national center on substance abuse and child welfare

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

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SAMHSA

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Summary

This paper describes the ten-element framework of system linkages that are necessary for effective collaboration between the substance abuse treatment, child welfare, and dependency court systems. It presents the opportunities and challenges that may be encountered by the systems in developing a collaborative approach to the issue of substance use disorders among parents in the child welfare and dependency court population. Reasons for the inclusion of the dependency court as a third partner in the collaborative are discussed, and the specific roles and responsibilities of each system are delineated. The paper describes seven program sites which are implementing the collaborative approach.

1. Background

Over the last two decades, increasing evidence of the association between parents' substance use disorders and child abuse and neglect has produced a heightened recognition of the importance of collaboration between the substance abuse treatment and child welfare systems. Children and Family Futures (CFF) developed Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Drug Services with Child Welfare to provide guidance and practical information about establishing and maintaining cross-system collaboration. The publication was developed under a contract with the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), as part of the Treatment Assistance Protocols (TAP) Series, and was published by CSAT in 2002.

Navigating the Pathways introduced ten critical elements of interagency collaboration that should be addressed by the collaborative partners in their efforts to create sustainable improvements in policy and practice for the benefit of families. These ten elements were referred to as the framework. Navigating the Pathways included three policy tools that supported the framework: a detailed chart identifying criteria for improved practice, good practice, and best practice for each of the ten elements, and two inventories that the collaborative partners could use to assess their capacity for collaboration and to identify shared values. The publication also described seven sites where promising programs of collaboration among substance abuse treatment and child welfare services were being implemented.

The experiences of collaborating agencies led to revisions of the framework and its supporting policy tools. This summary of the Framework and Policy Tools for Improving Linkages Between Alcohol and Drug Services, Child Welfare Services, and Dependency Courts presents the most current version of the framework.

Two significant advances have been incorporated:

- The dependency court is recognized as a partner in the collaboration, and the perspective of the dependency court has been integrated within each element of the framework.

- Linkages with community groups and family supportive systems are included as a distinct area of policy and practice.

This paper includes updated versions of the matrix of progress and the two collaborative inventories with a particular emphasis on the role of the court in these collaborative efforts.

2. The Elements of System Linkages

The ten-element framework was based on five domains of action highlighted in Blending Perspectives and Building Common Ground,[1] a 1999 Report to Congress by the Department of Health and Human Services. CFF added five elements identified through its work with multiple sites and jurisdictions and the framework was further revised based on feedback from participants in collaborations who were actively implementing system linkages. Assistance from the National Council of Juvenile and Family Court Judges in specifying the roles of the judiciary and attorneys is also reflected in these revisions.

The ten elements of the framework 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

The first element, Underlying values and principles of collaborative relationships, is the foundation of collaboration among systems. Each partner enters the partnership with its own perspective and assumptions about the mission and mandate of each system. Unless these differences can be identified and resolved, the collaborative partners may find it difficult to reach agreement on the issues they must address.

The next three elements, Daily practice–client screening and assessment, client engagement and retention in care, and services to children of substance abusers, concern services provided to the families served by the three systems. The partners must collaborate in these areas of practice: screening and assessing child welfare-involved parents for substance use disorders, screening and assessing parents in substance abuse treatment for risks of child abuse and/or neglect; engaging and retaining these parents in treatment; and providing services to their children.

The following four elements, Joint accountability and shared outcomes, Shared information systems, Budgeting and program sustainability, and Training and staff development concern structures and processes that the partners must establish jointly to ensure effective integration and maintenance of their collaborative efforts.

The last two elements, Working with related agencies and Working with the community and supporting families, concern the relationships of the collaborative partners with agencies, communities, and supportive families in the communities where the families live; these relationships support the goal of better outcomes for the families served by the collaborative.

Summary of the ten elements:

Underlying values. Each partner enters the collaboration with its own perspective and particular assumptions about the mission and mandates of the other partners. Unless these differences are identified and addressed, the collaborative will find it difficult to reach agreement on the issues. Often the values and definitional issues, such as who is viewed as the primary client, affect the ways in which staff work across agencies boundaries. Developing common principles of how the agencies and staff will work together to best serve the clients in each of their caseloads is critical.

