departments to develop a strategic plan for the next stage of operations. The primary purpose of the working group was to develop a client-based treatment model that would respond to the full range of issues which needed to be addressed during the substance abuse treatment episode and the family’s involvement with child protective services. Such issues included: (1) clearer priority access to treatment for the child welfare population; (2) strategies to improve treatment engagement, retention, and completion; (3) individual client and family outcomes; and, (4) budgeting and funding mechanisms.

The State of New Jersey

New Jersey officials estimate that 80% of their child welfare caseload involves substance abuse. This awareness stemmed in part from the results of a 1994 grant from the National Center on Child Abuse and Neglect to review the prevalence of parental/caregiver substance abuse in the 1992-94 child welfare caseload. In addition, a review board for child deaths revealed a history of substance abuse in many of these cases. In 1995, the Department of Human Services, Division of Youth and Family Services (DYFS) initiated the Child Protection Substance Abuse Initiative (CPSAI). The CPSAI is an assessment, referral and case management service which identifies the level of risk to the child posed by the parent/caregiver's substance abuse severity.

The CPSAI began in four (4) pilot cities. Initially, one statewide contract agency was selected to provide Certified Alcohol and Drug Counselors (CADC) and paraprofessional home visitation services to DYFS District Offices in those cities. DYFS workers refer parents to the CADC for assessment and case management of treatment services. In addition, they often act as consultants on substance-abuse issues to DYFS workers for specific cases. To enhance the initiative in 1996, DYFS, through a Memorandum of Agreement with the Department of Health and Senior Services, Division of Addiction Services, jointly expanded the bed capacity for women diagnosed with a substance abuse disorder. This agreement included development of procedures for granting priority access to mothers of DYFS-supervised children.

Due to the success of the CPSAI in the pilot cities, a Request for Proposals was issued in 1997 for the statewide expansion of the initiative to provide the aforementioned services in all of the Division's District Offices and Adoption Centers. The expansion came to fruition in 1998. As of the spring of 2000, there were 31 CADCs and 37 home visitors hired by the contract agencies and assigned to work with DYFS. To date, over 8,000 parents have been referred to CPSAI from the DYFS field offices.

Sacramento County

In 1993, Sacramento County's Department of Health and Human Services (DHHS) began developing an innovative response to the growing number of AOD-related child protective cases in the County. A system assessment showed that, on average, 2,000 drug-exposed infants were born annually and anecdotal reports from child welfare indicated that 70% of their caseload was AOD- impacted. DHHS leadership assessed the community's capacity to meet these AOD needs and concluded that it had the capacity to meet only about 25 percent of the need.

The Department, under the leadership of then-Director Robert Caulk, and with assistance from the Annie E. Casey Foundation, developed a multi-faceted initiative focused on changing the child welfare and other systems through training and making AOD assessment and intervention part of the responsibility of every worker. The clear and ambitious goal was to provide "direct AOD treatment on demand." From the inception of the project, a core set of values was part of the project's direction. These values and principles included prioritizing high-risk clients, expanding treatment and support service capacity within existing resources, and viewing the client as integral to successful intervention. Additional, and equally important goals, were "to

increase staff's level of knowledge, understanding and sensitivity to issues of addiction, recovery and relapse," as well as to enhance their skills and capacity to respond appropriately to AOD problems. These basic premises included an explicit recognition that the great majority of workers in the child welfare system and in the treatment agencies did not know enough about alcohol and drug abuse to work effectively across systems. However, project staff knew that working across systems was necessary to produce better results. The current outcome of their value- and data-driven system is reflected in the County's treatment access numbers. While the State of California treatment-access statistics show that women received 35% of available treatment resources, in Sacramento County 52% of resources were accessed by women.

The Alcohol and Other Drug Treatment Initiative (AODTI) provided core information on chemical dependence at the first training level, advanced assessment and intervention skills at the second level, and group treatment co-facilitation skills at the third level. Currently, more than 1,500 DHHS employees have received AOD training, using the services of a highly skilled instructor from the Sacramento County area.

Specific procedures were developed by AODTI and other relevant departmental policies for Child Protection Services (CPS) social workers to conduct alcohol and other drug screenings and assessments. According to the policy, "every case that entered the Child Welfare System would have a comprehensive substance abuse assessment to rule out or identify the severity of the AOD problem as an essential component of the risk assessment and case planning process." However, the deaths of two young children, who were involved in the CPS system and the resulting public reaction, caused significant increases in child welfare caseloads. Due to the increase in caseloads, the policy of having social workers complete AOD assessments was suspended in August of 1997.

Sacramento's use of screening and assessment tools was a central feature of the innovation. The training effort was aimed at familiarizing all DHHS employees, who had front-line roles in working with clients, with the tools necessary to screen and assess for AOD problems. The 3000 assessments completed on CPS cases in 1996-97 represented the fullest extent of implementation of this initial policy. As a result of the assessment policy suspension in 1997, the A&D Bureau developed and piloted AOD referral forms, preliminary screening instruments, treatment-matching protocols, and standardized assessment and data collection improvements with their contracted treatment providers. The intent of these changes was to better manage the available treatment slots in the County by matching clients with appropriate providers, ensuring that each client received the least restrictive, but safe level of care. In addition, the new system was implemented to ensure the widest possible access to clients from all potential referral sources, including child welfare, welfare, criminal justice, public health, mental health, and client self-referral. Sacramento's view was that knowledge about the severity of needs of those clients entering the treatment system through multiple referral sources would lead to improvement in client outcomes.

This new, more extensive screening-assessment-treatment authorization protocol considerably expanded the demand and utilization of information available to the A&D Bureau. This system clearly improved the Bureau's ability to allocate resources based on data and values, rather than

anecdotal information alone. At the client level, making this change “focusing on the importance of assessment” significantly improved the chances that clients were connected with appropriate services, thus improving long-term outcomes. At the system’s level, this change reduced the inefficient use of scarce resources which often occurs when clients are referred to inappropriate treatment programs, without supporting data for the referral. This new system went into effect across the County, affecting almost all clients seeking publicly-supported services, including CPS. By late 1999, the CPS policy requiring AOD assessment of all CPS cases had been reinstated. At present DHHS workers who have completed the assessment curriculum in the training program can conduct the preliminary assessment and referral to A&D services. They may make a referral to the Bureau for their counselors to conduct the AOD assessment treatment referral.

An important lesson emerged from this review of policy and practices, which had established AOD screening and assessment as distinct activities, with specialized roles and procedures for their completion. In the initial phase of the AODTI, a project assumption “correct or not” was that CPS workers could be trained to *both* screen and assess AOD problems. Some of the CPS workers do, in fact, perform both functions. Other staff are simply making “better handoffs” to the assessment process because their training and improved skills have increased awareness of AOD issues.

Cuyahoga County

The Sobriety Treatment and Recovery Teams (START) program alternatively, was initiated under the leadership of Judith Goodhand, Executive Director of the Cuyahoga County Department of Children and Family Services. Goodhand had operated a program similar to START in Toledo, Ohio. With Annie E. Casey funding for a linked set of child welfare reform projects, START was initiated in March 1997. Two START units, staffed by teams with ten social workers and ten family advocates, have been established in the child welfare agency. The family advocates are women, with at least five years in recovery, who work in a team approach with social workers. The role of the advocates is at the heart of client engagement, with a cap of fifteen cases for each team to enable close client contact. In early phases of the CPS case, the teams see the family at least once a week, taking the client to treatment and/or meetings the first three times the client participates.

The START program was founded on twelve tenets, which were discussed at great length among the program originators, service providers, and staff. The abstinence orientation is strong -the first principle beginning: “we believe that addiction is a disease that requires abstinence.” A concrete example of this orientation is that service providers are expected to call in information about a client’s relapse the day it is discovered, so that the social worker can immediately respond with a home visit or other intervention.

A second major value underlying START is that the program relies heavily upon the strengths of the family advocates who work directly with clients. These workers provide a wide base of knowledge about addiction and recovery to the child welfare staff. The advocates typically have been in recovery for at least three years and are participating in twelve-step programs. Supporters

of the program acknowledged that the advocates see the clients differently than the social workers and are able, at times, to see the signs of continuing use and abuse that may not be uncovered by traditional staff. The demands on the advocates are heavy, due to the emotional drain of being involved with a troubled family's crises on a day-to-day basis. Efforts had been made to match social workers and advocates, since the working relationship between them is of great importance.

