

**Virginia**  
**Safe Families in Recovery Project**  
**2004-2009 Strategic Plan – Executive Summary**



**COMMONWEALTH OF VIRGINIA**

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# **Safe Families in Recovery Project**

## **2004-2009 STRATEGIC PLAN Executive Summary**

June 2004 Distribution

# 1. EXECUTIVE SUMMARY

The Virginia **Safe Families in Recovery Project** (SFRP) is a collaboration between the Virginia Department of Social Services (DSS); the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and the Office of the Executive Secretary, Supreme Court of Virginia (OES), in partnership with regional agencies and community-based service providers. Since its inception in Fall 2003, the SFRP Advisory Team has grown to 35 members and includes representation from the Virginia Department of Health (VDH), Virginia Council on Indians, Department of Medical Assistance (DMAS), Virginia's Office of Comprehensive Service Act (CSA), the Mid-Atlantic Technology Transfer Center (MATTC) the Virginia Institute for Social Services Training (VISSTA), and Virginia's family treatment drug courts.

With the implementation of the Adoption and Safe Families Act and renewed emphasis on achieving safety, permanency and well-being for children in the child welfare system, finding effective ways to address concurrent substance abuse and child maltreatment problems in families takes on new importance. Over the last 10 years, a record number of single-parent families have entered the child welfare system because of parental substance abuse. Several elements must be present in order to effectively address this problem. Services must be comprehensive and well coordinated; staff from all systems must be cross trained in other systems in order to understand a family's needs and make appropriate referrals; practice must be empowerment-based, helping families and also solving external issues such as housing and employment; helpers must support the development of self-sufficiency in families and individuals; policies, procedures and agreements among systems must accommodate methods to share information, solve problems and overcome barriers; there must be a full continuum of services that are family-centered and community-based; gender specific services, involving the participation of children, must be available; and services must be individualized.

## ***The Goals of the SFRP Initiative***

1. Create the necessary statewide infrastructure to accommodate improved coordination of systems that will draw on the strengths of local communities and facilitate the development of local leadership teams, which will be tasked with implementing/ improving interagency collaboration across systems to improve outcomes for the target population; and
2. Achieve safe and timely permanency and well being for children and their families, with a particular focus on families' substance use recovery, by comprehensively addressing the needs of all family members.

## ***Key Accomplishments of the SFRP Initiative***

The SFRP has achieved a number of significant accomplishments. Foremost has been to increase stakeholders' awareness of the interface between substance use and child welfare involvement and the importance of providing integrated and timely services to these families. SFRP Advisory Team members have shared and promoted information within their respective systems at the state and local level contributing to increased communication between systems, enhanced collaboration, and integration of efforts. Following the distribution of a community stakeholders' letter through the Governor's Office of Health and Human Services in

January 2004, the Department of Social Services (DSS) issued a press release describing the initiative. From January – March 2004, the SFRP Advisory Team convened 5 workgroups (Community Development, Funding and Sustainability, Information Sharing, Professional Development and Service Delivery), which identified recommendations for the MOU and strategic plan. To obtain additional input from community stakeholders, 5 regional focus groups were conducted in April – May 2004 (in Culpepper, Newport News, Charlottesville, Roanoke, and Abingdon), with a total of 74 participants.

The activities of the SFRP have inspired or contributed to the development of several new initiatives – especially in the area of education and training:

- DMHMRSAS is in the process of contracting with the MATTC to develop a 5-session web based distance-learning class on family focused treatment for substance abuse treatment providers. The class will provide an overview regarding the importance of routinely addressing and promoting optimal family functioning; screening children for child safety, developmental delays, mental health issues, and health concerns and how to integrate parenting and childcare concerns into substance abuse treatment. The course will be offered twice by the MATTC to CSB staff at no charge and then made available to the general public for a modest fee. It is hoped that funds will be available in SFY 2005 to support the development of three additional web based courses: Identifying and Addressing Child Abuse and Neglect; Substance Abuse and Child Welfare; and Innovative Practices (Family Court, TANF initiatives etc.).
- DSS, DMHMRSAS and the Virginia Department of Health (VDH) are currently working with the National Technical Assistance Center for Children's Mental Health at Georgetown University's Center for Child and Human Development to develop a children's mental health and well being screening curriculum for substance abuse, social service, in-home health care providers and other providers that serve children and their families. Virginia's Children's Mental Health and Well Being curriculum will be based on the national Bright Futures in Practice Mental Health Curriculum developed for health care providers. This initiative was a direct outgrowth of SFRP's discussions regarding the importance of preparing service providers to screen children for developmental delays and mental health disorders.
- The Commonwealth Partnership for Women and Children Affected by Substance Use is a statewide consortium of providers that serves in an advisory capacity to DMHMRSAS and is represented on the SFRP's Advisory Team. The Partnership has elected to coordinate 3 regional cross trainings on substance abuse and child welfare and identified rural areas that aren't typically targeted for trainings. The cross trainings will provide an opportunity for local social service and substance abuse service providers to train one another on service delivery issues specific to their community.
- Virginia's Department of Social Services' Program Improvement Plan (PIP) includes strategies to improve access to substance abuse services, service availability, screening procedures, training for child welfare staff and foster parents and concurrent planning training in partnership with the goals, objectives and deliverables of Virginia's NCSACW SFRP strategic planning grant. Tasks associated with the SFRP have been incorporated in the 2004-2006 Strategic Plan for the Judicial System of Virginia and in the 2004-2010 Comprehensive State Plan of DMHMRSAS.
- DSS applied for a Federal Title IVE Waiver that includes funds to provide intensive case management services for substance using parents of children involved in Virginia's drug courts. The grant will provide intensive case management services for 12-18 months, with the goal of reunification, to birth parents and foster kinship care families that provide care for children of substance abusers. If awarded, one intensive case management position will be allocated to each of Virginia's 3 family treatment drug courts in the first year of the grant enabling them to expand the services they offer. Over the 5 years of the waiver, up to 11 additional positions will be made available to Virginia's other Best Practice courts so they may develop Family Treatment Drug Courts and provide similar intensive case management services.

***Resources Developed As A Result of this Initiative***

As noted, the 3 systems have incorporated support of the SFRP's MOU, strategic plan, recommendations and other resources into their respective state plans. In addition, DSS has incorporated action steps into its PIP that pertain to improving screening, access and availability of substance abuse treatment. Should DSS receive the requested Title IV-E waiver; this will significantly increase the ability to coordinate resources for substance using parents before the juvenile courts.

***A Call to Action***

The partnerships, increased communication and collaboration fostered by the activities and objectives of the Safe Families in Recovery Project have created new resources and opportunities for ongoing collaboration across systems throughout Virginia. SFRP stakeholders recognize that change is a process rather than an outcome unto itself. Both time and tenacity are prerequisites for systemic evolution in thinking and practice to take root, even in the presence of key assets such as stakeholder buy-in, resources and resolve. It is important that, at both the state and local level, we remain sensitive to this reality and persistent in our efforts. There continues to be considerable stigma, misinformation and misunderstanding regarding substance use, its impact on the family as well as the community, and the very real potential for lasting recovery. To facilitate the desired shift in thinking, providers, consumers and the community need ongoing education and information regarding the dynamics of addiction and recovery, children's developmental needs and the benefits of treatment. To facilitate the desired shift in practice, providers need the appropriate training, resources and tools. It is with optimism and commitment that the following goals and objectives are presented on behalf of the SFRP Statewide Advisory Committee, paired with a vision for achieving health and wellbeing in Virginia's children, families, and communities.

## 2. GOALS AND OBJECTIVES

### Information Sharing

**Goal:** To improve agency policies and cross-training practices related to information sharing between DSS and substance use providers in accordance with HIPPA, CFR 42 Part 2, child welfare confidentiality requirements and Best Practice recommendations.

**Objectives:** Facilitate information sharing between local DSS offices and Community Service Boards.

**Objective:** Develop education model training for SA and CW related staff.

**Objective:** Create necessary communication mechanisms to ensure ongoing dissemination of policy updates.

### Service Delivery

**Goal 1:** Implement uniform screening for substance use disorders in parents whose children come into contact with the child welfare system and for safety of children whose parents enter substance abuse treatment.

**Goal 2:** Provide integrated substance abuse and child welfare services to families affected by substance use who are involved in the child welfare system

**Objective:** Establish a joint protocol between local CSB and DSS offices for streamlined service planning, in which the DSS worker and CSB staff collaboratively discuss service goals prior to the development of an integrated, consumer-driven treatment plan.

### Professional Development

**Goal:** Ensure that SA, CW and court related staff has the necessary skills and knowledge to provide comprehensive integrated services to families affected by substance use who are involved with child welfare and court services

**Objective:** DSS, DMHMRSAS & OES will provide discipline- specific and cross training to child welfare, substance abuse, health care and court related staff at the local level.

### Community Development

**GOAL 1:** Influence community behaviors, attitudes, ideas, actions, and policies and empower communities through education about the inter-relationships among substance abuse, child welfare, and public safety.

**Objective:** Develop a formal social marketing strategy statewide, using established social marketing strategies and Memorandums of Agreements

**GOAL 2:** Develop a locally managed and controlled service delivery system that collaboratively addresses the intersection of substance abuse and child welfare.

**Objective:** OES, DSS, and DMHMRSAS will promote cooperation and collaboration among the systems through formal announcements of the interagency partnerships, memos to respective local agencies, and during state-wide conferences.

**Objective:** Identify and adopt unifying philosophies across the partnering systems to create a best practice system of care.

**GOAL 3:** Design and implement a community-level Results-Based Accountability (RBA) system to evaluate child and family well-being outcomes related to substance abuse addiction and recovery

**Objective:** Identify desired outcomes and establish community-level accountability for achieving those outcomes through a local reporting/ evaluation system in conjunction with a state entity to receive and analyze the data.

**Objective:** Establish a sustainable entity to continue the efforts of the Safe Families in Recovery Project post-technical assistance phase, e.g., continue to have representation from each partnering agency DMHMRSAS/OES/DSS. Incorporate this Center into one of the three partnering agencies, or establish as its own entity.

**Funding and Sustainability:**

**GOAL 1: Ensure that key funders and policy makers are well informed about the seriousness; the extent, the recommended solutions, and the funding needed to effectively address the safe and efficient adoption or reunification of children in Virginia's child welfare system, and for ensuring that adequate and appropriate prevention and treatment services are available in communities to avert legal involvement**

**Objective:** Provide informational presentations to the appropriate secretariats of the Commonwealth.

**Objective:** Provide informational presentations to relevant policy and advisory boards and commissions of the Commonwealth.

**Objective:** Dialogue with and provide information to relevant health care and social services policy committees of the General Assembly

**GOAL 2: Gain support from policy makers through education. Provide information on current social and financial indicators as well as outcome data regarding the safe and timely placement of children and services to these families**

**Objective:** Provide brief written reports and make presentations to the various target audiences described above.

**Objective:** Develop quarterly statewide newsletter to highlight Virginia's progress, provide recognition of highly functioning collaborative projects at the local level, and provide information about training opportunities, and distribute to all stakeholders e.g service providers, policy makers, funders, etc

**Objective:** Develop web-site that links with known state and federal agencies involved with related projects

### 3. TIMELINE FOR STRATEGIC PLAN IMPLEMENTATION

<u>Key Goal/Objective</u>	<u>Implementation Timeframe</u>
Improve cross-agency policies and practices related to information sharing	June 2005 – March 2006
Develop education model training for SA and CW related staff.	October 2005 – January 2006
Implement uniform screening for parental substance abuse and child safety in families who come into contact with the CWS.	September 2004 – July 2006
Establish a model joint treatment planning protocol between local CSB and local DSS.	September 2004 – September 2005
Ensure that SA, CW and court related staff have the necessary skills and knowledge to provide comprehensive integrated services to the target population	September 2004 – June 2006
Conduct a statewide social marketing campaign	March 2005 – December 2006
Identify and adopt unifying philosophies across the partnering systems to create a best practice system of care.	March 2005 – December 2005
Enact a results-based system to evaluate outcomes of child and family well-being related to substance abuse addiction	March 2006 – January 2007
Establish a Virginia Center on Substance Abuse and Child Welfare to continue the efforts of the Safe Families in Recovery Project.	2008 - 2009

**Safe Families in Recovery Project 2004-2009 Strategic Plan**



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## **2004-2009 STRATEGIC PLAN**

Summer 2004 Distribution

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# 1. BACKGROUND

Over the last 10 years, a record number of single-parent families have entered the child welfare system because of the mother's substance abuse. Several elements must be present in order to address this problem (Azzi-Lessing & Olsen, 1996): Services must be comprehensive and well coordinated; staff from all systems must be cross trained in other systems, to be able to understand and make appropriate referrals; practice must be empowerment-based, working toward helping families and also solving environmental issues; helpers must support the development of self-efficacy in families and individuals; policies, procedures and agreements among systems must allow sharing of needed information and methods to solve problems and overcome barriers; there must be a full continuum of services, that are family-centered and home-based for some families; women-centered services must be available, involving the participation of children in the services; and services must be individualized.

Substance abuse (including both licit and illicit drugs) can impair a parent's judgment and priorities, rendering the parent unable to provide the consistent care, supervision and guidance children need. For child welfare workers it is difficult to determine what level of functional improvement will enable a parent with substance abuse problems that have precipitated child maltreatment to retain or resume his or her parental role without jeopardizing a child's safety, particularly as relapse remains a significant possibility. With the implementation of the Adoption and Safe Families Act (ASFA, P.L. 105-89) and renewed emphasis on achieving permanency for children in the child welfare system, finding effective ways to address concurrent substance abuse and child maltreatment problems in families takes on renewed importance. (from *Blending Perspectives and Building Common Ground, A Report to Congress on Substance Abuse and Child Protection*. Washington, D.C.: U.S. Government Printing Office, 1999.)