Daily practice and protocols in client screening and assessment. It is in the first contacts with the client that agencies must begin the process of determining what kind of substance abuse problem, if any, the client has, what mode of treatment would be the best response to the problem, what risks exist for the children of parents entering substance abuse treatment, and what information needs to be communicated to other agencies. Legal advocates for parents play a pivotal role in this process by either encouraging or discouraging the client from seeking services and being forthright during the evaluation.

Daily practice in engaging and retaining parents in care. It is critical to engage and retain parents in treatment, and to keep them on track in meeting their parental goals. The Adoption and Safe Families Act (ASFA) requires this effort, and the developmental needs of children are at stake. Judicial officers in particular have an important role to play in enhancing retention in care among parents, as do parents' attorneys, who influence parents through the messages they give about engaging in substance abuse treatment and other services. Agency attorneys are positioned to inform the court and community about available resources and gaps in services.

Daily practice in services to children of substance abusers. The substance abuse disorders of parents have a major impact on their children. Substance abuse treatment services provided to families in the child welfare system should employ a family systems approach to mitigate the risk that a new generation will repeat their parents' pattern. Advocates for children can ensure that the special needs of this group of children of substance abusers are addressed in prevention and intervention programs. When residential substance abuse treatment is required,

parents and their children should be kept together during treatment. Agency attorneys can act as a liaison between the agency, community and media to advocate for improved services that increase family recovery and child protection.

Joint accountability and shared outcomes. Jointly developed outcomes guide the work of the collaborative and demonstrate that the collaborative has achieved agreement on desired results. Without agreement on shared outcomes, each of the partners is likely to measure its progress as it did prior to the collaboration, based on its own internally defined outcomes. Particular importance needs to be given to the outcomes for the whole family—parents' recovery as well as safety and permanency of the children to appropriately reflect a family-centered approach in monitoring the effectiveness of the collaborative effort.

Shared information systems. Shared information from each of the systems is a prerequisite for joint accountability; they form the basis of communicating across systems and are needed to track progress toward joint goals and determine whether joint outcomes have been achieved. Without effective sharing of information at the client, program and systems level, the partnership will lack guideposts to measure its programs' effectiveness.

Budgeting and program sustainability. The only way to develop multi-year stability for innovative approaches is to tap the full range of funding resources across multiple agencies that are available to a State or community. Jurisdictions that have been successful in sustaining these efforts have looked at cross-systems resources and maximizing budget leverage points.

Training and staff development. Cross-training efforts at all levels—management, administrative, and line-level staff—is needed to bridge divisions between the systems. In the absence of cross-training, the continuation of conventional practice deepens these divisions.

Working with other agencies. Many parents with substance use disorders also require services beyond treatment and child welfare to address the complex issues impeding the healthy functioning of their families. These services include mental health, domestic violence, primary health, housing, and employment-related services. The collaborative will need to develop and maintain relationships with the organizations that can provide these services.

Working with the community and supporting families. Community-based organizations and community and family support systems are important resources for families involved in child welfare and substance abuse treatment. These entities can serve as a front line of child protective services, advocating child and substance abuse prevention and providing ongoing support after formal services have ended.

Policy Tools

The Matrix of Progress in Building Linkages Among Alcohol and Drug Agencies, Child Welfare Services, and the Dependency Court is a tool for evaluating collaboration across the three systems. It specifies characteristics in improved system linkages that lead to improved outcomes and long-term well-being for families. The Matrix of Progress identifies criteria for improved practice, good practice, and best practice for each of the ten elements; it is included in Appendix 1.

Two interrelated collaborative inventories 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, and introduced in Navigating the Pathways. These policy tools are intended to assist states and communities in their collaborative efforts and are included in Appendix 2. These tools are available on the Children and Family Futures website (www.cffutures.org) for use by states and communities. On-line versions of the tools with data collection, analysis and summaries are available free of charge from the National Center on Substance Abuse and Child Welfare. The inventories are:

Collaborative Values Inventory (CVI) – This questionnaire 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 help the collaborative clarify the underlying values that its members bring to their work and identify issues that may become barriers to collaboration.

