

Q: What kind of information does SAFERR have about the actual screening tools?

Dr. Young: Over 30 screening and assessment tools for substance use disorders are profiled in SAFERR. Each profile includes a description of the tool and information on administrative issues, scoring, clinical utility, copyright, cost, and the source of the tool. SAFERR includes similar profiles for safety and risk assessment tools used in child welfare practice.

Q: Have you seen models where mental health is included? There was a pilot project in a community several years ago that seems quite relevant to the model you are presenting.

Dr. Young: The presenters from Washington will be providing information on both the UNCOPE tool that looks at substance use disorders, and the model that was implemented statewide in the state of Washington using the GAIN-SS (short-screen), which addresses both substance use and mental health.

Q: What is the best way to maintain communication between the systems to provide a continuum of care for the families?

Dr. Young: The first place that I saw this implemented was San Diego County, California. Representatives from the systems sat down together and decided what information the child welfare and court systems needed to know about a family's substance abuse treatment, and what the treatment system needed to know about the family's child welfare and court involvement. They created releases to share that information with the parent's attorney, the children's attorney and the court. They asked for specific, observable information to be provided twice a month.

In other words, they didn't ask the treatment provider to give them an opinion about the safety of the child, or about what type of visitation should be put in place. They recognized that the responsibility for those decisions really belongs with the child welfare system. The treatment provider could give measurable information to the child welfare worker, such as how many times the parent participated in treatment sessions compared to the number of times they were required to attend; how many times the parent took a drug test compared to the number of times they were required to take one; the results of the testing; and how many times they participated in a required self-help group. Treatment providers gave objective information about treatment participation twice a month to the recovery manager, who shared the information with the child welfare system and the court. When the child welfare worker was preparing court reports or getting ready to visit with the family, the worker already had information about how the parents' recovery plan was going. They didn't have to call the treatment provider to make sure that the right confidentiality procedures were being followed.

The system sustained that communication over a long period of time. When something changed on the child welfare side, such as visitation, there was a communication path in place so that the recovery manager could help facilitate that change for the family. The substance abuse treatment provider wasn't suddenly finding out that the kids were going home next week; they had a chance to work with the family and prepare them for the reunification plan or for what was going to happen in court. Effective communication is maintained over time. The twice monthly reporting takes place during the entire time that the case is open in child welfare.

SCREENING, ASSESSMENT, FOR FAMILY ENGAGEMENT (SAFERR)

The SAFERR monograph provides a model that helps professionals respond to families affected by substance use disorders.

The model includes screening and assessment tools and efficient communication strategies that support sound and timely decisions about the safety of children and about the treatment and recovery of parents. It includes guidance for developing collaborative relationships between the systems to help improve outcomes for these families.

If you would like to download or order a copy of SAFERR go to <http://www.ncsacw.samhsa.gov/products.asp>.

For more information call the National Center on Substance Abuse and Child Welfare at 714.505.3525.

Q: In the San Diego model, how are reports transmitted to the other agencies? How is the primary lead responsibility established?

Dr. Young: That particular model is similar to models in several other jurisdictions around the country, including Sacramento County, which modeled its communication after San Diego. The information was originally transmitted by fax, but is now transmitted by email. These issues are covered in the confidentiality agreement and in the procedures established through Memorandums of Understanding between the systems.

What is important is not just that the information is communicated, but that it really is a team approach. For example, when parents are testing with a recovery manager (in the Sacramento model), they are encouraged to let the worker know if the test is going to come back positive. This gives the parents a chance to say what is going on in their lives before the test results come back. The testing isn't conducted in the sense of "We're documenting this for our case records or for the court," but really as a way to facilitate recovery with parents, to help them be accountable. The communication itself is done very efficiently, and if the parent tests positive, they are encouraged to make the phone call to the child welfare case worker jointly with the recovery manager. The recovery manager and parent call the child welfare worker together to let them know what the test result will be, and what is going on in the recovery component of the case. This doesn't work for 100% of cases; not every parent shows up for testing. But it works enough of the time that they are able to increase reunifications and shorten the time for case closure, because the communication is in place to facilitate the engagement of parents in the change process.