## **What is Happening Across the Nation**

A preliminary review of alcohol and other drug issues in the States' Child and Family Services Reviews and Program Improvement Plans, prepared by the National Center on Substance Abuse and Child Welfare in July 2003, summarizes 33 state reports that have been submitted and approved and highlights the substance abuse issues included in the reports.

### ***Gaps in Services***

In general, substance abuse services were identified as an important gap in services available to families in the child welfare system. There were many occurrences of the comment that adequate treatment services were not available. Substance abuse was frequently seen as an underlying problem that was often not addressed in sufficient depth by the services provided to families in the child welfare system. In some reviews, the lack of substance abuse services was contrasted with the services most often made available, such as parenting classes and family counseling. Several reviews noted the lack of treatment services for adolescents in child welfare families. Services for children with fetal alcohol syndrome and fetal alcohol effects were

identified as lacking. Rural substance abuse needs were seen as a special concern in some states, noting issues related to inadequate transportation available to get those in need to treatment resources. Substance abuse was found to be the primary or an “included reason” for case opening in a range from 8-48% of the cases reviewed. Repeat cases were described as involving substance abusing families.

#### ***Assessment and Follow-up Issues***

References were made to needed substance abuse training in several reviews. Several references were made to the quality of assessments conducted by child welfare staff which does not address substance abuse as an underlying issue. A few reviews referred to problems with risk assessment tools that do not go deep enough in description of the substance abuse problems of the family. There was a concern in a few reviews about a lack of follow through when assessments are done and referrals to treatment are made.

#### ***Strengths related to Addressing Substance Abuse Issues***

Recent collaborative work with substance abuse agencies was seen as a strength in some reviews. Family drug courts were seen as a strength in some states and as a tool that ensures treatment services and closer monitoring of clients. One state reports a recent allocation of state general funds to reduce the waitlist for treatment access for the child welfare population.

#### ***Other Issues***

References were made in a few reviews to barriers to treatment above the levels authorized by gatekeeper contractors or Health Maintenance Organizations. Differences of opinion were noted in a few reviews between child welfare services, alcohol and other drug, and courts on reunification timing in substance abuse cases. Judges see termination issues differently in substance abuse cases, and differences were noted in perspectives on the time needed for treatment success and reunification vs. Adoption and Safe Families Act (ASFA) guidelines. One review noted that access to substance abuse services was cited by child welfare workers as an exception to filing for termination of parental rights under ASFA timelines. In a few reviews, there was some recognition that kin placements and biological parents may both have substance abuse problems.

#### ***Summary of 18 Program Improvement Plans***

Training was emphasized, along with a need for new competency-based curricula on substance abuse issues in some states. Specialized teams were seen as needing to include substance abuse workers. A general commitment was stated to improve the flow of information. A need to address premature closure of cases that involve substance abuse and develop clearer decision rules was discussed in one state. An in-depth needs assessment survey was described as needed to determine the extent of missing substance abuse services. One state developed a separate goal statement to improve practice related to chronic neglect and substance abuse cases, mentioning the need for technical assistance from the National Center on Substance Abuse and Child Welfare (NCSACW).

### **What is Happening in Virginia**

As a result of a successful collaborative application to the National Center on Substance Abuse and Child Welfare (NCSACW) submitted in early 2003, Virginia has received in-depth technical assistance on improving outcomes for substance-affected families that are involved with the child welfare system and the courts. Virginia's Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), the Department of Social Services (DSS) and the Office of the Executive Secretary of Supreme Court (OES) have partnered together to create the Safe Families in Recovery Project (SFRP). A key feature of the Safe Families in Recovery Project is assistance in developing the cross-system partnerships and making practice changes that are needed to address the issues of substance use disorders among families in the child welfare system. The two primary goals of the project are to:

- Create the necessary statewide infrastructure for improved coordination of systems. This infrastructure will draw on the strengths of local communities and facilitate the development and/or enhancement of state and local interagency partnerships to, improve child safety and parent recovery outcomes; and
- Achieve safe and timely permanency and well being for children and their families, in accordance with 1997 Adoption and Safe Families Act (ASFA), with a particular focus on families' recovery from substance use disorders, by comprehensively addressing the needs of all family members.

One of the key deliverables identified for the Safe Families in Recovery Project was the development of this coordinated, systemic interagency strategic plan, which is based on a community-driven assessment of Virginia's current system of training and service provision related to the developmental, cognitive, psychological and health care needs of the target population. The Statewide Advisory Committee emphasized that this plan must address family recovery and child safety, permanency and wellbeing in accordance with ASFA requirements. This multi-system strategic plan is organized in developmental phases which span a 3-5 year timeframe, to facilitate the expedient accomplishment of priority areas and short-term objectives, without losing the ability to focus on and plan for longer-term objectives.

This Strategic Plan is a companion document to an interagency Memorandum of Understanding between DSS, DMHMRSAS, and OES that institutionalizes the commitment to provide leadership for cross-system coordination and collaboration. Both documents are intended to serve as tools for local systems to adopt and adapt to their own communities.

The goals and objectives encompassed within this Strategic Plan are organized under the following headings: (1) Information Sharing; (2) Service Delivery; (3) Professional Development; (4) Community Development; and (5) Funding and Sustainability. Within each section, the following information can be found:

- Input from regional focus groups which were conducted throughout the state in Spring 2004;
- Recommended practices and strategies, based on research and work conducted by NCSACW; and
- Goals, objectives and high-level strategies pertinent to each focus area.

## 2. INFORMATION SHARING

Child welfare, substance abuse treatment agencies, the court system, and other state and community service providers have long struggled with how to share information in the best interest of participants served by each entity. Child welfare agencies need to have access to the most accurate and comprehensive information available to make informed decisions regarding child and family permanency. For substance abuse treatment agencies, it is imperative to create a safe context within which to foster a safe and trusting relationship with their clients. Each agency is bound by federal and state regulations pertaining to confidentiality and the protection of a client's privacy. However, the integration of service planning in order to facilitate state-of-the-art service delivery necessitates collaboration among service providers, family members, and other helping networks and therefore requires the exchange of information regarding the clients they mutually strive to assist. Ideally, this level of collaborative information exchange achieves the following objectives:

- Provides support for effective case planning,
- Honors participants' rights to privacy and confidentiality, and
- Promotes seamless interagency collaboration.

### Regional Focus Groups

In five regional focus groups conducted in Virginia in April and May 2004, the following question related to information sharing was posed to participants (a summary of responses from all five groups follows):

**What would improve communication and information sharing between agencies and organizations in your community to better serve these families?**

#### **IMPROVE DATA SYSTEMS**

- Improve the Management Information System (MIS). OASIS system is inefficient and antiquated.
- Utilize one computer system (Bristol & Washington County in process developing network health care systems in region)
- Computer system to connect all health services by Rick Boucher's office. Identify needs and will go into the computer and will connect with the provider. ONE CARE, 9th Congressional District, is the largest attempt ever to connect agencies/contacts.

#### **REMOVE BARRIERS RELATED TO CONFIDENTIALITY**

- Huge reluctance to share information between agencies, even with a signed consent of release of information form.
- HIPAA rules way too stringent.
- Updated M.O.U.'s with all service agencies within the community (Courts, DSS, Schools, etc).
- Confidentiality is too strict
- Revise confidentiality statutes for all agencies; can be traumatic to child in schools
- Federal policies and state policies; HIPPA
- Develop one release of information form so all agencies can have it. Include HIPPA information.
- Have state agencies work with AG's office to develop common release & referral forms that meet all state & federal information sharing regulations

**IMPROVE INTER-AGENCY COMMUNICATION AND CARE COORDINATION**

- Open lines of communication between agencies
- Relationships between agencies have improved. High rate of substance-exposed babies has increased communication between DSS and CSB.
- Communication and collaboration between agencies is not an issue in Norfolk. CPS cases are acknowledged as a service priority. To get access to evaluation it takes less than one week in Norfolk. There is a sliding fee scale for services.
- Intra-agency staffing is no longer done regularly because of lack of staff.
- Need better discharging planning with CPS to encourage clients to go forward with treatment.
- Have multiple agencies sign off on grants and contracts
- Need liaison between agencies
- multiple disciplinary teams; FAPT, CSA; Title IV-E separate and parents want it that way
- Too much overload for parents—more is not always better—setting people up for failure. Need to centralize our services to be most effective in one place.
- Need network & talk with one another
- Develop ongoing forum to keep providers in touch with one another
- Develop referral form that facilitates information sharing
- Communicate with agencies outside of human services including Economic Development Commission.
- Needs advisory board, forum to keep in touch with every agency. Opportunity to get together and talk.
- Referral process to include brief reason as to why they are there from that agency. Make a verbal referral, no longer excepted.
- Take referral from other agency, then contact client, call referring agency. Important to facilitate the process to get families into treatment.
- Don't send to the agency, send to a person. Agency will need liaison to respond to walk-ins.

**INTERAGENCY TRAINING**

When there is change in personnel in the hospitals, there needs to be re-training. Rate of reporting by one hospital has been reduced 50% since there was a personnel change. It is difficult for hospital personnel to report when they do not know what is going to happen on the other end. Hospitals have fear over legal responsibilities and liability in reporting. Care coordinators are manipulated by clients.

- Pamphlets and booklets
- Involve more community agencies that also work with this population
- Models & recommendations for making referral e.g. make referrals to specific person, identify liaison

## Recommended Practices and Strategies

The following table pertaining to key information sharing elements is excerpted from the ***Matrix of Progress Linkages Among Alcohol and Drug and Child Welfare Services and the Dependency Court System*** – a framework describing ten elements on which to measure the capacity of agencies to work as partners on the substance abuse needs of CWS clients. The entire document can be found on the National Center for Substance Abuse and Child Welfare's website at: <http://www.ncsacw.samhsa.gov/products.asp>

	MINIMUM/ADEQUATE PRACTICE	GOOD PRACTICE	BEST PRACTICE
<b>Information Sharing and Data Systems</b>	<p>The three systems have documented the gaps in their current client information systems and are addressing them</p> <p>AOD assessment at intake captures data about child needs among child welfare families</p> <p>Data on the overlap between child welfare families and the caseloads of other systems has begun to be available to AOD, CWS and court systems</p> <p>An interagency process has identified the confidentiality provisions that affect AOD-CWS and court connections and has devised means of sharing information while observing these regulations</p>	<p>The three systems have agreed upon information systems that track parents= referral, prior episodes in each system, progress in treatment, and family outcomes for those parents whom the agencies can regularly identify as shared clients</p> <p>Data on the overlap between child welfare families and the caseloads of other systems is consistently available to AOD, CWS and court systems</p> <p>Interagency communication protocols have been developed and are being utilized for information sharing between the three systems</p>	<p>The systems have developed and are fully utilizing information systems that can be linked to track parents through all three systems and monitor family and treatment outcomes, using data to re-allocate resources toward client and community needs and toward the most effective programs</p> <p>Overlap data is being used to redirect resources</p> <p>The systems are monitoring the outcomes of information sharing</p>

## Statewide Strategic Plan

With this guidance in mind, the following strategic planning goals and activities related to information sharing have been defined:

<b>Goal 1</b>		
<b>To improve agency policies and cross-training practices related to information sharing between DSS and substance use providers in accordance with HIPPA, CFR 42 Part 2, child welfare confidentiality requirements and Best Practice recommendations.</b>		
<i>Objective: Facilitate information sharing between local DSS offices and Community Service Boards.</i>		
<b>ACTION</b>	<b>PARTY RESPONSIBLE</b>	<b>DATE</b>
Adopt all three family drug court information release forms as a model, draft a template, and create a Virginia standard package to provide to LDSS and CSBs. Allow LDSS and CSBs to select which drug court forms best suits their practice	DSS/DMHMRSAS/CSB's and LDSS	6/05 and ongoing
Develop consent forms/templates for DSS that meets federal requirements allowing release of information to the CSB concerning postpartum, substance using women referrals	DSS/DMHMRSAS/CSB's and LDSS	9/2005
Develop consent forms/templates that meet federal requirements signed at the CSB, permitting release of information to CPS concerning postpartum, substance using women who have been reported to CPS	DSS/DMHMRSAS/CSB's and LDSS	9/2005
Evaluate use of templates and agreements for LDSS, CSBs, and courts for the development of best practices	DSS/LDSS, DMHMRSAS, CSB's	3/06 and ongoing

<b>Objective:</b> <i>Develop education model training for SA and CW related staff.</i>		
Provide HIPPA and CFR 42 training for CW staff	DSS/VISSTA	01/06 and ongoing
Provide CW and courts information sharing training for SA staff	DSS/VISSTA	01/2006 and ongoing
Revise foster care and CPS policy to address HIPPA and CFR 42 information sharing with CSBs	DSS	10/2005
<b>Objective:</b> <i>Create necessary communication mechanisms to ensure ongoing dissemination of policy updates.</i>		
Work with Child Welfare Advisory Committee and VA Substance Abuse Services Council to address cross information sharing needs and concerns	DSS, DMHMRSAS, OES	1/05 and ongoing
Identify clear expectations about how to institutionalize a collaborative effort between DSS and DMHMRSAS, via operationalization of the MOU.	DSS, DMHMRSAS, OES	8/2004 and ongoing
Establish an ongoing Interagency Workgroup - with representation from DSS, DMHMRSAS & OES - responsible for identifying, addressing and monitoring issues related to information sharing.	DSS, DMHMRSAS & OES	9/2004 and ongoing

### 3. SERVICE DELIVERY

Drug problems are not isolated, and they are usually only one of the difficulties the family is struggling with. It is clear that the designation of a "drug problem" as the issue is narrow and superficial. For effective blending of services, it is recommended that we reach well beyond typical enforcement and drug prevention strategies, for example, to proposals for fundamental restructuring of community involvement in prevention and in treatment (Weinstein, et. al., 1991). Many disciplines need to be involved, including social services, public health, mental health, education, housing, law enforcement and the courts (Wallen, 1999).