Close links between service providers and the START team are a key feature of the program. Monthly meetings between providers and supervisors and weekly contact between the team and the service providers are convened during the client's treatment episode. Communication has also improved between service providers and children's services. Previously, providers may not disclose client relapse to the children's social worker, due to the fear that the clients' children would be removed. As a result of lengthy discussions among treatment providers and DCFS staff about definitions of "relapse" and "slips," the UNC-RTI evaluation indicated that both sides felt that adjustments had been made, with DCFS staff more flexible in its response to relapse and AOD counselors more willing to report relapse as a result.

Jacksonville, Florida

Relative to the other case study sites, Jacksonville is a more recently-developed program in its efforts to address AOD and child welfare issues. The essential element of the project is the use of TANF funds (under the WAGES program in Florida) to outstation AOD counselors with specific child protective services investigation units. The program was implemented in early Spring of 2000. The primary role of the AOD counselors is to assist CPS workers in assessment, treatment referral, and engagement of parents in substance abuse intervention programs.

Jacksonville is the major population center of the State's Region IV of the Department of Children and Families. It has benefited from its status as one of four sites for the Edna McConnell Clark Foundation's Community Partnerships, which has meant that training and technical assistance resources have been made available to the community. The Community Partnerships are child welfare reforms, aimed at widening community involvement in support of the prevention mission of child protective services. A "two-track" system is developed, in which less serious cases of abuse and neglect are to be handled by community agencies. A generic reform in the four Clark-funded sites is a family-focused treatment plan, the Individualized Course of Action (ICA). A primary feature of the ICA is the development of a family plan, which incorporates the strengths of the family and the input of all the relevant agencies and staff.

Jacksonville also benefited from the involvement of the Child Welfare League of America (CWLA), which assisted in conducting a "Think Tank" training session held in February, 2000. Philip Diaz, the current director of Gateway Community Services, (the largest community treatment agency in NE Florida), was a consultant on AOD issues for the CWLA. Gateway had been an active player in the Community Partnership, first under its prior director, Dr. Virginia Borrok, and currently under Mr. Diaz. State child welfare officials in the Jacksonville area, who are in the Department of Children and Families (DCF) gave Gateway substantial credit for initiating contacts from the AOD side. As the original community governance unit for the

Community Partnership did not include AOD representatives, Gateway successfully sought membership in the group, allowing the agency to become active participants in the Partnership.

For several years, senior child welfare staff had believed that “AOD treatment did not work with this population” and they were frustrated that families too often “recycled” through the treatment system. This attitude hampered cooperative efforts between the two sets of staff. Gradually, with efforts by Gateway and state officials, this attitude shifted, and joint efforts became possible. A Steering Committee of the Community Partnership, including officials from both agencies, held regular quarterly meetings. Senior child welfare officials saw the potential for a “seamless system” which achieved “treatment on demand” for all TANF and CPS clients who needed it, and provided leadership in moving toward such a system in its recent efforts.

Gateway has been funded by the state to provide assessments on site at the CPS office in the Jacksonville area, using part of its State TANF allocation. The Gateway staff were assigned to CPS units and the co-location of substance abuse counselors on child safety teams was welcomed by staff in both systems. Treatment system workers believe that this co-location provide CPS clients “a smooth entry into the system,” since they are not required to make appointments at separate agencies for assessments. As of mid-2000, there were six units of approximately 30 CPS workers who had a Gateway staff member performing these functions.

CPS workers stated that the ICA process was making “a huge difference.” It is seen as a tool for bringing all of the agencies and resources together with the family. For AOD-CWS relations, the major breakthrough was having AOD workers as part of the team. As one supervisor put it, “Having substance abuse staff as part of the ICA team makes all the difference in getting this problem discussed.”

The actual assessment, conducted by Gateway workers, takes approximately two hours. The worker produces an initial DSM-IV diagnosis, administers the Addiction Severity Index (ASI), and conducts a more detailed psycho social assessment using American Society of Addiction Medicine’s Patient Placement Criteria (ASAM-PPC) for treatment referrals. The cases assessed by the Gateway staff are priority ranked by CPS workers by different time frames-needs immediate response, 3-hour response, 24-hour response, or 72-hour response. Workers from the AOD treatment system view workers in the investigations unit as somewhat more responsive to AOD staff than the units concerned with longer-term services. This discrepancy was believed to be related to the investigations unit’s primary mission and they were assisted by the AOD screening process. AOD treatment staff have also become more knowledgeable about the child welfare system and CPS staff are getting more input as to how case plans should address alcohol/drug issues.

Faster engagement in the treatment process is a key effort of the out-stationed AOD staff members. This is accomplished through a joint endeavor made possible by the Gateway staff’s relationship with his/her assigned CPS unit. CPS workers, within that unit, refer and consult with AOD staff members regarding the families that are assigned to the unit. Drug testing is used as an integral part of the assessment and treatment monitoring process, and is continued after

treatment discharge. As part of early recovery services, relapse is monitored by Gateway staff as they meet with DCF staff on a regular basis.

San Diego County

The San Diego Dependency Court Recovery Project (DCRP) began in 1998 with an agreement between Judge James Milliken, who became Presiding Judge of Juvenile Court in 1996, (which hears both juvenile delinquency and dependency cases) and the then-Director of Health and Human Services, Dr. Robert Ross. They agreed to jointly make policy on AOD-CWS issues. Judge Milliken had reviewed the caseloads when he became Presiding Judge and took a six-month sabbatical to look at dependency and drug courts around the nation (as well as the dependency system in New Zealand). San Diego is a large system; there are 3000 new dependency cases annually, resulting from 90,000 reports of suspected child abuse or neglect, with 7000 children under county jurisdiction, and about 4500 in foster placement. “We didn’t feel like we reunifying enough families,” said Judge Milliken. Of equal importance, the process was taking too long, with an average of 34 months from intake to permanent placement as of June 1994, which was twice the limit under California law and almost three times the limit permitted by ASFA since its adoption in 1997.

The goal of the DCRP is to achieve a reunification or permanency plan “on time”-in essence, to observe the law, with 6 months to placement for children under 3, and 12 months for older children. While there were other issues, such as sexual and physical abuse, domestic violence and mental health, “usually drugs and alcohol were the triggers that took the inhibitions off, causing a problem.” Treatment was, thus, often seen as a prerequisite to working on other issues.

Unfortunately, all of the AOD treatment programs in the County had extensive waiting lists. So typically the parent would get to his or her 6-month review, and in almost every case, the parent had not been in treatment because there was no institutionalized connection between clients needing treatment and available treatment slots. As the Judge put it, “We left it up to an addicted parent and a social worker, with no clout, to try and arrange for treatment.”

A new approach was designed, with the Board of Supervisors’ approval, to give parents in the dependency system top priority for access to AOD treatment. There were eight key elements of the DCRP:

- implementation of a Substance Abuse Recovery Management System (SARMS)
- implementation of the Dependency Drug Court
- availability of alcohol and drug treatment for this population upon identification
- increased participation of Court-Appointed Special Advocates
- redefinition of the roles of key players within the dependency system
- utilization of settlement conferences
- utilization of family group conferences
- improvement of the automated tracking system

SARMS was intended to make alcohol and drug treatment immediately available for parents. Its operation was contracted out to Mental Health Systems, Inc., a private nonprofit firm, which began receiving referrals from the Dependency Court in April 1998. MHS performs assessments and monitors clients' progress in treatment through weekly face-to-face contacts, random drug testing to monitor compliance with treatment, reports to the Court on the 15th and 30th of each month, and conducts a 30, 60, and 90 day review of all cases.

The SARMS goal is to have the parent in treatment within two days after a positive AOD assessment. SARMS functions as the gatekeeper to treatment, using 25-30 different providers under contract to the County. SARMS serves all seven Dependency Courts throughout San Diego County, and SARMS offices are within walking distance of the four court sites.

A Recovery Specialist employed by SARMS conducts an ASI interview once a client is referred. The ASI is used for assessment and to determine what kind of treatment a parent needed; based upon the ASI, a Recovery Services Plan (RSP) is developed that delineates everything the parent needs to do in his or her treatment program for reunification. This role, which was previously performed by social workers, has formally passed to the SARMS Recovery Specialist. The RSP requirements is incorporated into the Dependency Court reunification plan, which results in the RSP becoming a formal court order. SARMS monitors the parent's compliance with the RSP and reports to the Court twice a month.

Client engagement is integral to the San Diego DCRP, with incentives and sanctions built into each stage of the process. "A combination of coercion and praise is what we believe in passionately." DCRP is only a nine-month process so that parents could graduate before the required 12-month period for reunification services is up. If parents are completely uncooperative in treatment, they are reassigned to the "regular" track and returned to the 12-month process, which could lead to termination of parental rights.