Collaborative Capacity Instrument (CCI) – This self-assessment tool includes questions designed to elicit discussion among and within the child welfare and substance abuse treatment systems, dependency courts, and community agencies about their progress in addressing specific issues. It helps agencies prioritize their most urgent program and policy plans.

3. Rationale for a Trilateral Relationship

There are families involved in substance abuse treatment and child welfare services that 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. An important part of the context of the problem is the large number of child abuse and neglect reports through which families enter the child welfare service (CWS) system. The extent of overlap between these families and the other two core systems—substance abuse and the dependency court—is substantial, as indicated by the following national estimates.

Alcohol and Drug Treatment – 2004

- 1.84 million adults were admitted to the public treatment system[2]
- 566,648 (30.8% of 1.84 million) were women[3]
- 1.085 million (59% of 1.84 million) were parents of minor children[4]
- 294,000 parents (27% of 1.085 million) had one or more children removed by child welfare services[5]
- 106,000 parents (36% of 294,000) had parental rights terminated[6]

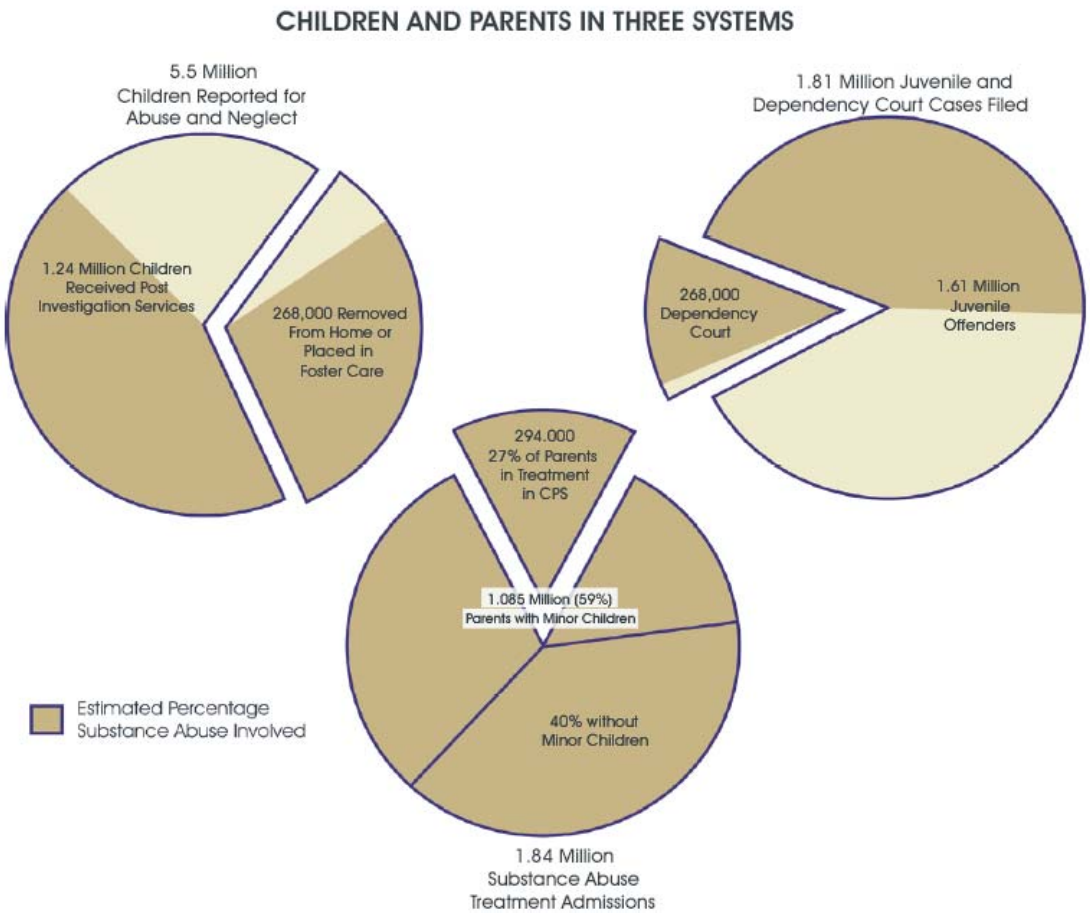
Child Welfare Services - 2004

- 5.5 million children were reported for abuse/neglect in 2004[7]
- 3.5 million children received an investigation (62.7% of referrals made to Child Protective Services)[8]
- 1.24 million children received post-investigation services[9]
- 872,000 children (47.8% of those receiving an investigation or assessment) were victims of neglect (64.5%); physical abuse (17.5%); sexual abuse (9.7%); emotional or psychological abuse (7%); medical neglect (2.1%); and other (14.5%)[10]
- 268,000 children entered out-of-home care[11]
- One-third to two-thirds of families in child welfare services are affected by substance use disorders[12]

Dependency Court - 2002

- 1.81 million juvenile court cases were filed[13]
- 1.615 million delinquency cases were filed in juvenile court[14] (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)
- 193,200 cases (about 12% of 1.615 million) were for drug-related offenses[15]
- The total number of dependency cases filed is not known; however, 268,000 children were court-involved due to placement in foster care[16]
- The number of children who were court-involved but not removed from parents' custody (often referred to as "in home" cases) and for whom a petition alleging parental abuse or neglect was filed in court is not known[17]

The graphic below illustrates how each system interacts with the others for some percentage of its total population. While the overlap 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 the issue is the fact that each system includes a significant number of cases that do not interact with in the other two systems.



4. Challenges to Collaboration

Given the magnitude of the population of children within the child welfare and dependency court systems whose parents are challenged by substance use disorders, it is important to engage all three systems—the dependency courts, child welfare services, and treatment providers—in planning for systemic change. Challenges to 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 add new challenges. 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 on 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 understanding of 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. Both treatment and child welfare staff may lack the training to work well within the dependency court system, which can be intimidating to other professionals and bewildering to families.