Q. We use team decision making meetings to develop safety plans to prevent removal. Is this SAFERR process one that could easily work as part of a team decision making process?

Dr. Young: Absolutely. Do you currently have your substance abuse treatment providers at the table in the team? (*Sometimes we do, but not always. It would seem we would need a more structured or organized approach.*) It does take a very structured and organized approach. Often what comes into play is that the payment system on the substance abuse treatment side doesn't allow the time for an individual counselor to go to those meetings, or even to go to court when subpoenaed, so it becomes a cost issue. However, the increased efficiency that occurs when the systems collaborate results in cost reduction for both child welfare and substance abuse treatment. One of the sites that uses a joint team approach originally focused on infants that had been prenatally exposed to substances. This was in Cleveland, Ohio, and they have used this joint team approach for quite some time, looking at the safety and risk factors for the newborn and for the family. SAFERR would easily work with a team decision-making approach.

Q. We are also a structured decision making county. Does the guide describe how you would integrate SAFERR with the current screening and assessment tools that we are using? SDM is a good safety risk assessment tool for reunification but it needs an integration of how you articulate the co-occurring disorder issues that you are presented with as you go out and investigate. Does the guide help us integrate that into an SDM format?

Dr. Young: Yes, absolutely. I am not sure if you already have your information system in place for the way that you are using SDM. Some jurisdictions have modified their SDM data collection in order to accommodate the additional information that needs to be collected in terms of the substance use disorder or mental health issue that may exist.

Q. Do you know of any counties in California that have integrated screening tools into their risk and safety assessments?

Dr. Young: In California, I don't know who may have modified their SDM. The State of Michigan modified their SACWIS system, which is the acronym for the Child Welfare Information System that is required in all States. In Michigan they changed their system to reflect an approach of "screening out" rather than "screening in." The underlying assumption is that there is a substance use disorder unless the worker responds affirmatively that there is not. In other words, their information system was changed so that a

worker has to rule out a substance use disorder in the family, rather than screen it in. This is a very different approach, and it is applied statewide now that they have changed their information system to accommodate it.

Q. How is the data collection managed? Do you enter data into a common database?

Mr. Brenna and Mr. de la Fuente: Each one of the systems has a very different data system, and within each system there may be numerous databases. In our system you enter the data in a one-page GAIN-SS form that can be scored and included in the clinical chart. That information is entered into our target management information system. Our department of corrections also enters their data into this system, since all of their facilities are certified agencies within my division also. Other agencies gather it by hand and enter it in later on into a database. Some don't have the database to integrate placement information yet, and they are just electronically gathering the GAIN-SS information. I would acknowledge that in the case of the Children's Administration, there is not that kind of assessment process that goes on at a traditional mental health or chemical dependency facility.

Q. Are there standardized screening and assessment tools for children?

Dr. Young: Does this refer to children and their own substance use disorders? If so, I would refer you to some of the same instruments, particularly GAIN for adolescents. The SAFERR manual includes information on standardized assessment tools for children, including the Ages and Stages, Social-Emotional, and the Child Behavior Checklist.

Mr. Brenna and Mr. de la Fuente: If the question is about what ages the GAIN-SS is appropriate for, the answer is that we don't use the screening with children. The Children's Administration is using age 13 and up, and I think the GAIN-SS may be normed slightly lower. Screening is much more difficult to do with children. Having been a family therapist, assessment would certainly be my choice.

Q. How receptive were the mental health providers in implementing a mandatory screening for co-occurring disorders?

Mr. Brenna and Mr. de la Fuente: There was a contract requirement that all contracted chemical dependency and mental health agencies, use the screening and generate data on it. I suspect that some felt it was redundant, because they probably included chemical dependency questions in their assessment process. For others, since part of the intent of this is to raise the bar on screening and assessment for co-occurring disorders, it was welcomed. I have not heard any widespread resistance from mental health workers about doing the screening. From providers at the local level, the response has been surprisingly quiet.