Client engagement was also a critical element in the recruitment of Recovery Specialists. Recovery Specialists had at least two years of experience in the AOD field, and were state-certified as addiction-trained or had 18 units of relevant course work in addiction or a B.A. degree. The staff are very diverse, and many had worked in or been in treatment with the providers used in the program.

If parents are found to be non-compliant, they are reprimanded on the first offense and jailed for contempt for 3 days after the second (which really amounts to 36 hours, given processing time). Non-compliance includes testing "dirty," a "no-show" for drug testing, failure to participate in treatment program activities, failure to appear for court hearings, violation of program rules, etc. The net affect of this policy is to ensure immediate access to treatment, backed by incarceration for non-compliant clients, which reduces the possibility of contested hearings in which parents argue that they are not given access to treatment and reasonable efforts to reunification.

As a result of these changes, the majority of CPS clients in San Diego do not pass through the Dependency Drug Court, but do receive the benefits of the SARMS process. As of December 1999 there were 808 dependency parents actively participating in the SARMS program, with

79% in compliance with their Recovery Services Plans, including negative drug testing and completion of other treatment plan requirements.

Judge Milliken views the critical ingredients in this system as (1) the case management function; (2) clear court orders; (3) timely feedback to the Court on treatment events; (4) immediate access to treatment; (5) consequences for non-compliance with treatment; and violation of court orders; and, (6) positive reinforcement for achieving milestones of recovery.

Since the DCRP seeks client engagement, a major issue has been whether the client's legal rights were adequately protected during the process. A good deal of effort was made, according to Court staff, to secure the buy-in of attorneys representing parents in dependency cases. Lawyers initially resisted efforts to attain client compliance. However, lawyers have subsequently been able to say to parents, as Judge Milliken put it, "This judge is obsessed with sobriety. If you are not sober in 30 days, he'll put you in jail, and if you're not sober in 6 months, he'll take your kids away." Refusing to go through the SARMS process is seen as an unacceptable risk to clients who want their children back, and attorneys consistently advise clients of this caveat.

It has taken an extensive modification in the culture of parents' attorneys to accept these changes. One of them noted that she felt parents, under the prior system, had been giving up on reunification if they had AOD problems. She also pointed out that San Diego had historically been a "very litigious system" prior to the DCRP. At present, she said it has been possible to re-allocate resources more effectively with the results of the DCRP. "We are on a diet from litigation," she remarked. "There is a definite benefit to parents in the SARMS program, since a stronger case can be made on their behalf that they are complying with the reunification process and they do not carry the burden of having to prove their case."

The County's own attorneys pointed out that historically, social workers have feared returning kids to their parents too soon. At present, the twice-monthly SARMS report on clients' progress helps to alleviate this fear, as workers are given greater assurance that their clients' AOD problems are being monitored by SARMS. One comment was that "SARMS cuts down the workload for social workers. Now they can do more social work concerning the other problems that led parents to [court]." Social workers continue to visit clients monthly, aided by the SARMS reports on how substance-abusing parents were proceeding with their treatment.

Miami, Florida

In Miami-Dade County's Eleventh Judicial District, Circuit Court Judge Jeri Beth Cohen has been the leader in establishing the Dependency Drug Court (DDC), which began operations in March 1999. She presides over one of three courtrooms in the Juvenile Court, each of which handle about 300 dependency cases a year, with cases assigned on a random basis to the judges. The Drug Dependency Court operates as one of three national demonstration sites for the Center for Substance Abuse Treatment.

As a result of Judge Cohen's prior work with DUI offenders, she had developed positive relationships with community mental health and substance abuse treatment providers. These

relationships, and her experience working with alcohol-and drug-abusing individuals, became the foundation for initiating the Dependency Drug Court.

In Judge Cohen's experience, only a small number of addicted parents were succeeding for any sustained period of time in regaining or maintaining custody of their children. Given the frequency of relapse of substance-affected individuals, coupled with the multiplicity of needs of children and families entering the dependency system, Judge Cohen believed that only a system that provided intensive monitoring and a holistic approach to services had a chance of successfully reunifying children under ASFA guidelines. Services needed to include substance abuse counseling and intensive and interactive parenting classes, as well as the following (as needed): (1)competent psychological and psychiatric evaluations; (2)trauma counseling; (3)psychotropic medication; (4)housing referrals; (5)vocational training; (6)medical and family planning services; (7)developmental assessments/interventions for infants and children, and should include counseling and substance-abuse prevention classes for older children, as well as therapeutic visitation, when warranted. Given the fact that child welfare was overwhelmed with the crush of cases coming into the system, Judge Cohen felt that it was crucial that dedicated and well-trained staff be assigned to the Drug Court and that the ratio of parents to caseworkers be kept low. Moreover, the Judge believed that the DDC must be able to obtain funding to hire trained addiction and mental health counselors to work with the court.

Prior to setting up the Dependency Drug Court, Judge Cohen negotiated agreements with DCF to dedicate three case workers to the DDC. She obtained funding from the Florida state legislature to fund three positions for addiction specialists, including a program administrator. The funds were submitted through the Administrative Office of the Courts and constituted a recurring budget item. In addition, TANF monies funded two additional addiction specialists. The addiction specialists serve as the link between the court, the parents, and the treatment providers. The addiction specialists conduct the initial screening for AOD and mental health problems. The screenings included the ASI, ASAM- Patient Placement Criteria, Beck Depression Inventory, and Readiness to Change Scales.

The DDC protocol was a combination of several different drug court protocols from other sites and adapted to the needs of Dade County. Judge Cohen convened approximately 30 substance abuse and mental health treatment providers to acquaint them with DDC and emphasized the need for collaboration. Dade County was not a community where the courts and the treatment programs shared a history of collaboration. In fact, treatment providers rarely informed the court about the progress of parents who were also in the dependency system. Nor were the courts aware of what was occurring in the treatment facilities, including the women's residential treatment programs, where children were being sent with their mothers. Since Miami is a relatively treatment-rich community for adult substance abusers, Judge Cohen was able to work only with those providers who agreed to cooperate with DDC and provide accurate and detailed reporting to the court. Four women's substance abuse programs provide intervention to the majority of parents. One of these treatment programs also provide residential care for fathers and their children as well.

The treatment providers that work with DDC signed a Memoranda of Understanding (MOU) between themselves and the court, which specified reporting, screening, intake, and monitoring requirements that the treatment providers must observe. In addition, the facilities agreed not to release any client from residential treatment without consultation with the court, and a detailed discharge and safety plan. DDC addiction specialists, in conjunction with the Department of Children & Families (DC&F), develop a comprehensive case plan for the parents, which the treatment providers are responsible for jointly implementing with DDC. Case plans are based upon comprehensive psycho-social evaluations performed by court evaluation units and DDC specialists, as well as past history. The plans include services for all family members, including teenagers, children and infants, and non-substance abusing spouses and significant others. DDC treats the entire family as a unit and seeks to address all treatment needs. As a result, parents understand that the court expects nothing less than a complete life style change which promotes health and safety for children. In the view of the Judge, the treatment providers understand that the court expects accountability and collaboration.

During the first year of operation, DDC enrolled 92 parents. Of the referrals to DDC, 15 refused to participate, 77 accepted DDC, and 10 dropped out, their cases proceeding to termination of parental rights. The remaining 67 cases represented 212 children, with 84 of them under the age of four. About 80% of the parents selected for DDC are women.

In May 2000, DDC graduated its first class of 13. All the graduates except one were female. Presently there are four fathers in DDC. The Judge pointed out that failure to comply with DDC was also a "success; if lack of commitment and dedication is determined early, and the children can be moved to permanency expeditiously. DDC plans to enroll 100 parents in DDC during 2000-2001.