The development of new policies to support improved practice requires all three systems to work in a collaborative mode, 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 making the best interests of abused and neglected children and their families the primary focus, all three partners can plan for effective systemic change, including the development of treatment and support service options that best meet the needs of children and their families and respond the various timelines required by the service systems.

The policy focus on the best interests of children and their families can guide planning for change in court and agency practice. When the focus is on the needs of children, policy will take into consideration the child's developmental needs, the child's sense of time, and the child's sense of well-being. A holistic approach to assessing and revising policy can ensure that appropriate and immediately accessible substance abuse services will be available to parents and that the mental health needs of children and parents will be met.

Collaboration among the three systems can present 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 may arise in reallocating resources or identifying new sources of support and these issues must 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 these gaps and find new or redirected resources to meet the needs of children and families within their communities.

Some challenges faced by the collaborative partners result from the high rate of turnover in each system. Judges are frequently required to rotate. Child welfare agencies often encounter high rates of turnover, and substance abuse treatment providers face similar challenges in retaining staff.

The ethical considerations in building collaboration with judicial officers and attorneys should be addressed early in the collaborative process. Participants must learn to think beyond traditional judicial, legal, child welfare and service provider roles; they should bring a sense of cooperation to the partnership and be willing to "think outside the box."

Strengths and Challenges of the Dependency Court

Judicial officers and attorneys bring both strengths and challenges with 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 and plan and implement meaningful changes in practice;
- The 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 and 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.

5. Roles and Responsibilities

It is imperative that staff members in each system understand the roles and responsibilities of the staff members in each of the other systems. A fundamental prerequisite to building effective teams is the joint training of staff. Staff must be given sufficient time to become familiar with the roles, responsibilities, nomenclature, values and practices in the other fields. A description of the roles and responsibilities of each system follows.

Substance Abuse Treatment System – Staff have a primary responsibility to address clients' substance use disorders and guide clients to sobriety and recovery. They also have a legal mandate to report suspected child abuse or neglect.

Counselors – Their primary role is to help the client recognize their 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, and employment. The counselor is coach, critic, and cheerleader. To achieve and maintain sobriety and promote continued recovery, the treatment must consider the safety of the child and the healing of the entire family.

Supervisors – Their primary role is 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 to ensure that services are provided on a timely basis.

Administrators – Their primary role is to provide appropriate policies, protocols and adequately trained staff to meet the system responsibilities.