In providing integrated collaborative services, plans and services can and should be a complex interweaving of individual, family, neighborhood services of prevention and intervention. This blending opens up so many new opportunities to address the needs by building on the strengths. Bloom (1998) suggests that we must look at the whole configuration of strengths, supports and resources of the family, the social context, and the neighborhood and community environment as well as the personal, social and environmental difficulties of the individual needing services. Doing so means the challenging of sacred cows, system-specific language, traditions, institutional rigidities and categorical funding.

Parent education, family therapy, and respite care are services that also need to be considered. Family therapy and family-based psychoeducational services are effective strategies to add to traditional AOD treatment (McCreary, et. al., 1998). Although budgetary constraints for long-term child services are considerable, a larger barrier is that society does not like to think about the long-term management of drug-related child abuse, regardless of the prospects for success. Making commitment to these families means addressing the concomitant real and multiple needs (Besharov, 1996). When services are blended, the societal negative response to drug abuse is reduced by including treatment with an array of other services.

Changes in attitudes, knowledge, and skills are required of both the child welfare and the substance abuse treatment worker. These two systems must combine their perspectives to address both the mother's recovery and the child's well-being (Tracey & Farkas, 1994). Many of the interrelationships of the wide variety of service settings (child protection services, primary health care providers, social service settings, legal system, vocational rehabilitation systems and employment settings) encountered by substance abusers were studied by Rose, et. al. (1999). Their analysis identified the same challenges and barriers to the current system of service, and suggests areas for development of nearly identical "best practices".

With the effort to collaborate and blend service delivery to families, good case management becomes more than just seeing that the case plan gets written and implemented. Case management, when done in a collaborative and intensive manner, can greatly improve success measures for treatment success and post-

treatment maintenance (McLellan, 1999; Greenfield, 1997). With intensive case management, individuals and families receive more, and a wider variety of, services while in treatment than do people without case management. That increase in services can result in improved outcomes following treatment. Use of AOD can be reduced significantly; furthermore, people are more likely to show improvement in employment, family relations, emotional and health functioning, and legal status. A new title for case management might be "service coordination". This title more accurately reflects the roles and responsibilities of someone in this relationship with a family. Helping the providers coordinate their services, so as to be complimentary and appropriate, is a difficult task. It takes someone who can help bridge the differences among the various systems and phase the services so that they are not delivered at the same time.

Resnick (1998) outlines many of the elements of community- and neighborhood-based components and services to succeed. First of all, the services should be for the family, not just an individual. They must be comprehensive, and clearly be focused on positive outcomes. Foster care, if needed, should be part of the constellation of neighborhood supports, with the children placed for short term in the neighborhood. The community should focus on increasing the protective factors, decreasing the risk factors, and building child and family resiliency. Families should be fully involved as partners. The effort should be community-wide.

## Regional Focus Groups

In five regional focus groups conducted in Virginia in April and May 2004, the following questions related to service delivery were posed to participants (a summary of responses from all five groups follows):

**What challenges and opportunities do you see for the implementation of:**  
**b) Uniform screening for substance abuse by child welfare workers and for child safety by substance abuse clinicians?**

### **CHALLENGES**

- Concern about adding another tool and how much time it would require.
- All wonderful ideas, but the "system" (DSS, Courts, CSB) are all strained to the limit, can't take any more demands. Caseloads already overloaded and expecting more.
- Concern that current therapists/counselors are not reporting children alleged to be abused by clients who abuse substances because they are afraid to get involved or break that "therapeutic" relationship with the client.
- Assessments are insidious, not being used and reviewed properly.
- Screening is fine, but then what do you do with the information?
- Lack of understanding of child welfare system and other systems (MH, SA, and Courts ).
- Lack of understanding of what the agencies can and cannot do.
- Lack of understanding of child safety issues.
- Lack of knowledge on child welfare/safety issues and substance abuse issues.
- Buy-in from all agencies (DSS, MH, Schools, Courts, etc).
- A contrary view was expressed about the ability of mental health professionals to recognize substance issues and child safety issues with their clients. They do not have the training or the interest in addiction issues. Also, child safety is not taught in graduate schools. There is a lack of real experience in graduate schools. There is an ivory tower approach to training. There is a major need for cross training.

- At the Summer Addiction Institute, rarely do mental health professional or social services personnel participate. Scholarships are now being provided to get criminal justice professionals to attend.
- From the perspective of the social services agency staff: child welfare workers do need training on substance abuse. It is difficult for some child welfare workers to understand why addicts do not just stop using drugs when they have lost their children to foster care and getting treatment is necessary to get their children returned. Why isn't the loss of their children enough to get their attention?
- There is a discomfort with social services personnel identifying substance as a problem with a client.
- Joint service/treatment planning used to be conducted more frequently in these localities, but has been cut back severely with the budget cuts of recent years.
- CWS lack screening tool
- Concern that could lead role confusion & interfere with collaboration i.e. who does what; assuming other disciplines area expertise.
- Do not have a specific tool – information comes from information received. Everyone is now an informant.
- MH/DSS will second-guess each other. Can create problems between workers and families. Leave testing to medical professionals.
- How will the effect the counselor/client relationship if they report to DSS? Do not know if CSB training issues. Not clear-cut on abuse.
- Court tends to trump CSB recommendations. Does not have time to apply for drug court grant. How judges participate in family courts.

#### **OPPORTUNITIES**

- Adopting a “screen out” versus “screen in” approach: Norfolk J&DR Court views that every child has substance abuse problems, and then screens them out if they don't.
- If possible, specialize the social workers in a specific area; might be possible in large urban areas, but not rural DSS offices.
- Collaboration among all agencies
- Integration of services where all service needs can be met.
- Reduce the duplication of services.
- Joint treatment planning only goes on informally. It would be helpful for social services and the csb to meet together more frequently. CSB does ask for a copy of the foster care plan. The plan helps to answer: How long should residential treatment last? How intense is the treatment regimen that is required by the court? There are many case management issues to address.
- Need to address legal and professional jargon that is used by and between agencies and parents.
- One example of a discharge planning meeting was discussed where all of the parties were present. The CSB case manager brought everyone together: providers and client. This was seen as very beneficial to the agencies and the ultimate positive outcome for the client who had been in the service system for a long time.
- Having structure; legal issues being shared; Cost; Family Support Program
- Have screening and services in place to assist clients; signed releases; confidential
- Have trainings between agencies; turnover of key staff; train with investigators
- CWS need education & training re: screening
- Need self assessment tool clients can use
- SA providers need training re: reunification, family intervention, need to report abuse & neglect, getting comfortable exploring issues with families
- Difficult SA providers screen for child safety when don't see child; need guidance re: how to conduct
- Resource is hospital labs for interview (long-term 72 hour)/drug screens.
- Needs lots of training and talking to understand substance abuse. Learning curve that has to occur.
- Opinions of CPS workers have changed. Would like to do screenings in the field. Staff is more receptive. Possibility of role confusion. Affect quality of agency collaborations.
- Client may take assessment easier with CSB rather than DSS. DSS is looking for social workers to look at substance abuse in families in assessments/investigation. 90% of DSS cases involve substance abuse.
- CSB doing child safety screenings. CSB not present in homes to observe behaviors. Kids may disclose information. Has good relationship with DSS.
- CSB is more knowledgeable in substance issues. Need to coordinate more effectively.

- Develop best practices for events throughout the state.

### **THINGS TO CONSIDER**

- All child welfare workers should screen children for substance abuse exposure and/or all substance abuse treatment workers should screen all children for child welfare issues.
- Assessments are just that: unless you have proof, the family has the right to deny the services.
- From the perspective of the CSB: Hampton/Newport News Mental health counselors are trained to identify child safety issues. There is good on-going communication between the department of social services and the csb.
- There is no need for a uniform screening instrument - plenty of empirically based instruments available.
- Drug use is not clandestine in this area. Recognition of drug use is easy in the Hampton/Newport News area. What to do about it is the challenge.
- Agencies do share plans based on needs of clients.
- Probations officers were doing SA screenings–need tool that would identify at risk
- DSS workers initially responded re: SA testing. Seem assume screening means testing!!) Now okay with testing, see need; more comfortable doing it
- Now have a 5-question cache to CPS policy effective July 2004.
- Training on how to do simple screenings now going on.

**What challenges and opportunities do you see for the implementation of:**

**b) Joint treatment planning protocol where substance abuse clinicians and child welfare workers jointly develop a family treatment plan?**

### **CHALLENGES**

- Services lacking in rural areas ....no substance abuse treatment or specialized social workers.
- Time! CSB performance standards require certain activities – may not allow time participate in meetings.
- CSB's need for billable hours reduces time staff available to collaborate
- Volume & serious nature of problems require more staff
- Need less paperwork – not more!
- Attitudes
- Case load size
- Time studies prove that all agencies need additional staff. No more studies. Need the time for clients.
- Time – state implements work on computer and in office rather than working with the family.
- Time-difficult to be responsible for hours of direct services to clients. Need more staff to collaborate with other agencies.
- Support – Performance Standards becomes priority. Direct billable hours take away from collaborative. Has impact on quality of services provided.

### **OPPORTUNITIES**

- Might need joint case management to be mandated.
- If there is a protocol, there needs to be structure and support.
- We know that coordinated treatment works.
- Fewer turf issues these days, because we are all swamped.
- FAPT teams; structured risk assessment tool; educate the judges and county attorneys
- Need model for collaboration!
- How to streamline work more effectively. Model Program.
- Education in joint protocol – communication to promote MH and DSS.

## Recommended Practices and Strategies

The following table pertaining to key service delivery-related elements is excerpted from the *Matrix of Progress Linkages Among Alcohol and Drug and Child Welfare Services and the Dependency Court System* – a framework describing ten elements on which to measure the capacity of agencies to work as partners on the substance abuse needs of CWS clients.

	MINIMUM/ADEQUATE PRACTICE	GOOD PRACTICE	BEST PRACTICE
<b>Daily Practice: Client Screening and Assessment</b>	<p>Joint policy on decision-making regarding screening and assessment and impact of results on removal/placement decisions</p> <p>Jointly developed risk assessment includes a formal review of parents= and children’s AOD needs which is recorded for all clients</p> <p>Issues of culture and gender are included and appropriately addressed in the assessment process</p>	<p>AOD workers have been out-stationed at CWS offices and dependency courts for screening and assessment or contracted staff have been assigned screening and assessment roles for CWS parents</p> <p>Joint case assessments and plans have been developed with CWS parents with substance abuse problems</p>	<p>Screening and assessment roles have been negotiated with clarity among all three systems about which system will perform each, using tools that have been revised and refined based on interagency discussions of how best to detect and follow up on substance abuse problems</p> <p>Jointly developed quality assurance mechanisms have been implemented for interpretation of assessment information</p>
<b>Daily Practice: Client Engagement and Retention in Care</b>	<p>Systems have begun Adrop-off mapping@ of the points at which parents are not responding to referrals and not complying with treatment requirements</p> <p>Systems have agreed on procedures for cultural and gender specific approaches to outreach for parents who miss appointments</p> <p>The issue of relapse has been identified as a major area needing clarification between the two agencies and the courts, and discussions are under way to negotiate a consensus on shared outcomes that reflects both child safety and recovery goals</p> <p>Dependency courts understand that they have a role in monitoring compliance with court orders for treatment and case plans</p>	<p>Staff have been trained in motivational interviewing and/or other methods of engaging and retaining parents in treatment</p> <p>Programmatic responses have been put in place to improve family participation/completion rates</p> <p>Systems understand and are responding to how AOD issues and treatment requirements of families interplay with CWS and court requirements</p>	<p>Client relapse typically leads to a collaborative intervention to re-engage the parent in treatment and to re-assess child safety</p> <p>Systems are monitoring and responding to how compliance with case plans and requirements is resulting in changed behavior</p> <p>The three systems have agreed upon how aftercare will be monitored and what are the desired long-term outcomes of treatment as they affect children and families</p> <p>Efficient case management and outcomes monitoring tools are in place that enable tracking the progress of individual clients as well as the effectiveness of the whole system that deals with substance abusing parents in the court system</p>