Appendix 1

Matrix of Progress in Building Linkages Among Alcohol and Drug Agencies, Child Welfare Services, and the Dependency Court

MATRIX OF PROGRESS IN LINKAGES AMONG ALCOHOL AND DRUG AND CHILD WELFARE SERVICES AND THE DEPENDENCY COURT SYSTEM			
May 17, 2003**	Fundamentals for Improved Practice	Good practice	Best practice*
Underlying Values and Principles of Collaborative Relationships	<p>Values clarification efforts have begun among the three systems</p> <p>There is an understanding and articulation of the value of family strengths and how family systems, issues of culture and gender are related to addiction, recovery, relapse and its effect on families</p> <p>Discussions have begun concerning the priority/political will to address the overlapping AOD/CWS population</p> <p>Different time limits and developmental needs of children have been identified as critical issues</p>	<p>A formal joint statement of principles has been negotiated and drafted among the three systems covering responses to CWS children and parents with substance abuse problems</p> <p>Cross-system discussions and problem solving among policy makers, administrators and practitioners are instituted</p>	<p>Formal values clarification efforts have included all staff of the three systems</p> <p>The systems have agreed upon individual and joint goals to serve the whole family as their primary client</p>
Daily Practice: Client Screening and Assessment	<p>The three systems have a joint policy on decision-making regarding screening and assessment and impact of results on removal/placement decisions</p> <p>There is a jointly developed and implemented risk assessment protocol that includes a formal review of parents= and children's AOD needs and is recorded for all clients</p> <p>Issues of culture and gender are included and appropriately addressed in the assessment process</p>	<p>Roles for screening and assessment have been clarified; AOD workers have been out-stationed at CWS offices and dependency courts for screening and assessment or contracted staff have been assigned screening and assessment roles for CWS parents.</p> <p>Culture and gender appropriate joint case assessments and plans have been developed with CWS parents with substance abuse problems</p>	<p>Screening and assessment roles have been negotiated with clarity among all three systems about which system will perform each, using tools that have been revised and refined based on interagency discussions of how best to detect and follow up on substance abuse problems</p> <p>Jointly developed quality assurance mechanisms have been implemented for interpretation of assessment information</p>

* Best practice refers to the most fully developed system envisioned by a collaborative of the substance abuse, child welfare and dependency courts working together. It does not imply "evidence-based practice" and there is a desire to continue to assess best practice. **This document will continue to be revised as systems across the nation improve their efforts and programs.

MATRIX OF PROGRESS IN LINKAGES AMONG ALCOHOL AND DRUG AND CHILD WELFARE SERVICES AND THE DEPENDENCY COURT SYSTEM

May 17, 2003**	Fundamentals for Improved Practice	Good practice	Best practice*
<p>Daily Practice: Client Engagement and Retention in Care</p>	<p>Systems have begun “drop-off mapping” of the points at which parents are not responding to referrals and not complying with treatment requirements</p> <p>Systems have agreed on procedures for cultural and gender specific approaches to outreach for parents who miss appointments</p> <p>The issue of relapse has been identified as a major area needing clarification between the two agencies and the courts, and discussions are under way to negotiate a consensus on shared outcomes that reflects both child safety and recovery goals</p> <p>Dependency courts understand that they have a role in monitoring compliance with court orders for treatment and case plans</p>	<p>Staff have been trained in motivational interviewing and/or other methods of engaging and retaining parents in treatment</p> <p>Programmatic responses have been put in place to improve family participation/completion rates</p> <p>Systems understand and are responding to how AOD issues and treatment requirements of families interplay with CWS and court requirements</p>	<p>Client relapse typically leads to a collaborative intervention to re-engage the parent in treatment and to re-assess child safety</p> <p>Systems are monitoring and responding to how compliance with case plans and requirements is resulting in changed behavior</p> <p>The three systems have agreed upon how aftercare will be monitored and what are the desired long-term outcomes of treatment as they affects children and families</p> <p>Efficient case management and outcomes monitoring tools that enable tracking progress of individual clients as well as the effectiveness of the whole system are in place</p>
<p>Daily Practice: Services to Children of Substance Abusers</p>	<p>Systems are taking a developmental perspective to addressing needs of children of substance abusers in their own system</p> <p>Each system has a focus on child safety as well as family recovery</p> <p>Each system is ensuring that children and youth are being assessed for the effects of parental substance use on children as well as youth’s own AOD use</p> <p>Issues of culture and gender are incorporated in service delivery and programs for all children</p>	<p>Each system is ensuring that children and families are linked to specific programming for family treatment and children of substance abusers prevention and intervention services</p> <p>Each system understands and implements its role in ensuring child safety</p> <p>Independent Living Programs include AOD prevention and intervention programs for youth</p>	<p>All children involved with CWS receive developmentally appropriate interventions to address their status as a child of a substance abuser</p>

MATRIX OF PROGRESS IN LINKAGES AMONG ALCOHOL AND DRUG AND CHILD WELFARE SERVICES AND THE DEPENDENCY COURT SYSTEM

May 17, 2003**	Fundamentals for Improved Practice	Good practice	Best practice*
<p>Joint Accountability and Shared Outcomes</p>	<p>Each system has their own outcome measures with beginning recognition of the overlapping issues in cross-system outcomes</p> <p>Some shared outcomes have been agreed upon but each systems feel primarily accountable for their own measures of success</p>	<p>Systems use outcome criteria in their contracts with community-based providers (who serve CWS-AOD parents) to measure their effectiveness in achieving shared outcomes</p>	<p>The child welfare agency has accepted shared accountability for recovery outcomes for its clients and the treatment agency has accepted shared accountability for child safety for the children of its clients and the court has accepted responsibility for monitoring the outcomes for children and families in the court system</p> <p>All three systems have accountability for safety, permanency and well-being outcomes for children and families</p> <p>Systems use summaries of outcome data from across the three systems to inform policy leaders and community on progress against consensus benchmarks</p>

MATRIX OF PROGRESS IN LINKAGES AMONG ALCOHOL AND DRUG AND CHILD WELFARE SERVICES AND THE DEPENDENCY COURT SYSTEM

May 17, 2003**	Fundamentals for Improved Practice	Good practice	Best practice*
Information Sharing and Data Systems	<p>The three systems have documented the gaps in their current client information systems and are addressing them</p> <p>AOD assessment at intake captures data about child needs among child welfare families</p> <p>CWS assessment at intake captures data about AOD issues</p> <p>Data on the overlap between child welfare families and the caseloads of other systems has begun to be available to AOD, CWS and court systems</p> <p>An interagency process has identified the confidentiality provisions that affect AOD-CWS and court connections and has devised means of sharing information while observing these regulations</p>	<p>The three systems have agreed upon information systems that track parents= referral, prior episodes in each system, progress in treatment, and family outcomes for those parents whom the agencies can regularly identify as shared clients</p> <p>Data on the overlap between child welfare families and the caseloads of other systems is consistently available to AOD, CWS and court systems</p> <p>Interagency communication protocols have been developed and are being utilized for information sharing between the three systems</p>	<p>The systems have developed and are fully utilizing information systems that can be linked to track parents through all three systems and monitor family and treatment outcomes, using data to re-allocate resources toward client and community needs and toward the most effective programs</p> <p>Overlap data is being used to redirect resources</p> <p>The systems are monitoring the outcomes of information sharing</p>
Training and Staff Development	<p>Commitment has been made to staff development in each system to address substance abuse and child welfare issues</p> <p>Training for all stakeholders has begun with regular updates and a set curriculum that devotes adequate time to substance abuse and child welfare issues</p> <p>Training for parents, guardians and foster parents has begun to address substance abuse issues</p>	<p>Training in each system has been institutionalized with regular updates and a set curriculum that devotes adequate time to substance abuse & child welfare issues</p> <p>Multi-disciplinary training has been implemented</p> <p>Training for parents and foster parents addresses substance abuse issues by drawing upon parents' experience and the lessons of services and prevention efforts with children of substance abusers</p>	<p>The three systems have engaged local colleges, universities and law schools to develop pre-service education that addresses the cross-system issues</p> <p>Systems are monitoring the outcomes of the training</p> <p>Training for parents and foster parents is treated as an equal priority to professional training</p>

MATRIX OF PROGRESS IN LINKAGES AMONG ALCOHOL AND DRUG AND CHILD WELFARE SERVICES AND THE DEPENDENCY COURT SYSTEM

May 17, 2003**	Fundamentals for Improved Practice	Good practice	Best practice*
<p>Budgeting and Program Sustainability</p>	<p>Systems have begun to develop an inventory of all funds available for treatment and children=s services in the state/community</p> <p>Systems have begun to identify the outcomes of innovative practices that merit sustained funding</p>	<p>TANF, Medicaid, and other major funding sources for treatment are used regularly for funding treatment for child welfare parents</p>	<p>A multi-year funding plan has been developed with input from all three systems, which includes negotiated commitments from multiple funding sources, including those beyond the direct control of substance abuse and child welfare agencies</p>
<p>Working with Related Agencies</p>	<p>A partnership with law enforcement is in place to appropriately address the needs of children during any needed police action</p> <p>Recognition by all three systems that each member of a family may have a variety of co-occurring needs</p> <p><u>Core clinical issues</u>—mental health, family violence and trauma</p> <p><u>Concrete support services</u>—income support, employment training, transportation, housing and child care</p> <p><u>Other needed supports</u>—primary health care, HIV/AIDS, education, dental services</p> <p>Staff are aware of how to identify and link families with the other services that are frequently needed by AOD-CWS involved parents and make referrals to those agencies</p> <p>Parent education courses for substance-involved child welfare parents include significant content on alcohol and drug issues</p>	<p>Staff are assessing and addressing children and parents= needs as barriers to family recovery</p> <p>The three systems monitor receipt of services</p> <p>Parent education courses are formally evaluated for their impact on parenting practices</p> <p>The three systems have developed a case management role of mentoring and facilitating engagement in and delivery of services</p> <p>The three systems coordinate with law enforcement and corrections agencies and criminal courts to meet the needs of parents and their children affected by the criminal justice system (e.g., visitation and treatment while parents are incarcerated)</p>	<p>All three systems are evaluating outcomes of services provided to families and are routinely monitoring the effectiveness of services</p> <p>A fully collaborative process exists across systems with the resources needed by parents with substance abuse problems, including screening, assessment, follow-up, and joint advocacy for the added resources needed in each system to adequately serve families who have co-occurring problems affecting their parenting, family stability, and risks to children</p>