Child Welfare System – Staff have a primary responsibility to ensure the safety and well-being of the child and address 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 staff are 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 both the child and 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 – Their primary role is 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 services are provided on a timely basis.

Administrators – Their primary role is to provide appropriate policies, protocols and adequately trained staff to meet the system responsibilities.

Dependency Court System – The dependency court has jurisdiction in cases of child abuse and neglect. The system includes both 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 dealing with substance abuse issues, judges and attorneys are also being asked to assume new roles in their work with families affected by domestic violence and mental health issues. This comes at a time of evolution in the overall role of the courts in addressing a variety of societal problems through court-based interventions. The practice 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 this arena.

The role of dependency court judges is shifting from that of power and authority to shared responsibility with the collaborative 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; they have a unique role in 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 raise public awareness and gain support for additional resources.

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

The specific roles of the attorneys who represent parents, children, social services and the State in the dependency court 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."[18]

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.

Dependency Court Judges—Their primary role is to make 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—Their primary role is to 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 of the reasonableness or unreasonableness of the agency efforts and of alternative efforts that could have been made. Further, they should be prepared to obtain court orders for specific services, including visitation when appropriate.[19]

Children's Attorneys—Their primary role is to advocate 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, 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.[20]

Social Services' Attorneys—Their primary role is to advocate for the social worker and to present the legal position of the social services department in the case. They help develop policies and protocols (e.g., 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.[21] 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.[22]

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 in their communities to educate community members about the needs of clients.

6. Brief Synopsis of the Sites and Program Models

The seven sites included in Navigating the Pathways were chosen because they exemplified "promising practices" addressing specific barriers to collaboration. Some of the sites were advanced in their implementation of their programs and were making revisions of their model that amounted to a second-phase innovation. Others were in the early implementation stages of program development. The following sections are short descriptions of the program models as they existed in early 2000; updates from the sites and outcome data from Sacramento County are available from Children and Family Futures (www.cffutures.org).

The State of Connecticut

Project SAFE (Substance Abuse Family Evaluation) began in Connecticut in 1995, after an extensive review of the Department of Children and Families (DCF) was requested by the governor. The review found that substance abuse was a contributing factor in many cases; it also found that DCF was not systematically screening for substance abuse. Initially, the project's purpose was to produce an evaluation and systematic response to families' substance abuse treatment needs to guide decision-making concerning the removal of children from their parents' custody and to be used as evidence in court hearings. Workers and policy leaders wanted a "clinical tool" that they could rely on 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 had been 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. Arrangements were made through the state Medicaid system for providers to be included in the ABH network in order to maximize funding. DCF clients who needed other intensive levels of care were 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 involves 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 DMHAS, the major state agency for managing adult behavioral-health issues, including services for persons with substance abuse problems. A primary goal in improving linkage between the two state agencies was to better tap existing substance abuse assessment and treatment resources—both funding and expertise—through the publicly-funded substance abuse treatment 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 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 to make AOD assessment and intervention part of the responsibility of every worker. The

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 substance use disorders 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 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 reinstituted. 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. More recently Sacramento County has added a Dependency Drug Court program to its initiatives and 24-month outcome data are positive; reports on their evaluation are available from Children and Family Futures (www.cffutures.org).

Cuyahoga County

The Sobriety Treatment and Recovery Teams (START) program 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, were 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 meetings the first three times the client participates.

The START program was founded on twelve tenets, which were discussed at length among the program originators, service providers, and staff. The abstinence orientation is strong; the first principle states: "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 the reliance on 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 could 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

Compared with the other sites, Jacksonville is a more recently-developed program. The primary feature 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

means 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 has been developed, in which less serious cases of abuse and neglect are 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 and 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. The process was also 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 seen as a prerequisite to working on other issues.