<p><b>Daily Practice: Services to Children of Substance Abusers</b></p>	<p>Systems are taking a developmental perspective to addressing needs of children of substance abusers in their own system</p> <p>Each system is ensuring that children and youth are being assessed for their own AOD use</p> <p>Issues of culture and gender are incorporated in service delivery and programs for all children</p>	<p>Each system is ensuring that children and families are linked to specific programming for family treatment and children of substance abusers prevention and intervention services</p> <p>Independent Living Programs include AOD prevention and intervention programs for youth</p>	<p>All children involved with CWS receive developmentally appropriate interventions to address their status as a child of a substance abuser</p>
<p><b>Joint Accountability and Shared Outcomes</b></p>	<p>Each system has their own outcome measures with recognition of overlapping issues</p> <p>Some shared outcomes but systems feel primarily accountable for their own measures of success</p>	<p>Systems use outcome criteria in their contracts with community-based providers (who serve CWS-AOD parents) to measure their effectiveness in achieving shared outcomes</p>	<p>The child welfare agency has accepted shared accountability for recovery outcomes for its clients and the treatment agency has accepted shared accountability for child safety for the children of its clients and the court has accepted responsibility for monitoring the outcomes for children and families in the court system</p> <p>All three systems have accountability for safety, permanency and well-being outcomes for children and families</p> <p>Systems use summaries of outcome data from across the three systems to inform policy leaders and community on progress against consensus benchmarks</p>

<p><b>Working with Related Agencies</b></p>	<p>Recognition by all three systems that families have a variety of co-occurring needs</p> <p><u>Core clinical issues</u>—mental health, family violence and trauma</p> <p><u>Concrete support services</u>—income support, employment training, transportation, housing and child care</p> <p><u>Other needed supports</u>—primary health, HIV/AIDS, education, dental services</p> <p>Staff are aware of how to identify and link families with the other services that are frequently needed by AOD-CWS involved parents and make referrals to those agencies</p> <p>Parent education courses for substance-involved child welfare parents include significant content on alcohol and drug issues</p>	<p>Staff are assessing and addressing children and parents= needs as barriers to family recovery</p> <p>The three systems monitor receipt of services</p> <p>Parent education courses are formally evaluated for their impact on parenting practices</p> <p>The three systems have developed a case management role of mentoring and facilitating engagement in and delivery of services</p> <p>The three systems coordinate with law enforcement and corrections agencies and criminal courts to meet the needs of parents and their children affected by the criminal justice system (e.g., visitation and treatment while parents are incarcerated)</p>	<p>All three systems are evaluating outcomes of services provided to families and are routinely monitoring the effectiveness of services</p> <p>A fully collaborative process exists across systems with the resources needed by parents with substance abuse problems, including screening, assessment, follow-up, and joint advocacy for the added resources needed in each system to adequately serve families who have co-occurring problems affecting their parenting, family stability, and risks to children</p>
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## Statewide Strategic Plan

The following services and sub-populations were identified as priorities within the target population:

<p><b>Substance abuse and mental health treatment services for caregivers whose children are in child welfare system (child protective services, foster care, family preservation, family support/stabilization)</b></p>	<p><b>Developmentally appropriate substance abuse, mental health, prevention and early intervention treatment services for youth in child welfare system</b></p>
<ul style="list-style-type: none"> <li>● Integrated substance abuse and mental health assessment services</li> <li>● Detoxification: Social/outpatient/Inpatient</li> <li>● Crisis stabilization</li> <li>● Transitional services after detoxification</li> <li>● Case management services</li> <li>● Outpatient treatment including Motivational Enhancement Therapy             <ul style="list-style-type: none"> <li>○ Individual/Couples/Family</li> <li>○ Group (including gender specific)</li> <li>○ Psychiatric assessment and medication</li> <li>○ Intensive outpatient</li> </ul> </li> <li>● Medical care for substance-related problems</li> <li>● 12 Step and other support groups</li> <li>● Psychoeducational services e.g. parenting, self sufficiency &amp; home management skills</li> <li>● Domestic violence services</li> <li>● Opiate replacement therapy</li> <li>● Residential treatment (including family-centered)</li> <li>● Aftercare services</li> </ul>	<ul style="list-style-type: none"> <li>a) Targeted prevention and early intervention services             <ul style="list-style-type: none"> <li>● Indicated population</li> <li>● Prevention services (Group and individual)</li> </ul> </li> <li>b) Comprehensive continuum of treatment services             <ul style="list-style-type: none"> <li>● Integrated substance abuse and mental health assessment services</li> <li>● Crisis intervention and stabilization</li> <li>● Detoxification services</li> <li>● Outpatient treatment</li> <li>● Individual/Group/Family</li> <li>● Psychiatric assessment and medication</li> <li>● Intensive outpatient treatment</li> <li>● After school day treatment</li> <li>● Day treatment</li> <li>● Therapeutic foster care</li> <li>● Group homes</li> <li>● Residential treatment</li> </ul> </li> <li>c) 12 Step and support groups</li> </ul>

<b>Goal #1: Implement uniform screening for substance use disorders in parents whose children come into contact with the child welfare system and for safety of children whose parents enter substance abuse treatment.</b>		
<b>ACTION</b>	<b>PARTY RESPONSIBLE</b>	<b>DATE</b>
1) Select instruments and define protocols <ul style="list-style-type: none"> <li>• DSS to identify child safety screening tools</li> <li>• DMHMRSAS to identify age appropriate substance abuse screening tools</li> <li>• Determine necessary protocols related to screening process (e.g. timeframes, screen-out vs. screen-in approach, etc.)</li> </ul>	DSS, DMHMRSAS	9/04
2) Train staff <ul style="list-style-type: none"> <li>• All child welfare workers <ul style="list-style-type: none"> <li>○ CPS and foster care mandated VISSTA courses</li> <li>○ CPS policy and foster care policy new worker training</li> </ul> </li> <li>• All substance abuse service providers <ul style="list-style-type: none"> <li>○ Virginia Summer Institute for Addiction Studies</li> <li>○ CSB new staff orientation</li> <li>○ CSB in-service training</li> <li>○ DMHMRSAS sponsored trainings and conferences</li> </ul> </li> </ul> <p>Cross-training between local CSB substance abuse clinicians and DSS CPS and foster care social workers</p>	DSS Virginia Institute for Social Service Training Activities (VISSTA) DMHMRSAS Mid-Atlantic Technology Transfer Center (MATTC)	7/06 and ongoing
<b>Goal #2:</b>		
<b>Provide integrated substance abuse and child welfare services to families affected by substance use who are involved in the child welfare system</b>		
<i>Objective: Establish a joint protocol between local CSB and DSS offices for streamlined service planning, in which the DSS worker and CSB staff collaboratively discuss service goals prior to the development of an integrated, consumer-driven treatment plan.</i>		
<ul style="list-style-type: none"> <li>• Establish a workgroup subcommittee responsible for identifying and addressing service delivery needs for the target population, with the following representatives: <ul style="list-style-type: none"> <li>○ Child welfare – front line social worker, supervisor, manager, local DSS director</li> <li>○ MH- child clinician, manager</li> <li>○ SA - adult clinician, manager</li> <li>○ CSB - Executive Director</li> <li>○ DMHMRSAS</li> <li>○ State DSS – both CPS and foster care</li> <li>○ DSS attorney</li> </ul> </li> </ul>	SFRP Executive Team, Facilitator	9/04
<ul style="list-style-type: none"> <li>• Meeting to develop protocol and finalize draft</li> </ul>	Workgroup, facilitator	11/04 – 2/05
<ul style="list-style-type: none"> <li>• Provide trainings and disseminate information regarding model protocol through:</li> <li>• State DSS regional policy trainings, DSS Directors meetings, Virginia League of Social Service Directors, VISSTA trainings, VACSB SA and MH Directors meetings, VACSB meetings, VACSB Child and Family task force on-line training, MATTC trainings, VIPACT trainings, VADAP regional trainings, Annual Supreme Court training for judges, Regional judges meetings, State Court Improvement Project, VSIAS, DMHMRSAS sponsored trainings</li> </ul>	DSS/VISSTA, DMHMRSAS, Workgroup members	9/05 with rolling implementation
<ul style="list-style-type: none"> <li>• Local self-evaluation of implementation process</li> </ul>	DSS/LDSS, CSB's, DMHMRSAS, Workgroup	1/06

## 4. PROFESSIONAL DEVELOPMENT

When either a child protection worker or a substance abuse treatment provider is working with a client, it is sometimes difficult to know when to bring in the other agency. A key factor in assuring that both substance abuse and child protection issues are addressed is making sure that workers (from both agencies) are trained to look for and identify both problems in families served (U.S. Department of Health and Human Services, 1999). Successful cross-disciplinary training efforts include involving professionals from all involved disciplines early in the process; implementing needs assessments to assure curricula address the needs of the target populations; employing intensive outreach and recruitment of potential trainees; and involving both management and line staff.

With the passage of ASFA, cross-disciplinary training curriculum must include information about ASFA timelines, how decision-making timeframes have changed, and the implications for practice and treatment. It also might include effective parenting and family interventions, engagement and retention of clients in treatment, relapse management, and post-treatment support.

### Regional Focus Groups

In five regional focus groups conducted in Virginia in April and May 2004, the following questions related to professional development were posed to participants (a summary of responses from all five groups follows):

**In terms of training, what do you need in order to more effectively serve substance affected families involved in the child welfare and Court systems? Please include your thoughts about content, training venues, and levels that various disciplines should be able to access.**

#### **AUDIENCE-SPECIFIC**

- Train faith based community
- Training for CSB for Child Welfare Safety Assessment, simple screenings have been modified.
- CSBs need to know what social services needs from them
- CSBs need know how to recognize abuse & neglect; when to report, health/safety issues
- Administrators & supervisory staff need separate training re; program development & implementation. Don't just train line staff
- GALs need training on understanding the dynamics of substance abuse.
- Schools need to be more involved; included in training
- Basic SA info for CWS
- Training re: the different drugs (DSS)
- How to recognize a meth lab (DSS)
- Need to include parents' attorneys in training, not just guardians ad litem for children. Parents' attorneys need to understand there is a time to advocate with their clients that the parents cooperate with treatment and change their lifestyles and not just fight the system.
- Parents and sometimes the agencies need help understanding what the implications are of orders entered by the courts in these cases. It can be difficult to understand what court orders mean.

- Schools should be informed and collaborate with boards.
- Training for faith-based community for substance abuse.

### **VENUES**

- Availability of in-service, on-site training and self-directed training.
- Provide on-line training
- Provide cross training – like opportunity get together
- Venues – on-line tutorials for recognition of child abuse reporting. Need for mental health professionals. They are not expensive, not a lot of downtime.
- Want to get out and see people for formal exchange of information.

### **PROJECTS/RESOURCES IN PROGRESS OR IN PLACE/OPPORTUNITIES**

- Louisa is developing a best practices court (J&DR Court) that encourages people and agencies to work together. Works with court staff, sheriff office, Guardians ad Litem, Social Workers. They have only met once so far.
- Hampton/Newport News CSB is a training site for students working toward a Masters in Social Work. There used to be stipends for students to support this training at the CSB. The money for stipends is gone, but there are still unfunded slots.
- There are resources to do this training through the consortium for substance abuse training. The Summer Institute has been quite successful. The expertise is out there. Jack Mallory invited those present to work with him to develop training and be a part of this effort. Martha Kurgans has suggested that the Summer Institute in 2005 be focused on training to support the SAFIR Initiative.
- The focus of the 2004 Summer Institute is on treatment of adolescents. Website: Mid-Atlantic Addiction Technical Transfer Center. There are all kinds of online training opportunities through this organization.
- There is good collaboration in Norfolk on these issues. As an initiative of Project Link there is an implementation team in Norfolk. The Community Agency Network has conducted training. Va. Beach also has this resource.

### **CONTENT**

- Encourage taking VISSTA course on “cross-training.” Maybe mandate taking the classes.
- Needs to be a unified understanding in comprehensive training about substance abuse addiction (from identification and assessment to understanding the recovery process).
- Training also needed for SA clinicians regarding court reports. They have horrible reputation for not submitting timely reports to courts or DSS.
- Training is needed for all systems (Foster Care, Child Welfare, Courts, SA) to understand each others’ mandates, missions, and limits.
- Family counseling is also needed for everyone.
- Training in child well-being and child safety needed for substance abuse clinicians.
- S/A training (basic and specific to women and children)
- Motivational interviewing
- Mandated uniformed training (MH and Child Welfare. Courts) on aspects of family dynamics, child safety and substance abuse.
- Cross agency training
- There needs to be mandated training on substance abuse for child welfare workers. There is a 2-day VISSTA training on substance abuse, but it is just a general overview. There needs to be training on a combination of issues that present themselves with clients involved in substance abuse. Examples: Why don’t addicts just stop? DSS workers just do not understand this. This training should be developed under VISSTA, so there is no cost of training for the staff.
- There needs to be joint training between dss and csb. This is a good use of money.
- Cross training; need to know about child welfare people need; reporting information
- State definitions of child abuse
- Examples of model programs
- Impact on kids of parental SAL Long term effects sub exposure?; What to look for in kids
- Agencies have different terminology – need to learn each other’s language & what means

- Agencies need to learn more re: services other agency provides & how they are provided. Once knowledgeable, yearly update mtg btw agencies could be effective way keep them informed
- Training needs be competency based.
- Substance Abuse issues not a lot of information is available. What should you look for in Methadone? Long-term effect? OxyContin/Methadone access to information.
- Training in street names of drugs, drug screen, basic information for drug courts. What to look for.
- Teach how to recognize meth labs and drugs.
- Introduce national programs for substance abuse - gender specific, best practices, MET.
- Know what DSS/CSB does, how they are funded, procedures for investigation, interviews, assessment as they are always changing.
- Define all terminology between agencies.
- Yearly update meeting to define jobs.
- Competency-based training. Expectation to learn something and then apply it.