MATRIX OF PROGRESS IN LINKAGES AMONG ALCOHOL AND DRUG AND CHILD WELFARE SERVICES AND THE DEPENDENCY COURT SYSTEM

May 17, 2003**	Fundamentals for Improved Practice	Good practice	Best practice *
<p>Working with the Community and Supporting Families</p>	<p>Community members are included in the planning and development process</p> <p>There are beginning stages of implementing proactive responses to prevention of substance abuse and child abuse/neglect and support for families through partnerships with community members and family support systems</p> <p>There is a system for community education about substance abuse, child abuse/neglect protection and reporting which includes civic groups in the collaborative efforts</p> <p>Efforts have begun to engaging faith-based communities in supporting families</p> <p>There are a variety of supports to provide mutual aid and recovery networks to families</p>	<p>Environmental data collection supports community education, e.g., Mapping liquor stores and DUI arrests</p> <p>Geo-mapping of family resource centers and other community assets has been implemented</p> <p>Program using consumer/families/graduates as active members of service implementation have been instituted</p> <p>A formal mechanism exists to solicit the support of a community advisory group including consumers in its membership</p> <p>There are community supports for sustaining sober living communities and environments</p>	<p>Sober living and transitional housing programs are linked to institutionalized funding sources</p> <p>Community-wide accountability (report cards) systems are in place and information is used to redirect resources toward highest-priority areas and most effective programs</p> <p>Community partnerships in child welfare recognize the central role of substance abuse and have shown their willingness to accept direct family support roles for substance-abusing parents</p>

Appendix 2

Collaborative Capacity Instrument (CCI) and Collaborative Values Inventory (CVI)



Collaborative Capacity Instrument: Reviewing and Assessing the Status of Linkages Across Alcohol and Drug Treatment, Child Welfare Services and Dependency Courts

This tool is intended to be used as a self-assessment by State (and/or local jurisdiction) alcohol and other drug (AOD) service and child welfare service (CWS) agencies and dependency courts* who are preparing to work with each other or who may be seeking to move to a new level of cooperation after some initial efforts. The questions have been designed to elicit discussion among and within both sets of agencies and the court about their readiness for closer work with each other.

Responses from this assessment should be tabulated and distributed, along with the total from all participants, to each State team. The results can be used to compare the jurisdiction with the matrix of progress in linkages and prioritizing any needed action. The NCSACW has the ability to tabulate these responses via the internet for interested sites.

Identify your own role in your organization:

<p>1. Staff Level:</p> <p><input type="checkbox"/> Front-line staff</p> <p><input type="checkbox"/> Supervisor</p> <p><input type="checkbox"/> Manager</p> <p><input type="checkbox"/> Administrator</p> <p><input type="checkbox"/> Other, Specify: _____</p>	<p>2. Gender:</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p>
<p>3. Area of Primary Responsibility:</p> <p><input type="checkbox"/> Substance Abuse Services</p> <p><input type="checkbox"/> Child Welfare Services</p> <p><input type="checkbox"/> Dependency Court Judicial Officer</p> <p><input type="checkbox"/> Attorney Practicing in Dependency Court</p> <p><input type="checkbox"/> Domestic Violence</p> <p><input type="checkbox"/> Mental Health</p> <p><input type="checkbox"/> Other, Specify: _____</p>	<p>4. Age: _____ Years</p>
<p>5. Jurisdiction of Agency or Court:</p> <p><input type="checkbox"/> Federal Government/National</p> <p><input type="checkbox"/> State Office</p> <p><input type="checkbox"/> Within State Regional Office</p> <p><input type="checkbox"/> County</p> <p><input type="checkbox"/> Community-Based Organization</p> <p><input type="checkbox"/> Reservation</p> <p><input type="checkbox"/> Other: Specify _____</p>	<p>6. Race/Ethnicity:</p> <p>African-American</p> <p>Asian/Pacific Islander</p> <p>Caucasian</p> <p>Hispanic</p> <p>Native American</p> <p>Other: _____</p>
<p>7. Years of professional experience in my primary program area: _____</p>	

* Dependency court is used in this document to include the courts that have jurisdiction in cases of child abuse and/or neglect and include judicial officers as well as the attorneys that represent parents, children, social services and the state.

Circle the response category that most closely represents your extent of agreement with each of the following statements:

I. Underlying Values And Principles Of Collaborative Relationships

- 1) **Our state has included the judicial officers and attorneys from the dependency court as partners in the development of new approaches to serving substance-abusing parents in the child welfare system.**
 Disagree Somewhat Agree Agree Not Sure/Don't Know

- 2) **Our state AOD and CWS agencies and dependency courts have used a formal values assessment process to determine how much consensus or disagreement we have about issues related to AOD use, parenting, and child safety.**
 Disagree Somewhat Agree Agree Not Sure/Don't Know

- 3) **Our state AOD and CWS agencies and dependency courts have negotiated shared principles or goal statements that reflect a consensus on issues related to families with AOD-related problems in child welfare and the dependency court.**
 Disagree Somewhat Agree Agree Not Sure/Don't Know

- 4) **Our state has prioritized parents in the CWS system for receipt of AOD treatment services.**
 Disagree Somewhat Agree Agree Not Sure/Don't Know

- 5) **In our state, CWS staff and the courts view alcohol abuse as being as important as other drug as a contributing factor in child abuse and/or neglect.**
 Disagree Somewhat Agree Agree Not Sure/Don't Know

- 6) **Our state has discussed and developed responses to the conflicting time frames associated with CWS, TANF, AOD treatment and child development.**
 Disagree Somewhat Agree Agree Not Sure/Don't Know

II. Daily Practice—Screening, And Assessment

- 1) **Our state has developed a joint AOD-CWS-Dependency Court policy on its approach to standardized screening and assessment of substance abuse issues among families in child welfare.**
 Disagree Somewhat Agree Agree Not Sure/Don't Know

- 2) **Our state has successfully out-stationed AOD workers at CPS offices and/or the dependency court to help with screening and assessment of clients.**
 Disagree Somewhat Agree Agree Not Sure/Don't Know

- 3) **Our state has multi-disciplinary service teams that include both AOD and CWS workers.**
 Disagree Somewhat Agree Agree Not Sure/Don't Know

4) Our state has developed coordinated AOD treatment and CPS case plans.

Disagree Somewhat Agree Agree Not Sure/Don't Know

5) Our state supplements child abuse/neglect risk assessment with an in-depth assessment of AOD issues and their impact on each of the family members.

Disagree Somewhat Agree Agree Not Sure/Don't Know

6) Our state's child welfare intake process is able to identify prior AOD treatment episodes based on previously negotiated information sharing protocols.

Disagree Somewhat Agree Agree Not Sure/Don't Know

7) Our state's AOD intake process identifies parents who are involved in the CWS system based on previously negotiated information sharing protocols.

Disagree Somewhat Agree Agree Not Sure/Don't Know

8) Our state's AOD providers have sufficient information about the child welfare case to conduct quality assessments among families referred by child welfare to treatment.

Disagree Somewhat Agree Agree Not Sure/Don't Know

9) Our state routinely documents AOD factors from its screening and assessment process in the information system.

Disagree Somewhat Agree Agree Not Sure/Don't Know

10) When our AOD treatment providers assess clients, they routinely include questions about children in the family, their living arrangements, and child safety issues.

Disagree Somewhat Agree Agree Not Sure/Don't Know

11) Our state routinely monitors the implementation and the quality of its screening and assessment protocols.

Disagree Somewhat Agree Agree Not Sure/Don't Know

III. Daily Practice—Client Engagement And Retention In Care

1) Our state's CWS staff have the skills and knowledge to talk with their clients about their AOD use and related problems.