Q. Would you recommend using the GAIN-SS screen for other populations such as CalWORKs, which is California's TANF program, or in the TANF case management approaches?

Dr. Young: I think that you should go through a similar process and look at the population to see if it matches the strengths of the instruments. Instruments continue to evolve. I think it is a useful instrument for us and I suspect it would be for that TANF population.

Mr. Brenna and Mr. de la Fuente: In our state we do have a similar CDP program in our CSO system, the place where public welfare is provided. I don't know that a screening instrument is used by the case managers as they interview clients, but they do have the services of a chemical dependency professional available when they flag something or if they are concerned about something. I think the advantage of screening, in any system, is that you start to get a uniform and consistent level of participation. You by-pass individual professionals who may or may not have the expertise to identify substance abuse or mental health disorders, and you bypass professionals who have their own personal bias about whether those services are effective or required. If we are really going to be systemic in improving services to clients, whatever the system, screening tools are the answer, but not in and of themselves.

Q. How did you create the team approach in Washington from the beginning?

Mr. Brenna: The Director of the Division of Alcohol and Substance Abuse can best be described as a doer and a maverick. We talked about the problems of substance abuse and child welfare in the mid-1980's and we were unsuccessful in moving in and working effectively with that system. This Director was the kind of person who would identify an opportunity and seize it. He paid for my position even though I reported to the child welfare agency, and I was basically a mole in the child welfare system, and could identify policy issues and system problems, difficulties that existed between the two systems. Sometimes that went well, sometimes it didn't. The program was continued and David de la Fuente took the position; the Division of Alcohol and Substance Abuse continued to fund his position.

It came down to the political will of one of the Directors and the political willingness of the other. The two systems enforced upon each other the need to coordinate and collaborate. I think that the other thing that we benefit from in this state is that we seem to get along cross system pretty well, if there is a clear objective about why we are getting together. When we don't get along, we don't get along, but when we understand that we should get along, there is good follow through. So when we got the county chemical dependency system, the provider system, the local child welfare office system, the two research offices and the two administrations sitting down and talking to each other about what we ought to do and what it should look like, it came together pretty quickly. The plan practically wrote itself.

Mr. de la Fuente: In regards to on-going collaborations, the statewide work group that oversees this process might be roughly akin to what Nancy Young described as some of the oversight committees in the SAFERR model earlier. That has representation from all the divisions and administrations of the social and health services departments that are implementing this screen, and that is really important. The Children's Administration has now taken over the funding of this position that David used to be in and that I am in now, so they have stepped up to the plate in terms of their recognition of how important it is. They allow me to go and actually have an office at the Department of Alcohol and Substance Abuse a couple days a week so I can personally facilitate those relationships and craft those collaborations that are so dependent.

We are also fortunate in that my Supervisor, Barb Putnam, is the former mental health program manager and has excellent connections with the mental health system. We didn't talk about the mental health system a lot because there just wasn't enough time in this short presentation, but we really can't talk about co-occurring disorders without talking about mental health. It's sometimes easy to forget about mental health because it doesn't always gravitate to the obvious practical surface of need like chemical dependency does, but it is very important that we regard it as just as serious and their partnership is very valuable, too. That is because everybody has representatives on the key committee, everybody is an equal player.

Q. How many children are under the supervision of the child welfare system in Washington? Do you think that having 26 chemical dependency professionals is adequate, in your opinion, for the child welfare caseload?

Mr. de la Fuente: At any point in time, there are about 6,000 children in out-of-home care in Washington State. As you saw earlier in the slide, there are 44 local offices, so we are not to the point yet where every single local office has a CDP. I would love to see that some day, but we have defined the job description so that they have the capacity to get beyond the local office and have more of a regional focus as well, so that nobody is left out.

Dr. Young: There are other states with similar models that broker or coach roles in a way to provide expertise to the child welfare office from the substance abuse agencies, and that includes Massachusetts, Oregon, Florida, Illinois, and Connecticut. If you are interested in some of those models, please contact us at the National Center for that information.