#### **CONCERNS ABOUT CURRENT TRAINING SYSTEM/RESOURCES**

- Concern given about VISSTA trainers (some really good.....some really bad), training too basic. FAPT teams can go for free, but are not attending these trainings.
- Concern stated again that the training needs to understand the huge differences between urban and rural services (quantity, quality, cultural).
- Agencies do chase IV-E funds for training purposes, but these funds only go so far.
- Is information about the Summer Institute given to child welfare workers? How does the information get to those who need this training?
- The dissemination of information about training opportunities to those who can benefit from them is a longstanding problem.

#### **IDEAS/CONCERNS ABOUT INFORMATION DISSEMINATION REGARDING TRAINING**

- Communication needs to be a two way street; outreach people needed
- identified person go out to work with courts and other agencies; additional staff
- Liaison to work with youth, etc. (all use the same procedure to get help)
- Contact person at each facility i.e. liaison would facilitate referrals, information sharing etc.

<p><b>What can state agencies do to encourage/support local staff to participate in training and education activities?</b></p>
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#### **TIME RESOURCES**

- Lighten up on reporting requirements.
- Most people do not have a 2-3 day lump of time to spare
- Reduce caseloads and time is an issue; have trainings more local not staying overnight

#### **FUNDING RESOURCES**

- Collaborative funding (funding now is too strict and focused) to allow collaborative efforts.
- Training funds to support attendance at trainings sponsored by others e.g. VISSTA funding restricts training to certain staff; could open it up if additional \$\$\$s provided

#### **STAFFING RESOURCES**

- Increase staffing levels (more \$\$\$ needed).
- guidance re: use of funds, services, model programs, streamline policies which interfere with providing services e.g. reduce paperwork, adjust caseload expectations, hire more staff
- State should set standards for reasonable case loads

#### **MOTIVATION/INCENTIVES**

- Probation officers have so many issues they need to address that substance abuse training is not a high priority. When there was money to be made in serving substance abuse clients, lots of probation officers were getting this training.

- Providing continuing education credits thru the Dept. of Health Regulatory Boards for the various professional licensees would encourage people to participate in training.
- Increased compensation for staff who are cross trained & offer dual services
- Provide food & amenities at trainings i.e. make it comfortable & enjoyable
- Mandate certain training
- Provide CEUs for the different disciplines
- Mandated training can be good, but for older employees they may need something else.
- Offer stipends for lodging, meals, and tuition.

#### **CONTENT/KNOWLEDGE RESOURCES**

- The State needs to provide free, meaningful, interagency, local training.
- Response: This training is available now! The problem is coordinating it. Assistance is needed from staff with the desired expertise to develop meaningful trainings. There is money to do the training. Jack Mallory indicated that he needs people to work with him to present trainings on topics that are identified as needed. Example: Motivational interviewing training is available at no cost and has recently been presented in this area.
- Line staff needs to be more involved in competencies, needs, trainings.

#### **ACCESSIBILITY**

- The problem is with paying for training not with the release of employees for training. Licensed professionals have continuing education requirements to meet, so they pursue training. However, there needs to be good planning at the supervisory level to get employees to training.
- Done by people in the local area to speak to policies that pertain to their area
- Reach out to the local agencies and get training out there and still possibly get CEUs
- Provide trainings in Abingdon! Need recognize burden of geographical distance – time away from agency & travel resources
- Make use of teleconferencing; utilize other agencies teleconference resources
- If mandate trainings will need to offer them more frequently!
- Adjust direct service hours requirement so don't get in way of training
- Recognizing geographic locations. Expensive time away from the job.
- Teleconferencing, respect with time and money in utilization of agencies with conference equipment.

#### **NEEDS ASSESSMENT**

- Determine core competencies
- Involve staff when developing training needs
- Look at both experience and expertise when developing training; staff have different training needs

#### **CONCERNS/BARRIERS/GENERAL COMMENTS**

- DJJ has a 2-hour requirement for continuing education of its staff per year. LAUGH.
- Social Services: While there is money available through Title IV-E for training, coming up with the 25% required local match is a problem.
- Lack of information on training by dss and csb is not their problem.
- Do you mandate or test (pre-post)? If mandated will have to offer more times.
- Is the training important?

#### **SUGGESTIONS**

- Include pre and post tests in trainings
- Provide positions in each community to coordinate training and/or focus on collaboration issues
- Encourage field trips btw agencies
- VISSTA training, open to CSB's. CSA needs funding to go to VISSTA.

## Recommended Practices and Strategies

The following table pertaining to key professional development-related elements is excerpted from the **Matrix of Progress Linkages Among Alcohol and Drug and Child Welfare Services and the Dependency Court System** – a framework describing ten elements on which to measure the capacity of agencies to work as partners on the substance abuse needs of CWS clients.

	MINIMUM/ADEQUATE PRACTICE	GOOD PRACTICE	BEST PRACTICE
<b>Training and Staff Development</b>	<p>Commitment has been made to staff development in each system to address substance abuse and child welfare issues</p> <p>Training has begun with regular updates and a set curriculum that devotes adequate time to substance abuse and child welfare issues</p> <p>Training for parents and foster parents has begun to address substance abuse issues</p>	<p>Training has been institutionalized with regular updates and a set curriculum that devotes adequate time to substance abuse &amp; child welfare issues</p> <p>Multi-disciplinary training has been implemented</p> <p>Training for parents and foster parents addresses substance abuse issues by drawing upon parents' experience and the lessons of services to children of substance abusers</p>	<p>The three systems have engaged local colleges, universities and law schools to develop pre-service education that addresses the cross-system issues</p> <p>Systems are monitoring the outcomes of the training</p> <p>Training for parents and foster parents is treated as an equal priority to professional training</p>

## Statewide Strategic Plan

The SFRP Advisory Team identified the following educational and training goals and strategies to educate and train service providers working with families in the target population.

<b>GOAL</b>		
<b>Ensure that SA, CW and court related staff have the necessary skills and knowledge to provide comprehensive integrated services to families affected by substance use who are involved with child welfare and court services</b>		
<b>Objective:</b> DSS, DMHMRSAS & OES will provide discipline- specific and cross training to LDSS child welfare, CSB substance abuse, health care and court related staff, as follows:		
<ul style="list-style-type: none"> <li>● SA &amp; court systems training for child welfare staff</li> <li>● Child welfare &amp; court systems training for substance abuse service providers</li> <li>● SA &amp; CW training for court related staff</li> <li>● Cross training for CWS, SA &amp; court staff regarding these systems of care and coordination of services for SA families involved in child welfare and court system e.g. referral procedures, available services, policies &amp; procedures that affect services etc</li> </ul>		
<b>ACTION</b>	<b>PARTY RESPONSIBLE</b>	<b>DATE</b>
Identify additional training resources and providers	DSS/VISSTA, DMHMRSAS, MATTC, OES	9/04
Establish an ongoing Interagency Workgroup - with representation from	DSS,	9/2004

DSS, DMHMRSAS & OES - responsible for identifying, addressing and monitoring cross system training concerns and mutual training needs.  ACTION STEPS: <ul style="list-style-type: none"> <li>• Invite representatives from VDH, VISSTA, MATTC and other stakeholders to participate (as ad hoc members?) in the Interagency Workgroup</li> <li>• Seek additional representation from university, professional &amp; credentialing organizations to determine most effective &amp; expedient ways to increase other providers (both new and currently practicing) awareness and competency related to SA &amp; CW issues</li> </ul>	DMHMRSAS, OES	and ongoing
Identify funding to support ongoing training efforts.	INTERAGENCY WORKGROUP	12/04 and ongoing
Identify core competencies for DSS, DMHMRSAS & OES staff.	INTERAGENCY WORKGROUP with input from line staff	12/04
Dedicate funds and/or resources for SA & CW training	DSS, DMHMRSAS & OES	12/2004
Develop & provide staff trainings for LDSS, CSB & court related staff targeted at their respective core competencies.	DSS/VISSTA, DMHMRSAS, OES	6/05 & ongoing
Develop appropriate protocols to evaluate education and training activities	INTERAGENCY WORKGROUP	6/05 and ongoing
Provide state funded courses, workshops & training event	DSS/VISSTA, DMHMRSAS, OES	6/05 and ongoing
Develop & distribute templates to CSBs & LDDS offices they can use to develop & provide: pre-service training i.e. orientation to job; In-service training; and community / agency based training re: SA & CW	INTERAGENCY WORKGROUP	6/05 and ongoing
Identify ways to support cross system trainings e.g. co-fund training activities, make trainings easily accessible to staff from other systems, fund staff attend trainings sponsored by other systems etc	INTERAGENCY WORKGROUP	6/2005 and ongoing
Incorporate training goals and expectations into DSS, DMHMRSAS & OES planning forums; e.g. agency Strategic Plans, contracts with local offices, contracts with training providers i.e. VISSTA & MATTC, other plans that affect delivery of services etc	DSS/VISSTA, DMHMRSAS, OES	6/2005 and ongoing
Provide recommendations regarding staff competencies, skills and training that can be incorporated into job descriptions and employee work plans	INTERAGENCY WORKGROUP	6/2005
Collaborate on the development of annual, regional cross training initiatives that promote collaboration and coordination of SA & CW services.	DSS/VISSTA, DMHMRSAS, OES	9/05 and ongoing
Develop and post appropriate SA & CW educational materials on DSS, VDH, DMHMRSAS & OES web sites	DSS/VISSTA, DMHMRSAS, OES	10/05 and ongoing
Enhance the identification and treatment of substance abuse in child welfare cases and neglect and abuse in substance abuse cases through collaborative, community-based trainings.	DSS/VISSTA, DMHMRSAS, OES	12/2005 and ongoing
Encourage Virginia's institutions of higher learning to integrate SA & CW issues into their curriculums.	INTERAGENCY WORKGROUP	6/2006
Work with Virginia's professional organizations and credentialing organizations to integrate SA & CW into their respective competencies and standards of care and promote appropriate trainings	INTERAGENCY WORKGROUP	6/2006

## 5. COMMUNITY DEVELOPMENT

Children are not safe enough when we rely solely on the child welfare system to protect them. Funding levels vary from locality to locality, and even with unlimited financial resources, there is no assurance that such reliance would be effective. All stakeholders in the community (e.g. child welfare services, substance abuse treatment, neighborhood associations, religious bodies, community organizations, mental health, domestic violence, criminal and juvenile justice, family members and citizens) are responsible, and necessary, to protect children. While the child welfare system has primary responsibility for the safety and permanency goals of children and their families, all child and family serving systems, as well as the other stakeholders in the community are needed in order to assure each child is safe, healthy, happy and educated; that each family has improved their well-being.

The self-help movement is well known, well respected, and available in most locations around the country (Riessman & Gartner, 1996). These groups are composed of people who have the same problem or life experience, to support each other, provide information, and enhance skills for coping. They are self-directing, rarely keep membership rosters or information about the group itself, or data. There are also community self-help groups, such as neighborhood associations, community development corporations, and community centers. The common denominator is that all are built on self-improvement through mutual aid-of the individual, the family, the neighborhood or community.

Many people in all of these formal and informal systems recognize that working together and learning from each other would positively impact the safety of children and the well being of their families. With a change in policy and procedures for the many systems, working together in this capacity would not mean the extra time now piled on top of the heavy workloads those systems already have.

### Regional Focus Groups

In five regional focus groups conducted in Virginia in April and May 2004, the following questions related to professional development were posed to participants (a summary of responses from all five groups follows):

**What barriers are you presently encountering in your efforts to work with others in your community to address the needs of children and families in the child welfare system that have substance abuse problems?**

#### **FUNDING ISSUES**

- Lack of funding to provide substance abuse services in rural areas
- Funding is a nightmare, and funding is too focused with too many barriers to expand and collaborate with other agencies/programs.

- An identified payor for services for children and parents. When children need substance abuse treatment CSA does not pay for residential services.
- There is no parity between mental health, mental retardation and substance abuse services funding. Lobbying is needed with the insurance industry to provide parity. There is a lack of third party reimbursement for family therapy. Where is the expertise going to come from to serve these parents when there is no reimbursement for family therapy? HMO's do not pay for family therapy, so the expertise to provide this therapy is not being sustained nor developed for the future.
- Third party issues- labeling a child to get the family into services. Need to diagnose child with a payable illness. Lack of clear value placed upon for family treatment.
- Major budget cuts in CSB's – outpatient services are cut. Where are folks to go to get treatment? Where is the expertise going to come from? Aging of substance abuse counselors. What would encourage young people to come into this field?
- Lack of funding for treatment i.e. no Medicaid coverage, no insurance, limited public services
- CSB funding requirements restricts what they can do i.e. required charge sliding fee which impacts on other funding issues
- CSB – if they have Medicaid – does not include substance abuse treatment. CSB provides some services at no charge, even if Sliding Fee Scale was in place, some people still could not afford the services.

#### **SERVICE AND RESOURCE AVAILABILITY**

- Lack of services, especially for persons with substance abuse problems; for all populations, not just for people involved in the child welfare system.
- Lack of outpatient services in rural areas.
- No preventive measures.
- Lack of resources within the community to address the needs of children and parents with SA problems.
- Lack of services or resources to families who are caring for the children while the parent is in treatment.
- Lack of safe affordable housing for individuals affected by mental illness. Newport News has maxed out its housing options.
- Lack of housing is a huge issue for reunification as goal for children in foster care. For women coming out of jail, lack of emergency shelters is problem. These women end up going back to their previous environment where drug use is prevalent. There is a 7- year waiting list for Section 8 housing in Va. Beach. DV programs do not permit women who are actively using to enter shelter programs.
- Housing for families. Subsidized housing is not available for felons. 90% of clients will not qualify for low-income housing. Federal regulations prohibit convicted felons from qualifying for public housing.
- Lack of treatment resources/lack full continuum of care
- Intensity of services lacking – no inpt or extended residential
- Need more half-way house type programs; five day detox is unrealistic.
- Local detox between county and CSB; short-term detox, not extended detox services. Need a long-term detox program, not a program that is funded for the general public.
- It is all or nothing for a treatment plan. It is the half-way house program and then back home. They must deal with drugs, rehab., and home within five days. There are fewer resources and bigger problems.