Disagree Somewhat Agree Agree Not Sure/Don't Know

2) Our state's AOD staff have the skills and knowledge to talk with their clients about child safety and CWS involvement.

Disagree Somewhat Agree Agree Not Sure/Don't Know

- 3) Our state's dependency court judges have the skills and knowledge they need to talk with their clients about child welfare and substance abuse issues.**
- Disagree Somewhat Agree Agree Not Sure/Don't Know
- 4) Our state's dependency court attorneys have the skills and knowledge they need to talk with their clients about child welfare and substance abuse issues.**
- Disagree Somewhat Agree Agree Not Sure/Don't Know
- 5) Our systems have assessed common drop-out points where clients in care leave the system prior to completing treatment.**
- Disagree Somewhat Agree Agree Not Sure/Don't Know
- 6) Our systems have implemented integrated case plans that include the substance abuse recovery plan integrated or linked with the child welfare case plan.**
- Disagree Somewhat Agree Agree Not Sure/Don't Know
- 7) Our dependency court system has adequate access to treatment monitoring information to determine how parents are progressing through treatment in a timely way.**
- Disagree Somewhat Agree Agree Not Sure/Don't Know
- 8) Our state's dependency court system has realistic expectations for CWS parents with AOD problems (e.g., approach to relapse and drug testing issues).**
- Disagree Somewhat Agree Agree Not Sure/Don't Know
- 9) Our state's CWS staff provides outreach to clients who do not keep their initial AOD appointment or drop out of treatment.**
- Disagree Somewhat Agree Agree Not Sure/Don't Know
- 10) Our dependency court staff follows up with the substance abuse treatment agency that the parent is ordered to attend if a parent fails to keep a court date.**
- Disagree Somewhat Agree Agree Not Sure/Don't Know
- 11) Our state AOD staff track the status of their clients' progress in the CWS system.**
- Disagree Somewhat Agree Agree Not Sure/Don't Know
- 12) Our state has developed and trained our staff in approaches with clients that improve rates of retention in treatment once they enter it.**
- Disagree Somewhat Agree Agree Not Sure/Don't Know
- 13) In our state, CWS and AOD agencies have agreed on the level of information about clients' progress in treatment that will be communicated from treatment agencies to CWS workers and the courts.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

14) In our state, there is an adequate system for monitoring jointly-agreed upon outcomes of child welfare, substance abuse and dependency court programs and interventions.

Disagree Somewhat Agree Agree Not Sure/Don't Know

15) In our state, client relapse typically leads to a collaborative intervention to re-engage the client in treatment and to re-assess child safety.

Disagree Somewhat Agree Agree Not Sure/Don't Know

16) In our state, drug testing is used effectively and in conjunction with a treatment program to monitor clients' compliance with treatment plans.

Disagree Somewhat Agree Agree Not Sure/Don't Know

17) Rate your state's AOD treatment on the following areas:

	Poor		Fair		Excellent
Gender specific	1	2	3	4	5
Culturally relevant	1	2	3	4	5
Geographically accessible	1	2	3	4	5
Family focused	1	2	3	4	5
Age-specific responses to children's needs	1	2	3	4	5
Adequacy of adolescent treatment	1	2	3	4	5

18) Rate your state's child welfare services in the following areas:

	Poor		Fair		Excellent
Gender specific	1	2	3	4	5
Culturally relevant	1	2	3	4	5
Geographically accessible	1	2	3	4	5
Family focused	1	2	3	4	5
Age-specific responses to children's needs	1	2	3	4	5
Adequacy of adolescent treatment	1	2	3	4	5

IV. Daily Practice - Services To Children

1) Our state has implemented substance abuse prevention and early intervention services for most children in the CWS system.

Disagree Somewhat Agree Agree Not Sure/Don't Know

2) Our state targets children of substance abusers in the child welfare system for specialized substance abuse prevention programming.

Disagree Somewhat Agree Agree Not Sure/Don't Know

3) Our state ensures that all children in the child welfare system have a comprehensive mental health assessment that includes screening for developmental delays, neurological, effects of prenatal AOD exposure, and the emotional and mental effects of their parents substance use.

Disagree Somewhat Agree Agree Not Sure/Don't Know

4) Our state ensures that all children in CWS are screened for:

a) Neurological effects of prenatal substance exposure

Disagree Somewhat Agree Agree Not Sure/Don't Know

b) Developmental delays associated with parental substance abuse

Disagree Somewhat Agree Agree Not Sure/Don't Know

c) Emotional/mental health problems associated with parental substance abuse

Disagree Somewhat Agree Agree Not Sure/Don't Know

d) Substance use disorders

Disagree Somewhat Agree Agree Not Sure/Don't Know

5) Our state's Independent Living Program includes significant content on the impact of AOD use.

Disagree Somewhat Agree Agree Not Sure/Don't Know

6) Our state has developed a range of programs for children of substance-abusing parents that are targeted on the special developmental needs of these children.

Disagree Somewhat Agree Agree Not Sure/Don't Know

7) Our state is familiar with national models of prevention and intervention for AOD-affected children.

Disagree Somewhat Agree Agree Not Sure/Don't Know

V. Joint Accountability and Shared Outcomes

1) Our state's AOD agency has identified system outcomes and has communicated them to CWS and the dependency court.

Disagree Somewhat Agree Agree Not Sure/Don't Know

2) Our state's CWS agency has identified system outcomes and has communicated them to the AOD agency and the dependency court.

Disagree Somewhat Agree Agree Not Sure/Don't Know

- 3) **Our state’s dependency court has identified system outcomes and has communicated them to the AOD and CWS agencies.**
- Disagree Somewhat Agree Agree Not Sure/Don’t Know
- 4) **Our state AOD and CWS agencies and the courts have developed shared outcomes for CWS-AOD involved families and have agreed on how to use this information to inform policy leaders.**
- Disagree Somewhat Agree Agree Not Sure/Don’t Know
- 5) **Our state has developed outcome criteria in their contracts with community-based providers (who serve CWS-AOD clients) to measure their effectiveness in achieving shared outcomes.**
- Disagree Somewhat Agree Agree Not Sure/Don’t Know
- 6) **Our state has shifted funding from providers who are less effective in serving clients in the CWS-AOD systems to those that are more effective.**
- Disagree Somewhat Agree Agree Not Sure/Don’t Know
- 7) **In our state, CWS-AOD involved parents are referred to parenting programs that have demonstrated positive results with this population.**
- Disagree Somewhat Agree Agree Not Sure/Don’t Know
- 8) **Our state CWS agency shares accountability with their AOD counterpart for successful treatment outcomes for their mutual clients.**
- Disagree Somewhat Agree Agree Not Sure/Don’t Know
- 9) **Our state AOD agency shares accountability for positive child safety outcomes for clients who have enrolled in treatment programs.**
- Disagree Somewhat Agree Agree Not Sure/Don’t Know
- 10) **In our state, drug testing is used in the court system as the most important indicator of clients’ status in resolving their AOD problem.**
- Disagree Somewhat Agree Agree Not Sure/Don’t Know

VI. Information Sharing and Data Systems

- 1) **Our state has assessed its data system to identify gaps in monitoring clients involved in both CWS and AOD systems.**
- Disagree Somewhat Agree Agree Not Sure/Don’t Know
- 2) **Our state’s data system can retrieve the percentages of families that receive services in both the AOD and CWS agencies.**
- Disagree Somewhat Agree Agree Not Sure/Don’t Know

3) Our state has identified the confidentiality provisions that affect CWS-AOD and dependency court connections and has devised means of sharing information while observing these regulations.

Disagree Somewhat Agree Agree Not Sure/Don't Know

4) Our state has developed formal working agreements with the courts that include how child welfare and treatment agencies will share information about clients in treatment with the court system.

Disagree Somewhat Agree Agree Not Sure/Don't Know

5) Our state consistently documents AOD factors related to the case in our management information system.

Disagree Somewhat Agree Agree Not Sure/Don't Know

6) Our state's AOD services have supplemented the alcohol/drug data system to generate data on their clients' children and their CPS involvement.

Disagree Somewhat Agree Agree Not Sure/Don't Know

7) Our state has developed the capacity to automate data about the characteristics and service outcomes of the clients who are in both the CWS and AOD caseloads.

Disagree Somewhat Agree Agree Not Sure/Don't Know

8) Our state is using data that can track CWS/AOD clients across information systems to monitor system outcomes.

Disagree Somewhat Agree Agree Not Sure/Don't Know

VII. Training and Staff Development

1) Our state CWS ensures that all managers, supervisors and workers receive training on working with AOD-affected families.