Unfortunately, all of the AOD treatment programs in the County had extensive waiting lists. Typically the parent would get to his or her six-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 are 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 can 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 three 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, and so on. The net effect 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 are adequately protected during the process. A great 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 are 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 and 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, and10 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	Values clarification efforts have begun among the three systems 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 Discussions have begun concerning the priority/political will to address the overlapping AOD/CWS population Different time limits and developmental needs of children have been identified as critical issues	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 Cross-system discussions and problem solving among policy makers, administrators and practitioners are instituted	Formal values clarification efforts have included all staff of the three systems The systems have agreed upon individual and joint goals to serve the whole family as their primary client
Daily Practice: Client Screening and Assessment	The three systems have a joint policy on decision-making regarding screening and assessment and impact of results on removal/placement decisions 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 Issues of culture and gender are included and appropriately addressed in the assessment process	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. Culture and gender appropriate joint case assessments and plans have been developed with CWS parents with substance abuse problems	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 Jointly developed quality assurance mechanisms have been implemented for interpretation of assessment information

* 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*
Daily Practice: Client Engagement and Retention in Care	Systems have begun "drop-off mapping" of the points at which parents are not responding to referrals and not complying with treatment requirements Systems have agreed on procedures for cultural and gender specific approaches to outreach for parents who miss appointments 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 Dependency courts understand that they have a role in monitoring compliance with court orders for treatment and case plans	Staff have been trained in motivational interviewing and/or other methods of engaging and retaining parents in treatment Programmatic responses have been put in place to improve family participation/completion rates Systems understand and are responding to how AOD issues and treatment requirements of families interplay with CWS and court requirements	Client relapse typically leads to a collaborative intervention to re-engage the parent in treatment and to re-assess child safety Systems are monitoring and responding to how compliance with case plans and requirements is resulting in changed behavior 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 Efficient case management and outcomes monitoring tools that enable tracking progress of individual clients as well as the effectiveness of the whole system are
Daily Practice: Services to Children of Substance Abusers	Systems are taking a developmental perspective to addressing needs of children of substance abusers in their own system Each system has a focus on child safety as well as family recovery 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 Issues of culture and gender are incorporated in service delivery and programs for all children	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 Each system understands and implements its role in ensuring child safety Independent Living Programs include AOD prevention and intervention programs for youth	All children involved with CWS receive developmentally appropriate interventions to address their status as a child of a substance abuser

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*
Joint Accountability and Shared Outcomes	Each system has their own outcome measures with beginning recognition of the overlapping issues in cross-system outcomes Some shared outcomes have been agreed upon but each systems feel primarily accountable for their own measures of success	Systems use outcome criteria in their contracts with community-based providers (who serve CWS-AOD parents) to measure their effectiveness in achieving shared outcomes	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
Information Sharing and Data Systems	The three systems have documented the gaps in their current client information systems and are addressing them AOD assessment at intake captures data about child needs among child welfare families CWS assessment at intake captures data about AOD issues 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 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	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 Data on the overlap between child welfare families and the caseloads of other systems is consistently available to AOD, CWS and court systems Interagency communication protocols have been developed and are being utilized for information sharing between the three systems	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 Overlap data is being used to redirect resources The systems are monitoring the outcomes of information sharing

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*
Training and Staff Development	Commitment has been made to staff development in each system to address substance abuse and child welfare issues Training for all stakeholders has begun with regular updates and a set curriculum that devotes adequate time to substance abuse and child welfare issues Training for parents, guardians and foster parents has begun to address substance abuse issues	Training in each system has been institutionalized with regular updates and a set curriculum that devotes adequate time to substance abuse & child welfare issues Multi-disciplinary training has been implemented 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	The three systems have engaged local colleges, universities and law schools to develop pre-service education that addresses the cross-system issues Systems are monitoring the outcomes of the training Training for parents and foster parents is treated as an equal priority to professional training
Budgeting and Program Sustainability	Systems have begun to develop an inventory of all funds available for treatment and children's services in the state/community Systems have begun to identify the outcomes of innovative practices that merit sustained funding	TANF, Medicaid, and other major funding sources for treatment are used regularly for funding treatment for child welfare parents	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

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*
Working with Related Agencies	A partnership with law enforcement is in place to appropriately address the needs of children during any needed police action Recognition by all three systems that each member of a family may have a variety of co-occurring needs Core clinical issues—mental health, family violence and trauma Concrete support services—income support, employment training, transportation, housing and child care Other needed supports—primary health care, HIV/AIDS, education, dental services 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 Parent education courses for substance-involved child welfare parents include significant content on alcohol and drug issues	Staff are assessing and addressing children and parents= needs as barriers to family recovery The three systems monitor receipt of services Parent education courses are formally evaluated for their impact on parenting practices The three systems have developed a case management role of mentoring and facilitating engagement in and delivery of services 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)	All three systems are evaluating outcomes of services provided to families and are routinely monitoring the effectiveness of services 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

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

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.