#### **LACK OF COORDINATION/COMMUNICATION BETWEEN SYSTEMS**

- Lack of communication between agencies and different foci (looking only at mental health problems, or substance abuse problems, housing, etc.....not taking a holistic, comprehensive view on how they are all inter-related). Drug Court does provide that approach.
- Agencies don't understand each others' roles.
- Funding is a nightmare, and funding is too focused with too many barriers to expand and collaborate with other agencies/programs.
- Issues with confidentiality. Clarification is needed regarding what type of information can be released or shared and with whom the information is provided.
- Difficulty receiving and sharing information (Courts, Schools, MH, DSS, etc).
- Multiple providers working with same families; duplicate services

- Territorial issues btw agencies; power struggles; different ways agencies & workers do things
- Multiple providers/cultural issues. Poor families deal with several providers. Work to coordinate services with DSS and outside agencies.
- Try to designate one case manager. Prefer the mental health or someone else to be a manager and have team meetings.
- Barriers in the community turn into a power struggle/territorial issue. Some do not bring the team in. Creates confusion.

#### **STAFF RECRUITMENT AND RETENTION**

- Hard to keep qualified substance abuse treatment staff working in rural areas (poor salaries).
- High turnover of MDT (multidisciplinary teams) members. MDT's lack focus as the membership teams are in a constant state of flux because members are entering or exiting the teams on a frequent basis.
- DJJ hired 32 substance abuse counselors some time ago. DJJ staff very excited about this, but these people were fired with the budget cuts. Is this a trend? Now DJJ has to hustle for treatment for juveniles. Using IV-E money to get treatment funds for juveniles. SABER program hired substance abuse counselors, and they were all cut. Where are these professionals now?

#### **SERVICE DELIVERY AND PROCESS ISSUES**

- Difficulty in scheduling quick assessments from Community Services Boards (CSB) (sometimes takes a month for CSB to do an assessment, expensive costs for quick assessments from private providers).
- Concern that CSB assessments are inaccurate, only taking "self-reported" information.
- Issues other than SA needs to be addressed
- Dual diagnosed clients -more comprehensive therapy
- Need to get services at time of need
- Paperwork requirements to refer & get person into treatment cumbersome; timely process; clients run out of momentum
- Getting into treatment in a timely fashion
- Not able get services for sufficient period time; also need more frequent services
- Dealing with clients relapse (DSS)
- Agencies see same families over time. Get to know families intensely; workers may get over involved etc.
- No success in some treatment programs-percentages discussed; some lose custody

#### **SYSTEM ISSUES**

- Hanover Social Svcs have excellent plans with consequences, but the judge doesn't enforce them.
- Systems (DSS, Courts, CSB) don't get involved in a case until it is very serious.
- Lack of Department of Social Services (DSS) consequences; don't have the court sanctions like drug courts do.
- Pressure from CSB to do it all, serve all, but not funded to do it all. CSB tries to do all, but quantity and quality of services are lacking, and can drop. Government expects more with less.
- Court system not including the family members in the treatment plan.
- Clinician perspective: The short period of time, 12-18 months, that addicted parents have to resolve their problems before termination of parental rights is faced is too short. It takes a long time for addicts to start working on recovery. These time frames need to acknowledge the relapses that we know will occur.
- DSS response: The system needs to focus on permanency for the child in this process.
- Attorney perspective: Clinicians can help parents recognize that they must change, because time is running out with regard to the parents' opportunity to get their children returned to them by the court. Clinicians cannot communicate this, if they do not know it, so training on child dependency time frames is important for these professionals. State needs to let parents know about the cultural and legal shift in timeframes for children in foster care.
- Overly focused on SA amongst indigent population; confusion re: what SA looks like in other populations

**TRAINING/KNOWLEDGE DEFICITS**

- Staff need appropriate training
- Lack of knowledge regarding the available community resources.
- Lack of knowledge of the GAL, judge or child welfare worker concerning substance abuse and its impact on the individual, children and families.
- What will work? What will help with improvement? Southwest Virginia has high incident of OxyContin use now that it is available in generic form. Methamphetamines/prescribed drugs. Needs to be more training and information in DSS/schools, etc. Need to know what to do and how to apply treatment.

**ENVIRONMENTAL ISSUES**

- Economic impact ( job loss, lack of public transportations, limited individual income).
- Attitudes on part of community that addicts do not deserve to have their children. Need to educate the community about these issues. These negative attitudes are more prevalent towards women.
- No prior treatment is barrier to getting individuals into treatment. There is a stigma to getting into treatment within the neighborhood and culture that addicts live in. Marijuana is culturally acceptable. It is not seen as a problem that needs to be addressed.
- Social & economic factors in community – unemp, poverty
- High suicide rate in this community (Abingdon)
- Community's depressed economy encourages meth labs

**ACCESS ISSUES**

- Lack of public and private transportation. Drive usually takes 30-40 minutes to Charlottesville (closest site for services).
- Lack of childcare (costs and transportation).
- no mental health other than going to other communities
- 6-8 week waiting list at CSB
- Spanish speaking case managers needed
- Lack transportation to appointments
- DSS barriers being able to get someone in to do treatment timely. Look at private providers, if child is not receiving Medicaid, then the case goes to the FAPT to get the money. Amount of time it takes is long, needs to be started within days not weeks or months.
- Waiting lists are long and cannot get them in.
- Admission requirements/process is timely.
- Child care programs for families to use while attending meetings.

**POPULATION CHARACTERISTICS**

- Wealthy areas have huge drug problems too, just not so much with illegal drugs, but more with prescription drugs, huge denial that they are drug addicts.
- Just because parent is an addict, doesn't mean s/he is a bad parent, but drug addictions will have effect on household income, employment, housing, and health.
- The behavior pattern of denial from the individual hinders the delivery of service and treatment.
- Drug convictions preclude people from qualifying for services. With a welfare fraud conviction, a person can qualify services but not with a drug conviction. Majority of parents have drug convictions. 80-85% of parents of children in foster care have drug problems.
- If a client has no work history, it is difficult to get employment. At the women's day treatment program in Norfolk, the best job opportunities are serving in custodial/ housekeeping type jobs that have no benefits and low pay.
- Lack of employment and a living wage for these clients.
- Major barrier is that parents have not decided that they have to change.
- Client's SA behaviors & SA related problems interfere with pursuing Tx
- Knowledge of how the system works. If involved with CPS, parents know how far they can go without treatment and still meet the requirements of CPS and the courts, so that consequences are not imposed.
- Socio-economic factors: risk factors/negatives: high unemployment, housing, jobs, health.
- Cultural barriers: Society has a mixed attitude toward substance abuse. Target people most vulnerable. They resist treatment and telling the truth.

**What resources and/or tools do you feel your community needs to address these problems collaboratively, and what can the state do to help?**

### **COLLABORATION**

- Need more Drug Courts in Virginia
- Family and/or J&D drug courts.
- The Best Practices Courts in Hampton and Newport News have motivated agencies to improve collaboration. However, with termination of parental rights being an option in such a short time frame, concrete resources are needed to help parents to regain custody. Concurrent planning is being pursued in this community, but this innovative practice cannot be successful without resources in place to help parents be successful with reunification efforts.
- Advantage of Best Practice Courts: stakeholder committee is in place and meets regularly to assist court and agencies with identifying available resources.
- The Best Practice Courts program has made a big difference in Hampton and Newport News. Newport News is working a family treatment drug court.
- Juvenile–structure to require collaboration–needs of parents as well as needs of child
- Drug Court–family court–good thing: they want their children to succeed
- Increased communication btw agencies
- Collaboration btw DSS & CSBs
- CSA & CPMT structure may be effective way bring agencies together & identify families needs (CSA currently focuses only on kid) Create new similar infrastructure or use CPMT's but avoid CPMT barriers i.e. bureaucracy & phenomenal paperwork!
- Develop strong link to childcare program at state level. Need childcare with treatment program. Need policy changes because day care program cannot pay.

### **RESOURCES**

- Funding of local services and programs.
- Resources in the community aimed to keep families together while the parent(s) are in detox.
- Resource need: training of professionals with addiction issues and family therapy. Substance abuse outpatient treatment has been cut. Va. Beach has only 12 counselors for 1600 patients.
- Money –short of help due to state cutbacks and rifts –RRCSB Clinical lost 40 employees
- Adult system: need someone to provide the services, not 6 months later
- Funding cuts have caused important closing of essential programs/loss of good employees
- CSA are making \$\$ for services but CSBs are not
- Need a comprehensive prevention program; intensive that target those at highest risk
- DARE programs should be continued into middle school
- Housing and education component to be able to get job skills
- Children's services
- Transportation
- Childcare
- Need additional SA services
- Federal grants which can provide additional funding
- Medicaid funding
- Money to pay for drug screen. Money to be used, Line 829, Family Preservation.
- Reinstate Substance Abuse Programs that once were available.

### **POLICY AND PRACTICE CHANGE**

- Medicaid: Virginia is hamstringing substance abuse treatment by not funding this part of the state plan. Localities hesitant because of the required local match fund.
- Too many unfunded State mandates.
- If child is out of the home, how are services made available? Lose insurance once children are gone.

- Parents who abuse their children – Currently, it is up to localities to make this a priority service population. The State should make this a priority population. In VA. Beach parents in CPS cases are not a priority.
- Policy changes regarding DSS funded child care. DSS offices return child care funds to state because \$\$\$ aren't always used; want to use them for this population but can't even though they are eligible population.
- State can push Medicaid to pay for substance abuse clientele.
- CSA need not to be so "child focused" and be more "family focused".
- CPS not identifying substance abuse cases, both before and after ASFA timelines were mandated.
- If substance abuse evaluation is needed and the parent cannot afford to pay for the evaluation, what happens? CSB works with the parent to identify what the parent CAN pay – Project LINK does this as part of its advocacy for parents. But clients who refuse to participate in payment planning do not get services. If the goal for the parents' children in foster care is not reunification, services may not be provided. Parents need to accept some responsibility towards working to reunification.
- Make better use of Early Intervention services
- Be more proactive about identifying & addressing problems

## Recommended Practices and Strategies

The following table pertaining to key community development-related elements is excerpted from the **Matrix of Progress Linkages Among Alcohol and Drug and Child Welfare Services and the Dependency Court System** – a framework describing ten elements on which to measure the capacity of agencies to work as partners on the substance abuse needs of CWS clients.

	MINIMUM/ADEQUATE PRACTICE	BETTER PRACTICE Good pre	BEST PRACTICE Best practice
<b>Working with Related Agencies</b>	<p>Recognition by all three systems that families have a variety of co-occurring needs</p> <p><u>Core clinical issues</u>—mental health, family violence and trauma</p> <p><u>Concrete support services</u>—income support, employment training, transportation, housing and child care</p> <p><u>Other needed supports</u>—primary health, HIV/AIDS, education, dental services</p> <p>Staff are aware of how to identify and link families with the other services that are frequently needed by AOD-CWS involved parents and make referrals to those agencies</p> <p>Parent education courses for substance-involved child welfare parents include significant content on alcohol and drug issues</p>	<p>Staff are assessing and addressing children and parents= needs as barriers to family recovery</p> <p>The three systems monitor receipt of services</p> <p>Parent education courses are formally evaluated for their impact on parenting practices</p> <p>The three systems have developed a case management role of mentoring and facilitating engagement in and delivery of services</p> <p>The three systems coordinate with law enforcement and corrections agencies and criminal courts to meet the needs of parents and their children affected by the criminal justice system (e.g., visitation and treatment while parents are incarcerated)</p>	<p>All three systems are evaluating outcomes of services provided to families and are routinely monitoring the effectiveness of services</p> <p>A fully collaborative process exists across systems with the resources needed by parents with substance abuse problems, including screening, assessment, follow-up, and joint advocacy for the added resources needed in each system to adequately serve families who have co-occurring problems affecting their parenting, family stability, and risks to children</p>

	MINIMUM/ADEQUATE PRACTICE	BETTER PRACTICE Good pre	BEST PRACTICE Best practice
<b>Working with the Community</b>	<p>Community members are included in the planning and develop process</p> <p>There are beginning stages of implementing proactive responses to prevention of substance abuse and child abuse/neglect and support for families</p> <p>There is a system for community education about substance abuse, child abuse/neglect protection and reporting</p> <p>Efforts have begun to engaging faith-based communities in supporting families</p> <p>There are a variety of supports to provide mutual aid and recovery networks to families</p>	<p>Environmental data collection supports community education, e.g., Mapping liquor stores and DUI arrests</p> <p>Geo-mapping of family resource centers and other community assets has been implemented</p> <p>Program using consumer/families/graduates as active members of service implementation have been instituted</p> <p>There are community supports for sustaining sober living communities and environments</p>	<p>Sober living and transitional housing programs are linked to institutionalized funding sources</p> <p>Community-wide accountability (report cards) systems are in place and information is used to redirect resources toward highest-priority areas and most effective programs</p> <p>Community partnerships in child welfare recognize the central role of substance abuse and have shown their willingness to accept direct family support roles for substance-abusing parents</p>

## Statewide Strategic Plan

The SFRP Advisory Team identified the following goals and strategies for developing community capacity to serve families in the target population.