Disagree Somewhat Agree Agree Not Sure/Don't Know

2) Our state AOD agency ensures that their staff/providers receive training on working with families in the CWS system.

Disagree Somewhat Agree Agree Not Sure/Don't Know

3) Our state has trained court staff in the principles of effective drug treatment and gender-specific services for mothers.

Disagree Somewhat Agree Agree Not Sure/Don't Know

4) Our state has trained attorneys who practice in the dependency court regarding effective advocacy and basic education regarding substance abuse and addiction.

Disagree Somewhat Agree Agree Not Sure/Don't Know

5) Our state has developed joint training programs for AOD, CWS and court staff and providers to learn effective methods of working together.

Disagree Somewhat Agree Agree Not Sure/Don't Know

6) Our state has a multi-year staff development plan that includes periodic updates to the training and orientation received by the staff of both CWS and AOD agencies on working together.

Disagree Somewhat Agree Agree Not Sure/Don't Know

7) Our state has training programs that include cultural issues to improve staff's cultural relevance and competency in working with diverse AOD-CWS client groups.

Disagree Somewhat Agree Agree Not Sure/Don't Know

8) Our state has revised the state university and social work pre-service educational programs so that future staff are prepared to work across systems on substance abuse and child welfare issues.

Disagree Somewhat Agree Agree Not Sure/Don't Know

9) Foster parents, guardians, kinship placement providers and group home providers are sufficiently trained to work on issues related to substance abusing families.

Disagree Somewhat Agree Agree Not Sure/Don't Know

10) Training programs regarding substance abuse, child welfare and dependency court issues that are offered in our state are multidisciplinary in their approach and in their delivery.

Disagree Somewhat Agree Agree Not Sure/Don't Know

VIII. Budgeting and Program Sustainability

1) Our state CWS agency currently uses a portion of its funding for AOD treatment services (excluding drug testing).

Disagree Somewhat Agree Agree Not Sure/Don't Know

2) Our AOD treatment agencies currently use a portion of their funding for services to improve clients' parenting skills.

Disagree Somewhat Agree Agree Not Sure/Don't Know

3) Our AOD treatment agencies currently use a portion of their funding for children development screenings for AOD effects on children of their clients.

Disagree Somewhat Agree Agree Not Sure/Don't Know

4) Our State uses a portion of its TANF allocations to fund programs for AOD-CWS clients.

Disagree Somewhat Agree Agree Not Sure/Don't Know

5) **Our state’s CWS and AOD agencies and dependency courts have jointly sought funding for pilot projects to work more closely together.**

Disagree Somewhat Agree Agree Not Sure/Don’t Know

6) **Our state has identified the full range of potential funding from all sources that could support the changes needed to work more closely across CWS-AOD agencies.**

Disagree Somewhat Agree Agree Not Sure/Don’t Know

7) **Our state has identified whether federal waivers would be appropriate to fully utilize available funds for families in the CWS-AOD systems.**

Disagree Somewhat Agree Agree Not Sure/Don’t Know

8) **Our state has a multi-year budget plan to support integrated CWS-AOD services.**

Disagree Somewhat Agree Agree Not Sure/Don’t Know

9) **Our courts have sought additional funding to take dependency drug court programs to a county-wide scale of operations.**

Disagree Somewhat Agree Agree Not Sure/Don’t Know

IX. Working with Related Agencies

1) **Clinical services to address mental health and trauma issues are included in comprehensive assessments and case plans for all families.**

Disagree Somewhat Agree Agree Not Sure/Don’t Know

2) **Domestic violence advocacy and services are included in comprehensive assessment and case plans for all families in the CWS and AOD services systems.**

Disagree Somewhat Agree Agree Not Sure/Don’t Know

3) **Our state ensures that primary health care and dental care are available for families in the child welfare and AOD services systems.**

Disagree Somewhat Agree Agree Not Sure/Don’t Know

4) **Specialized health services for substance abusing parents regarding HIV/AIDS, Hepatitis C and other diseases frequently transmitted among intravenous drug users are accessible in our state.**

Disagree Somewhat Agree Agree Not Sure/Don’t Know

5) **Our state CWS staff know how to identify and link families with the support services that are frequently needed by CWS-AOD involved clients (e.g., transportation, child care, employment, housing) and makes effective referrals to those agencies.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

- 6) Our state routinely assesses for rates of referral and service completions for all clinical and supportive services needed by families and monitors barriers to access for these services.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

- 7) Our state AOD staff/providers know how to identify and link CWS-involved families with the other services that are frequently needed services (e.g., transportation, child care, family violence services, mental health services) and make referrals to those agencies.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

- 8) Our state has AOD support/recovery groups that include a special focus on CWS and child safety issues.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

- 9) Our state coordinates with law enforcement, AOD, and CWS to meet the needs of parents and their children affected by the criminal justice system (e.g., visitation for children with incarcerated parents, treatment while parents are incarcerated).**

Disagree Somewhat Agree Agree Not Sure/Don't Know

X. Working with the Community and Supporting Families

- 1) Our state has developed strategies to recruit broad community participation in addressing the needs of AOD-CWS and dependency court involved families.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

- 2) Our state includes community members in its planning and program development for substance abuse issues in child welfare and dependency court services.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

- 3) In our state, prevention of child abuse/neglect and substance abuse operates at the community level as well as statewide.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

- 4) Our state has developed a formal mechanism to solicit support and input from community members and consumers and this is widely used.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

- 5) CWS and AOD staff members have access to up-to-date resource directories to locate family support centers and resources.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

6) Community-wide accountability systems or “report cards” are used to monitor AOD and CWS issues with specific indicators for both systems.

Disagree Somewhat Agree Agree Not Sure/Don't Know

7) Our state assists in supporting sober living communities and housing for parents in recovery.

Disagree Somewhat Agree Agree Not Sure/Don't Know

8) Consumers, parents in recovery and program graduates have an active role in planning, developing, implementing and monitoring services for families with substance abuse problems in the child welfare system.

Disagree Somewhat Agree Agree Not Sure/Don't Know

9) Our state provides aftercare services to parents in the AOD & CWS systems that include the full array of family income support programs (EITC, Child Support, SCHIP, Food Stamps, Housing Subsidies, etc.).

Disagree Somewhat Agree Agree Not Sure/Don't Know



Collaborative Values Inventory: What Do We Believe about Alcohol and Other Drugs, Services to Children and Families and Dependency Courts?

Many collaboratives begin their work without much discussion of what their members agree or disagree about in terms of underlying values. This questionnaire is a neutral way of assessing how much a group shares ideas about the values that underlie its work. It can surface issues that may not be raised if the collaborative begins its work with an emphasis on programs and operational issues, without addressing the important values issues affecting their work. Learning that a group may have strong disagreements about basic assumptions that affect its community's needs and resources may help the group clarify later disagreements about less important issues which are really about these more important underlying values.

After reviewing the results from a collaborative's scoring of the Inventory, it is important to discuss the areas of common agreement and divergent views. That discussion should lead to a consensus on principles that the collaborative members agree can form the basis of state or local priorities for implementing practice and policies changes, leading to improved services and outcomes for families.

Identify your own role in your organization:

1. Staff Level:

- Front-line staff
- Supervisor
- Manager
- Administrator
- Other, Specify: _____

2. Gender:

- Male
- Female

3. Area of Primary Responsibility:

- Substance Abuse Services
- Child Welfare Services
- Dependency Court Judicial Officer
- Attorney Practicing in Dependency Court
- Domestic Violence
- Mental Health
- Other, Specify: _____

4. Age: _____ Years

5. Jurisdiction of Agency or Court:

- Federal Government/National
- State Office
- Within State Regional Office
- County
- Community-Based Organization
- Reservation
- Other: Specify _____

6. Race/Ethnicity:

- African-American
- Asian/Pacific Islander
- Caucasian
- Hispanic
- Native American
- Other: _____

7. Years of professional experience in my primary program area: _____

Circle the response category that most closely represents your extent of agreement with each of the following statements:

1) Dealing with the problems caused by alcohol and other drugs would improve the lives of a significant number of children, families, and others in need in our community.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

2) Dealing with the problems caused by alcohol and other drugs should be one of the highest priorities for funding services in our community.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

3) Dealing with the problems of child abuse and neglect should be one of the highest priorities for funding services in our State.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

4) Illegal drugs are a bigger problem in our community than use and abuse of alcohol.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

5) People who abuse alcohol and other drugs have a disease for which they need treatment.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

6) People who are chemically dependent have a disease for which they need treatment.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

7) People who abuse alcohol and other drugs should be held fully responsible for their own actions.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

8) There is no way that a parent who abuses alcohol or other drugs can be an effective parent.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