<table>
<tr><td colspan="2">Identify your own role in your organization:</td></tr>
<tr><td>1. Staff Level:
Front-line staff
Supervisor
Manager
Administrator
Other, Specify: _____</td><td>2. Gender:
Male
Female</td></tr>
<tr><td>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: _____</td><td>4. Age: _____Years</td></tr>
<tr><td>5. Jurisdiction of Agency or Court:
Federal Government/National
State Office
Within State Regional Office
County
Community-Based Organization
Reservation
Other: Specify_____</td><td>6. Race/Ethnicity:
African-American
Asian/Pacific Islander
Caucasian
Hispanic
Native American
Other: _____</td></tr>
<tr><td colspan="2">7. Years of professional experience in my primary program area: _____</td></tr>
</table>

* 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

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

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

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

Our state has prioritized parents in the CWS system for receipt of AOD treatment services.

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

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

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

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

Our state has multi-disciplinary service teams that include both AOD and CWS workers.

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our state AOD staff track the status of their clients' progress in the CWS system.

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

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

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

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

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

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

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

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

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

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

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

- Neurological effects of prenatal substance exposure

  Disagree Somewhat Agree Agree Not Sure/Don't Know

- Developmental delays associated with parental substance abuse

  Disagree Somewhat Agree Agree Not Sure/Don't Know

- Emotional/mental health problems associated with parental substance abuse

  Disagree Somewhat Agree Agree Not Sure/Don't Know

- Substance use disorders

  Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

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:

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

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

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

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

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

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

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

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

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

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

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

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

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

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

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

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

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

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

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

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

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

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

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

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

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

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

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

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

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

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

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

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

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

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

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

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

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

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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%

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%

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_____

Notes and References

[1] The full report to Congress, *Blending Perspectives and Building Common Ground* can be downloaded at www.acf.dhhs.gov/programs/cb/

[2] Office of Applied Studies, Substance Abuse and Mental Health Services Administration (2005). Admissions by primary substance of abuse, according to selected race/ethnicity/sex/age groups: TEDS 2003. Accessed at: http://www.oas.samhsa.gov/2k5Teds/teds_03_tbl3.3a.htm. April 9, 2006.

[3] Office of Applied Studies, Substance Abuse and Mental Health Services Administration (2005). Admissions by primary substance of abuse, according to sex and race/ethnicity: TEDS 2003. Accessed at: http://www.oas.samhsa.gov/2k5Teds/teds_03_tbl3.1b.htm. April 9, 2006

[4] Based on data published in Yih-Ing Hser, Y.I., Evans, E., Teruya, C., Ettner, S., Hardy, M., Urada, D., Huang, D., Picazo, R., Shen, H., Hsieh, J. & Anglin, D. (2003). The California Treatment Outcome Project (CalTOP) Final Report. Accessed at: http://www.uclaisap.org/caltop/FinalReport/Chapter%20IX%20Treatment%20Outcomes.pdf p. 9. April 9, 2006.
There are no national data on the number of children of persons in treatment. The CalTOP (California's implementation of the CSAT Treatment Outcome Performance Pilot Study [TOPPS-II]) study found that 60% of persons in treatment were parents. The cross-state analysis of the TOPPS-II Study also found that 58.5% of persons admitted to treatment had a child under the age of 18. These data were from the Inter-State TOPPS-II Data Set from the 16 TOPPS II Primary Data States. These data were analyzed by Dr. Kazi Ahmed of Johnson, Bassin & Shaw under contract to the Center for Substance Abuse Treatment on January 29, 2006 Unpublished data.

[5] Based on data published in Hser, Y-I., et al. (2003) Op cit. The CalTOP study found that 27.1% of parents had a child removed from their custody by Child Protective Services. Similar analyses of the TOPPS-II data set by Dr. Ahmed found that 22% of parents in the 16 State dataset had a child removed by CPS.