<b>GOAL 1</b>		
<b>Influence community behaviors, attitudes, ideas, actions, and policies and empower communities through education about the inter-relationships among substance abuse, child welfare, and public safety.</b>		
<i>Objective: Develop a formal social marketing strategy statewide, using established social marketing strategies and Memorandums of Agreements</i>		
<b>ACTION</b>	<b>PARTY RESPONSIBLE</b>	<b>DATE</b>
Identify appropriate lead entity to manage/oversee development of SFRP social marketing campaign.	Interagency Workgroup	2 <sup>nd</sup> qtr 2005
Identify funding sources to develop and implement marketing strategies (i.e., charitable contribution from ad agency, in-kind assistance in the form of staff or other resources from partnering agencies).	Lead entity	4 <sup>th</sup> qtr 2005
Develop timelines for campaign development and execution. <ul style="list-style-type: none"> <li>● Planning</li> <li>● Development - Message &amp; Materials</li> <li>● Market testing</li> <li>● Implementation</li> <li>● Evaluation</li> </ul> Integrate feedback throughout process & adjust timelines accordingly	Lead entity	Complete by 12/06

<b>GOAL #2</b>		
<b>Develop a locally managed and controlled service delivery system that collaboratively addresses the intersection of substance abuse and child welfare.</b>		
<i>Objective: OES, DSS, and DMHMRSAS will promote cooperation and collaboration among the systems through the dissemination of information regarding services and initiatives e.g. formal announcements of the expected partnerships, memos to respective local agencies, and during state-wide conferences.</i>		
<b>ACTION</b>	<b>PARTY RESPONSIBLE</b>	<b>DATE</b>
Develop implementation plan that addresses the following: <ul style="list-style-type: none"> <li>• Communication mechanisms</li> <li>• Timeframes</li> <li>• Key stakeholder mailing list for each community</li> <li>• Recognition plan</li> </ul>	DSS, DMHMRSAS & OES	02/05
Implement plan in conjunction with social marketing effort	DSS, DMHMRSAS & OES	06/05
Provide formal recognition and marketing of effective local efforts	DSS, DMHMRSAS & OES	Annually, beginning 06/06
<i><b>Objective:</b> Identify and adopt unifying philosophies across the partnering systems to create a best practice system of care.</i>		
<b>ACTION</b>	<b>PARTY RESPONSIBLE</b>	<b>DATE</b>
Research models/philosophies of systems of care addressing SA, CWS	SFRP Executive Team in conjunction with Interagency Workgroup	2 <sup>nd</sup> qtr 2005
Choose/develop most effective and appropriate approach based on research and evidence gathered in previous task.	Same as above	3 <sup>rd</sup> qtr 2005
Identify and disseminate effective culturally-sensitive models to adapt to local communities which address specific locality resource issues and share with each locality through focus groups and trainings.	Same as above	4 <sup>th</sup> qtr 2005
<b>GOAL #3</b>		
<b>Design and implement a community-level Results-Based Accountability (RBA) system to evaluate child and family well-being outcomes related to substance abuse addiction and recovery</b>		
<i>Objective: Identify desired outcomes and establish community-level accountability for achieving those outcomes through a local reporting/ evaluation system in conjunction with a state entity to receive and analyze the data.</i>		
<b>ACTION</b>	<b>PARTY RESPONSIBLE</b>	<b>DATE</b>
Identify desired results based on model selected under Goal 2.	SFRP Executive Team	03/06
Identify funding resource to conduct evaluation.	DSS, DMHMRSAS & OES	07/06
Develop evaluation plan and identify resources to implement evaluation, including data collection, measures, and reporting.	Contracted evaluator	4 <sup>th</sup> qtr 2006
Implement evaluation plan and publish results to legislature	DSS, DMHMRSAS & OES with evaluator	January 2007 and ongoing

<b>Objective:</b> Establish a sustainable entity to continue the efforts of the Safe Families in Recovery Project post-technical assistance phase, e.g., continue to have representation from each partnering agency DMHMRSAS/OES/DSS. Incorporate this Center into one of the three partnering agencies, or establish as its own entity.		
Develop purpose, mission and vision plan.	DSS, DMHMRSAS & OES	2008
Identify mechanism for funding/reallocation of resources to support the Center.	DSS, DMHMRSAS & OES	2008
Center established.	DSS, DMHMRSAS & OES	2009

## 6. FUNDING AND SUSTAINABILITY

Connecting separate agencies that serve children and families at the intersection of child welfare, substance abuse services and dependency courts involves connecting the multiple funding streams that flow into child welfare, substance abuse and other health and human service agencies serving families. The more comprehensively a continuum of care is defined in children and family services, the wider an array of funding streams are needed. The more committed an agency is to 'family-centered services', the more master is needed of all the different funding streams that can support families. No single agency has adequate funding sources by itself to achieve comprehensive outcomes; interagency funding streams are therefore critical to converting hopes for new linkages into reality.

Fiscal context always matters, and in tight fiscal climates tapping new sources of funding is both desired and resisted. It is desired for the obvious reason that hard-pressed agencies are anxious to find alternative funding streams to support their programs; it is resisted for the equally obvious reason that agencies seek to protect "their own" funding streams even more when funding is tight. (*excerpted from the NCSACW White Paper on Funding Comprehensive Services for Families with Substance Use Disorders in Child Welfare and Dependency Courts—February 2004 draft document*)

### Regional Focus Groups

In five regional focus groups conducted in Virginia in April and May 2004, the following question related to funding and sustainability was posed to participants (a summary of responses from all five groups follows):

**If you had funding to support the most cost-effective solutions to serve the needs of families with parental substance abuse in your community, which services would be your priorities?**

**INVESTMENT IN DIRECT SERVICES**

- There is a need for more creative treatment options. Residential treatment for parents is needed where children can reside with their parents while the parents get treatment. It would be less expensive to support the children living with their parents than to support the children in the foster care system.
- Increase recreation & services – provide alternatives to sub use.
- Provide respite care
- need childcare/transportation
- Anger management (can help with parenting skills)
- In-patient drug treatment.
- Project Link.
- Adolescent drug treatment.
- Services are spotty and inconsistent across counties.

**INVESTMENT IN COMMUNITY COLLABORATION**

- Possible software for joint communication
- Support Family Treatment Drug Court like programs that “wrap around” the whole family with comprehensive services.
- Allow each community to design and organize their own system, respect that the communities know themselves best and are different from each other (urban vs. rural).
- Have CSB clinician go with DSS workers on home visits.
- DSS and Project Link work closer together.
- The Hampton Best Practice Court is working with Hampton DSS to establish a supervised visitation center for children in foster care to be able to visit with their parents in a supportive environment. This will be a significant asset to this community.
- Put in each locality instead of moving to another county; traveling

**INVESTMENT IN STAFF RESOURCES**

- If you want trained social workers (with Master degrees) to stay in social services workforce, they need financial incentives. Help with paying off college loans. Most workers are working second jobs just to make ends meet; too many leaving for higher paying jobs out of the social service field.
- Specialized training for CW staff and SA providers

## Recommended Practices and Strategies

The following table pertaining to key sustainability-related elements is excerpted from the **Matrix of Progress Linkages Among Alcohol and Drug and Child Welfare Services and the Dependency Court System** – a framework describing ten elements on which to measure the capacity of agencies to work as partners on the substance abuse needs of CWS clients.

	MINIMUM/ADEQUATE PRACTICE	GOOD PRACTICE	BEST PRACTICE
<b>Budgeting and Program Sustainability</b>	Systems have begun to develop an all-funds inventory of current 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

# Statewide Strategic Plan

The SFRP Advisory Team identified the following goals and strategies for developing funding and sustaining the state's capacity to adequately serve families in the target population.

<b>GOAL 1</b>		
<b>Ensure that key funders and policy makers are well informed about the seriousness, the extent, the recommended solutions, and the funding needed to effectively address the safe and efficient adoption or reunification of children in Virginia's child welfare system, and for ensuring that adequate and appropriate prevention and treatment services are available in communities to avert legal involvement</b>		
<i>Objective: Provide informational presentations to the appropriate secretariats of the Commonwealth.</i>		
<b>ACTION</b>	<b>PARTY RESPONSIBLE</b>	<b>DATE</b>
Convene/assign presentation team(s) to develop the agenda, content and educational materials for presentations to the Secretaries and the management teams of the Secretary of Health and Human Resources, Secretary of Public Safety and the Superintendent of Public Instruction. Include discussion regarding the attached funding matrix, its possible strengths and limitations.	Executive Team/Interagency Workgroup to determine content;  Designated lead staff person from VDSS or VDMHMRSAS to organize.	4 <sup>th</sup> quarter 2004
<i>Objective: Provide informational presentations to relevant policy and advisory boards and commissions of the Commonwealth.</i>		
Same as above for the various policy and advisory boards of the Commonwealth —e.g., SASC; DMHMRSAS Board; DMAS Board; State Executive Council (SEC) for CSA, Virginia Health Care Foundation (VHCF), Child and Family Services Review Team, etc.	Executive Team to determine content;  Designated lead staff person from VDSS, VDH or VDMHMRSAS to organize.	1 <sup>st</sup> quarter 2005
<i>Objective: Dialogue with and provide information to relevant health care and social services policy committees of the General Assembly</i>		
<b>ACTION</b>	<b>PARTY RESPONSIBLE</b>	<b>DATE</b>
Same as above for the various policy committees of the General Assembly e.g., Joint Commission on Health Care (JCHC)	Executive Team to determine content; lead staff person from VDSS or VDMHMRSAS to organize.	02/05
<b>GOAL #2</b>		
<b>Gain support from policy makers through education. Provide information on current social and financial indicators as well as outcome data regarding the safe and timely placement of children and services to these families</b>		
<i>Objective: Provide brief reports and make presentations to the various target audiences described in Goal 1.</i>		
<b>ACTION</b>	<b>PARTY RESPONSIBLE</b>	<b>DATE</b>
Convene/assign a special work group sub-committee to evaluate pertinent data and identify new data needed	Executive Team; assign one member from a state	Data review and selection: Sept - Dec

to accurately assess the social and financial impact of the problem and evaluate recovery and reunification/adoption outcomes. Develop reports based on available data.	agency to serve as primary liaison.	, 2004. Data dissemination: Spring 2005.
<b>Objective:</b> <i>Develop quarterly statewide newsletter to highlight Virginia's progress, provide recognition of highly functioning collaborative projects at the local level, and provide information about training opportunities, and distribute to all stakeholders e.g service providers, policy makers, funders, etc</i>		
Convene/assign a special work group sub-committee to oversee development of the proposed newsletter. Content will highlight Virginia's collaborative efforts, including substance use disorder treatment efforts and outcomes, and the safe and timely placement of children.  Select & recruit representatives from the SFRP Advisory group to serve on this sub-committee. Assign one member from a state agency to serve as primary liaison.	Executive Team	Develop sub-committee, determine content and distribution plans: September – November, 2004.  Target date for initial publication: January, 2005
<b>Objective:</b> <i>Develop web-site that links with known state and federal agencies involved with related projects</i>		
Determine most appropriate strategic "home" for web page and assign a web master from any of the relevant state agencies to work with the Executive Committee in development of web page.	Executive Team to determine content; designated lead staff person from VDSS or VDMHMRSAS to organize.	4 <sup>th</sup> quarter 2004

## Service by Funding Matrix

The following table is intended to convey possibilities and opportunities related to funding resources for a specified service or target population, as well as actual resources that are currently in place. While every effort has been made to ensure that this matrix is as comprehensive as possible, it may not be all-inclusive, and will continue to be updated over the course of the strategic plan's implementation.