9) There is no way that a parent who uses alcohol or other drugs can be an effective parent.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

10) There is no way that a parent who is chemically dependent on alcohol or other drugs can be an effective parent.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

11) In assessing the effects of the use of alcohol and other drugs, the standard we should use for deciding when to remove or reunify children with their parents is whether the parents are fully abstaining from use of alcohol or other drugs.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

12) Parents who have been ordered to remain clean and sober should face consequences for non-compliance with those orders.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

13) Parents who are noncompliant with dependency court orders should face jail time as a consequence.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

14) We have enough money in the systems that respond to the problems of alcohol and other drugs today; we need to redirect the money to use it better.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

15) We should fund programs that serve children and families based on their results, not based on the number of people they serve, as we often do at present.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

16) We should fund programs that treat parents for their abuse of alcohol and other drugs based on their results, not based on the number of people they serve, as we often do at present.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

17) We should provide incentive funds and penalties to courts based on their results in meeting statutory timelines.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

18) If we funded programs based on results, some programs would lose some or all of their funding.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

19) In our community, agencies should involve people from the community and court system in planning and evaluating programs that respond to the problems of substance abuse.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

20) In our community, agencies should involve people from the community in planning and evaluating programs that serve families affected by child abuse/neglect.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

21) In our community, dependency courts do a good job of involving people from the community in planning and evaluating services and programs in the dependency court.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

22) Judges have a responsibility to be involved with planning community-wide responses to the problems associated with alcohol and other drug use.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

23) Children of substance abusers who are also in children’s services should be a high priority group for targeted substance abuse prevention services.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

24) Substance abuse treatment outcome measures should include indicators regarding the safety, permanency and well being of the children of parents who are in their treatment programs.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

25) Child welfare service outcome measures should include indicators regarding the substance abuse recovery status of parents of the children they seek to protect.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

26) Child welfare service outcome measures should include indicators regarding the parents’ ability to be effective parents.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

27) Persons who are in recovery and have successfully transitioned out of the child welfare system should play a significant role in supporting and advocating for parents in the child welfare and family court systems.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

28) Changing the system so that more services were delivered closer to the neighborhoods and community level would improve the effectiveness of services.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

29) Services would be improved if agencies were more responsive to the cultural differences between client groups.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

30) The problems of Indian children and families are significant in our community.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

31) Our agencies and courts do a good job in responding to the needs of Indian children and families in the child welfare and treatment systems.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

32) Services would be improved if all clients, regardless of income, who receive services made some kind of payment for the services with donated time, services, or cash.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

33) In our community, the judges and attorneys in the dependency court and the agencies delivering services to children and families often are ineffective because they don't work together well enough when they are serving the same families.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

34) The dependency courts should provide increased monitoring of parents' recovery as they go through substance abuse treatment, and should use the power of the court to sanction parents if they don't comply with treatment requirements.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

35) The most important causes of the problems of children and families cannot be addressed by government; they need to be addressed within the family and by non-governmental organizations such as churches, neighborhood organizations, and self-help groups.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

36) Judges should be the leaders of collaboratives seeking to solve problems associated with substance abuse and child welfare.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

37) Our judges and attorneys' response to parents with problems of addiction is generally appropriate and effective.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

38) The problems caused by use of tobacco by youth are largely unrelated to the problems caused by the use of alcohol and other drugs by youth.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

39) A neighborhood's residents should have the right to decide how many liquor stores should be allowed in their neighborhood.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

40) The messages which youth receive from the media, TV, music, etc. are a big part of the problem of abuse of alcohol and other drugs by youth.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

41) The price of alcohol and tobacco should be increased to a point where it pays for the damage caused in the community by use and abuse of these legal drugs.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

42) I believe that the significant barriers to interagency cooperation would be resolved if children’s services, substance abuse and dependency court staff were involved in a comprehensive training program for child welfare staff.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

43) I believe that confidentiality of client records is a significant barrier to allowing greater cooperation among alcohol and drug treatment, children’s services agencies, and the courts.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

44) I believe that publicly-funded alcohol and drug treatment providers should give higher priority in allocating treatment slots than they do at present to women referred from child protective services.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

45) Judicial ethics should be interpreted that judges not participate in collaborative efforts that involve attorneys who may appear in their courts.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

46) Attorneys who represent parents in dependency court proceedings have an ethical conflict if they advise parents to admit that they have a substance abuse problem or to seek treatment prior to the court taking jurisdiction in a case because the substance abuse admission could be negatively interpreted during the investigation of the child abuse and neglect allegations.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

47) Some parents with problems with alcohol and other drugs will never succeed in treatment.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

48) The proportion of parents who will succeed in treatment for alcohol and other drug problems is approximately (circle one).

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

49) The proportion of parents in substantiated CPS cases who will succeed in family services, regain custody of their children, and not re-abuse or re-neglect is (circle one).

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

50) The most important causes of problems affecting children, families, and others in need in our community are [circle only three]:

A lack of self-discipline

The level of violence tolerated by the community

A loss of family values

Lack of skills needed to keep a good job

Racism

The harm done by government programs

Drug abuse

Too few law enforcement personnel

Mental illness

Fragmented systems of service delivery

Domestic violence

Deteriorating public schools

Alcoholism

The way the welfare program works

Poverty

Children born and raised in single-parent homes

Child abuse

A lack of business involvement in solutions

Low intelligence

Too few jails and prisons

Illiteracy

Inadequate support for low-income families who work

The drug business

Economic changes that have eliminated good jobs

Incompetent parenting

An over-emphasis upon consumer values

Illegal immigration

Media concentration on negatives

Other _____

References

- ¹ Young, N.K., Gardner, S.L. & Dennis, K. (1998). *Responding to Alcohol and Other Drugs in Child Welfare: Weaving Together Practice and Policy*. Washington, DC: Child Welfare League of America.
- ² A summary of the five major reports on substance abuse and child welfare is available at <http://ncsacw.samhsa.gov/files/Summary5NationalReports.pdf>
- ³ The full report to Congress, *Blending Perspectives and Building Common Ground* can be downloaded at www.acf.dhhs.gov/programs/cb/
- ⁴ The full report, Young, N.K. & Gardner, S.L., *Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Other Drug Treatment with Child Welfare Services*, SAMHSA Publication No. SMA-02-3639. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, April 2002 can be accessed electronically through www.samhsa.gov or free copies are available from the National Clearinghouse on Alcohol and Drug Information at www.ncadi.samhsa.gov inventory number BKD436 or 1-800-729-6686.
- ⁵ Substance Abuse and Mental Health Services Administration at www.dasis.samhsa.gov
- ⁶ Ibid.
- ⁷ Based on data from the California statewide study conducted by Dr. Yih-Ing Hser, et al. of the UCLA Integrated Substance Abuse Program (2002). California Treatment Outcome Pilot (CalTOP) prepared for the California Department of Alcohol and Drug Programs with support from the Center for Substance Abuse Treatment that found that 60% of persons admitted to treatment had a minor child.
- ⁸ Ibid. Based on data that 25% of parents admitted to treatment had a child welfare case
- ⁹ Ibid. Based on data that 35% of parents with a child welfare case had parental rights terminated for at least one child.
- ¹⁰ National Child Abuse and Neglect Data System (NCANDS), Summary of Key Findings from Calendar Year 2000. [Http://www.calif.com/nccanch/pubs/factsheets/canstats.cfm](http://www.calif.com/nccanch/pubs/factsheets/canstats.cfm).
- ¹¹ Ibid.
- ¹² Ibid.
- ¹³ Ibid.
- ¹⁴ U.S. Department of Health and Human Services, The AFCARS Report: Preliminary FY 2001 Estimates as of March 2003. www.acyf.dhhs.gov
- ¹⁵ U.S. Department of Health and Human Services. *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Welfare*. (1999). Washington, D.C.: Department of Health and Human Services. The full report to congress, *Blending Perspectives and Building Common Ground* can be downloaded at www.acf.dhhs.gov/programs/cb/
- ¹⁶ Youth Law Center. (2000). *Making Reasonable Efforts: A Permanency Home for Every Child*. San Francisco: Author.
- ¹⁷ Ibid.
- ¹⁸ Ibid.
- ¹⁹ U.S. Department of Health and Human Services. *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Welfare*. This estimate is based on the higher end estimate of two-thirds of cases in child welfare involved with substance use disorders.
- ²⁰ Youth Law Center. (2000). *Making Reasonable Efforts: A Permanency Home for Every Child*. San Francisco: Author.
- ²¹ Ibid. p. 22
- ²² Ibid. p. 19
- ²³ Ibid. p. 23
- ²⁴ Ibid. p. 27