[6] Based on data published in Hser, Y-I., et al. (2003) Op cit. The CalTOP study found that 36.6% of parents who had a child removed from their custody by Child Protective Services (CPS) had their parental rights terminated. However, the percentage of parents varied significantly by the type of treatment that they received. Among parents with a child removed by CPS, 29% in Outpatient programs, 53% in residential programs, and 80% in Narcotic Treatment (primarily methadone maintenance) had their parental rights terminated. Similar analyses of the TOPPS-II data set by Dr. Ahmed found that 22% of parents in the 16 State dataset had a child removed by CPS and only 10% of those had their parental rights terminated. However 36% of parents had parental rights terminated or a child removed. In the cross-State data set, termination of parental rights also varied by type of treatment program. Of parents with a child removed by CPS, 66% of those in outpatient programs, 29% in residential care, 3% in narcotic treatment and 1% in other programs had their parental rights terminated.

[7] U.S. Department of Health and Human Services, Administration on Children, Youth and Families. *Child Maltreatment 2004* (Washington, DC: U.S. Government Printing Office, 2006). Accessed at: http://www.acf.hhs.gov/programs/cb/pubs/cm04/chaptertwo.htm#screen. April 9, 2006.

[8] U.S. Department of Health and Human Services, Administration on Children, Youth and Families. *Child Maltreatment 2004* Op Cit. Accessed at: http://www.acf.hhs.gov/programs/cb/pubs/cm03/chaptertwo.htm#backnotethree. Author generated data by applying 62.7% to 3.0 million referrals. And children victims Accessed at: http://www.acf.hhs.gov/programs/cb/pubs/cm04/chapterthree.htm#types. April 9, 2006.

[9] U.S. Department of Health and Human Services, Administration on Children, Youth and Families. *Child Maltreatment 2004* Op Cit. Accessed at: http://www.acf.hhs.gov/programs/cb/pubs/cm04/chaptersix.htm#prevent. April 9, 2006.

[10] U.S. Department of Health and Human Services, Administration on Children, Youth and Families. *Child Maltreatment 2004*. Op Cit. Accessed at: http://www.acf.hhs.gov/programs/cb/pubs/cm04/chapterthree.htm#types. April 9, 2006. The total percentage adds up to more that 100% because children may be victims of more than one type of abuse of abuse or neglect and as a result are coded multiple times.

[11] U.S. Department of Health and Human Services, Administration on Children, Youth and Families. *Child Maltreatment 2004*. Op Cit. Accessed at: http://www.acf.hhs.gov/programs/cb/pubs/cm04/chaptersix.htm#prevent. April 9, 2006.

[12] 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 can be downloaded at www.acf.dhhs.gov/programs/cb/.

[13] Snyder, Howard N., and Sickmund, Melissa. 2006. Juvenile Offenders and Victims: 2006 National Report. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. Chapter 6: Juvenile offenders in court. Accessed at: http://ojjdp.ncjrs.org/ojstatbb/nr2006/downloads/chapter6.pdf. April 9, 2006. Author derived number from total juvenile offender cases added to the number of children placed in out-of-home care who would have had a court case filed as a dependent of the court. The number of court cases filed in which the child is not removed from the home is not known.

[14] Snyder, Howard N., and Sickmund, Melissa. 2006. Juvenile Offenders and Victims: 2006 National Report. Op cit. Chapter 6: Juvenile offenders in court. p. 157.

[15] Snyder, Howard N., and Sickmund, Melissa. 2006. Op cit.

[16] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, The AFCARS Report: Preliminary FY 2003 Estimates as of April 2005 (10). Accessed at: http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report10.htm. April 9, 2006.

[17] The number of child victims under continuing court supervision is not known. There are an annual estimated 769,000 child victims who were not placed in out of home care and thus are not declared dependents of the court requiring court supervision of their care (i.e., 906,000 child victims less 137,000 child victims who were placed in care).

[18] Youth Law Center. (2000). *Making Reasonable Efforts: A Permanency Home for Every Child*. San Francisco: Author.

[19] Ibid. p. 22

[20] Ibid. p. 19

[21] Ibid. p. 23

[22] Ibid. p. 27