Entity(ies) Responsible to Use, or to Plan for Use of Funds, to Implement Services		Current or Proposed Funding Source(s) to Support the Services to be Delivered:
<b>Services For Adult Parents</b>		
Substance Use Disorder Screening & Assessment for Youth and Adults in or At-Risk for Child Welfare System Involvement	<u>Screening:</u> Local DSS staff; local DPH staff <u>Assessment:</u> Local CSB, or contracted private provider	<u>Agencies:</u> DMAS; VDSS, DMHMRSAS; VDH  <u>Funding Streams:</u> FAMIS; Medicaid - EPSDT; Title IV-E Administrative Pre-Placement Prevention Funding; SAPT BG; private insurance; Title IVB Subpart 1 and 2; Child Abuse Prevention and Treatment Act (CAPTA)
Substance Use Disorder Treatment Services for Youth and for Adults in or At-Risk for Child Welfare System Involvement	Local CSB, or contracted private provider	<u>Agencies:</u> DMAS; DMHMRSAS; VDSS; VDH  <u>Funding Streams:</u> MEDICAID; SAPT FBG; TANF; FAMIS; Title IV-E

		Administrative Pre-Placement Prevention Funding, Title IVB Subpart 1 and 2? CAPTA?; Safe & Drug Free Schools; private insurance
Expanded Women's Gender-Specific Outpatient Treatment Services	Local CSB, or contracted private provider	<u>Agencies:</u> DMAS; DMHMRSAS; VDSS, VDH <u>Funding Streams:</u> MEDICAID; SAPT FBG; TANF; private insurance
Expanded Women's Gender-Specific Residential Treatment Services for Pregnant and Parenting Women That Allow Children To Enter Treatment With The Mother	Local CSB, or contracted private provider	<u>Agencies:</u> DMAS; DMHMRSAS; VDSS, VDH <u>Funding Streams:</u> MEDICAID; SAPT FBG; TANF; Title IV-E Administrative Pre-Placement Prevention Funding, private insurance
Intensive Case Management	Local CSB; local DSS; local VDH;	<u>Agencies:</u> DMAS; DMHMRSAS; VDSS, VDH <u>Funding Streams:</u> MEDICAID; SAPT FBG; TANF; private insurance; Title IV-E Administrative Pre-Placement Prevention Funding, Title IVB Subpart 1 and 2? CAPTA?
Self-Help Recovery Support, plus Referral and Support for Self-Help Group Affiliation for Persons Recovering From Substance Use Disorders	Local Recovery Community (AA; NA; COA; Al Anon; Families Anonymous, etc) <u>Referrals to and Facilitative Support Provided by:</u> Local CBS; local DSS; local J & D Courts	N/A
Vocational Training & Continuing or Remedial Adult Education	Local school systems; local DSS; Department of Rehabilitative Services (DRS)	<u>Agencies:</u> DRS <u>Funding Streams:</u> state federal vocational rehabilitation funds (Section 110 of Rehabilitation Act?)
<b>Services For Children</b>		
Substance Abuse Prevention Services – Behavioral Health Inoculation; Adaptive Skill Development Training	Local CSB's prevention services; local school systems; contracted private providers;	<u>Agencies:</u> DMHMRSAS; VDOE; GOSAP; VDSS; VDH; VTSF <u>Funding Streams:</u> SAPT FBG Prevention set aside; GOSAP SDFS; VDOE SDFS; TANF; Title IV-E Administrative Pre-Placement Prevention Funding; VTSF grants
Al-Anon, Ala-Teen and Families Anonymous Support, plus Referral and Support for Self-Help Group Affiliation for Persons Who Are Family Members of a Person With A Substance Use Disorder	Local Family-Oriented Recovery Support Community (COA; Al Anon; Families Anonymous, etc) <u>Referrals &amp; Supports:</u> Local CBS; local DSS; J & D Courts	N/A
Screening for Evidence of Child Abuse or Neglect, Developmental Delays; Appropriate Nutrition	Local Pediatric Group Practices; local CSB's early intervention services; local DSS; local DPH; local school systems	<u>Agencies:</u> Virginia DSS, DMHMRSAS; VDH; VDOE <u>Funding Streams:</u> EPSDT; MEDICAID; SAPT FBG; TANF; Foster Care Funds (I need something more specific here, folks)
Early intervention services (0-3); services to promote maternal/infant bonding e.g.	Local CSBs & community early intervention programs; private	<u>Agencies:</u> DMHMRSAS, DSS, VDH <u>Funding Streams:</u> Part C Early

therapeutic infant massage	providers & community agencies	Intervention Services; SAPT FBG
<b>Services For Families</b>		
Advocacy For The Child's Interests In Court and in Agencies	CASA; SCAN; local DSS	<u>Agencies:</u> VDSS, <u>Funding Streams:</u> FSSBG; TANF;
Child Care Service For Mothers/Fathers In Treatment For Substance Use Disorders	Local DSS; local CSBs; faith based providers	<u>Agencies:</u> VDSS, DMHMRSAS; VDH <u>Funding Streams:</u> State GF; SAPT FBG – women's set aside; TANF;
Family Problem-Solving and Other Behavioral Skill Development Training to Increase Families' Sense of Self-Efficacy at Developing Appropriate Family Solutions	Local CSBs or contracted private providers; local DSS	<u>Agencies:</u> DMHMRSAS; VDSS; VDH <u>Funding Streams:</u> State GF; SAPT FBG – women's set aside; TANF; Title IV-E Administrative Pre-Placement Prevention Funding; CAPTA
Transportation for Parent & Children of Families Engaged in Services Related to Safe Families in Recovery Objectives	Local DSS; local CSBs; MEDICAID transportation providers;	<u>Agencies:</u> VDSS, DMHMRSAS; VDH <u>Funding Streams:</u> MEDICAID (to and from a Medicaid covered service only); TANF; State GF
Parenting Skills Development	Local CSB's prevention services, early intervention services and women's substance abuse services or contracted private providers; local housing authorities?; Prevent Child Abuse Virginia ; VDH programs (Fatherhood Initiative; Resource Mothers; Healthy Start; Healthy Families)	<u>Agencies:</u> DMHMRSAS; VDSS, VDH <u>Funding Streams:</u> GOSAP SDFS grants to localities; MEDICAID; TANF; Title IV-E; HUD supportive housing funds; SAPT FBG; Title V
<b>Services For Staff:</b>		
Annual Cross-Training of local Attorneys, DSS and DPH Workers in the Detection and Screening for Substance Use Disorders in Parents, Foster Care Youth, and Older Custodial Children of Parents Involved in the Child Welfare System	VISSTA; MID-ATTC; VDSS; VDMHMRSAS; VDH; VSIAS; NASW and other professional organizations	<u>Agencies:</u> Virginia DSS, DMHMRSAS; VDH <u>Funding Streams:</u> SAPT FBG; TANF; Title IV-E;
Annual Cross-Training of Local Attorneys, CSB and Private Provider Substance Abuse Treatment Staff in the Screening and Detection of Child Abuse, Neglect, Endangerment, Developmental Delays, etc., for Families Involved in Child Welfare and non-Child-Welfare Services Systems	Local Bar Associations; Local J & D Courts, with support of Office of Executive Secretary to Supreme Court; VISSTA; MID-ATTC	<u>Agencies:</u> Local Bar Associations; Virginia DSS; VDH <u>Funding Streams:</u> ???
Annual Cross-Training of Local Attorneys, CSB and Private Provider Substance Abuse Treatment Staff and DSS Workers in the Applicable Federal and State Code Requirements Pertaining to Child Welfare, Case Processing, Foster Care and Adoption	VDSS & Local DSS; Office of the Executive Secretary to the Supreme Court	<u>Agencies:</u> Virginia Office of the Executive Secretary to the Supreme Court; Virginia DSS, DMHMRSAS; VDH <u>Funding Streams:</u> State GF; SAPT FBG; TANF; Title IV-E Administrative Pre-Placement Prevention Funding
State or Local Annual Training of the Judiciary on the Nature of Addiction, Treatment and Recovery.	Office of the Executive Secretary to the Supreme Court; DMHMRSAS & local CSBs; MID-ATTC; SAARA of VA; Lawyers Helping Lawyers	<u>Agencies:</u> Office of the Executive Secretary to the Supreme Court; DMHMRSAS & local CSBs; <u>Funding Streams:</u> State GF; SAPT FBG; TANF; federal grants

<b>Services For Communities:</b>		
Annual Training for Hospital Administrators and Obstetrics Staff on the Code Pertaining to Reporting Substance Exposed Births	Commonwealth Partnership for Women and Children Affected by Substance Use; DMHMRSAS; VDSS; VDH	<u>Agencies:</u> DMHMRSAS; VDSS; VDH <u>Funding Streams:</u> TANF; STATE GF; SAPT FBG – women’s set aside; VDH funds?
Annual Training for Hospital Social Workers and Obstetrics Staff on the Procedures for Contacting Local DSSs and local CSBs to Report Substance-Exposed Births	DMHMRSAS & local CSBs; VDSS & local DSS; Commonwealth Partnership for Women and Children Affected by Substance Use; local and state-wide professional associations	<u>Agencies:</u> Virginia DSS, DMHMRSAS, VDH  <u>Funding Streams:</u> TANF; STATE GF; SAPT FBG – women’s set aside;
Publication & Promotion Of Key Social Need Indicators And Service And Court Processing Outcome Results Indicators To Assess Levels Of Need/ Scope Of Problem, and to Evaluate Progress, At State And Local Levels.	DMHMRSAS; VDSS; VDH; Office of the Executive Secretary to the Supreme Court;	<u>Agencies:</u> Office of the Executive Secretary to the Supreme Court; DMHMRSAS; VDSS; VDH; <u>Funding Streams:</u> State GF; GOSAP SDFS; possible federal grants; SAPT FBG – women’s set aside.
Incentives / Prompts For Communities To Establish And Support (Socially And Financially) Interagency Collaborative Planning & Services Teams	Safe Families in Recovery Executive Committee and Work Group; VDSS; DMHMRSAS; local government administration; local DSS; SASC; local J & D Courts	<u>Agencies:</u> Virginia DSS, DMHMRSAS; VDH  <u>Funding Streams:</u> SAPT FBG; TANF; Title IV-E;
Social Marketing Effort; Statewide With Local Components To Change Levels of Knowledge and Understanding as well as Ideas, Beliefs & Attitudes about the nature of Addiction, Recovery and the Treatment Process.	Substance Abuse Services Council (SASC); GOSAP; DMHMRSAS; VDSS; VDH; VCU Institute on Drug and Alcohol Studies (IDAS); Regional Drug Free Coalitions	<u>Agencies:</u> Virginia DSS, DMHMRSAS; VDH  <u>Funding Streams:</u> SAPT FBG; Title IV-E; TANF;
Incentives / Prompts For Communities To Serve as Models and Mentors for Other Communities Looking to Establish Their Own Family Drug Treatment Courts or Other Collaborative Process Teams.	Safe Families in Recovery Executive Committee and Work Group; VDSS; DMHMRSAS; local government administration;	<u>Agencies:</u> Virginia DSS, DMHMRSAS; VDH <u>Funding Streams:</u> SAPT FBG; TANF;
Evaluation Design and Data Collection to Inform the Evaluation of Process and Outcomes of Services and Court Processing	Universities with established evaluation expertise and access to graduate students; Safe Families in Recovery Executive Committee and Work Group; VDSS; DMHMRSAS; OES;	<u>Agencies:</u> Virginia DSS, DMHMRSAS; VDH <u>Funding Streams:</u> State GF; possible federal grants; SAPT FBG – women’s set aside; TANF;
Assess the Extent to Which Health Care Insurance is Adequately Covering Recommended, Evidence-Based Substance Use Disorder Treatment for Youth and Adults	Virginia General Assembly; SASC	<u>Agencies:</u> DMHMRSAS; IDAS <u>Funding Streams:</u> State GF

## APPENDIX A: GLOSSARY OF TERMS AND ACRONYMS

**ASFA:** Adoption and Safe Families Act

**CSB:** Community Service Board

**CWS:** Child welfare system

**DSS:** Department of Social Services

**DMHRSAS:** Department of Mental Health, Mental Retardation and Substance Abuse Services

**FAMIS:**

**FAPT:**

**LDSS:** Local DSS offices

**MATTC:** Mid-Atlantic Technology Transfer Center

**MH:** Mental health

**MOU:** Memorandum of Understanding

**OES:** Office of the Executive Secretary, Supreme Court of Virginia

**SA:** Substance abuse

**SAPT:** Substance Abuse Prevention and Treatment (block grant)

**SASC:**

**TX:** Treatment

**VADAP:**

**VIPACT:**

**VSIAS:** Virginia Summer Institute for Addiction Studies

**VISSTA:** Virginia Institute for Social Service Training Activities

# APPENDIX B: EXECUTIVE TEAM AND STRATEGIC PLANNING WORKGROUPS

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# APPENDIX B: REPORT TO VIRGINIA'S SFRP ADVISORY COMMITTEE - A COMPENDIUM OF EVIDENCE-BASED, BEST, AND PROMISING PRACTICES

*PREPARED BY KARI DEMETRAS, M.ED, CONSULTANT LIAISON*

## INTRODUCTION

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This report is intended to provide the Virginia team with information that will assist the strategic planning workgroups and the Executive Team in establishing goals and objectives for improving daily practice and creating systemic change related to families in the child welfare system that are involved with substance abuse problems – particularly those with children placed in out-of-home care. The information presented here is by no means exhaustive, and should be considered as guidance based on what is already happening in other parts of the nation, and even within the state. There is a wealth of information on best, promising, and evidence-based practice that exists, and this report attempts to capture a snapshot of that information within its narrative, as well as provide references to guide those interested in conducting more involved exploration. The report highlights practices related to collaboration and systems integration as the “first order of business”, and follows this section up with individual sections on practices related to child welfare, substance abuse, and the courts.

It should be noted that the section on the courts is the most abbreviated, for the simple reason that the majority of “best/promising practice” information related to model courts has been developed by the National Council of Juvenile and Family Court Judges, and is contained on their website, which is referenced herein. The narrative itself notes that Virginia has a significant number of model courts within its borders, and is clearly very aware of the components that characterize “best practice”.

## COLLABORATION AND SYSTEMS INTEGRATION

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*Policy Issues.* Policies must be free of punitive aspects and the personal biases of policy makers. The literature is full of tales of the most troubled families being singled out for punitive intervention, while other less troubled families, engaging in identical behaviors, are not. We are primed to see low income and low status families differently than high income and high status families. Populations believed to be the cause of most of the child abuse and substance abuse are targeted for research related to that abuse, while studies of non-abusing parenting are normally done on affluent white families. There becomes a cycle, where the bias leads to surveillance, which leads to detection, which influences research that influences policy (Colby & Murrell, 1998). This cycle of bias leading to policy must be interrupted.

Policies must support the increase in improving the health of mothers and their children through better assessments and increased treatment and other services. Policies must support the inclusion of fathers, as well. Even though single parenthood is predominantly a female phenomenon, the fathers can still be important for the intervention. Policies must address the effects and impacts of the abuse on the individuals, not singling out and targeting certain drugs themselves. It is not coincidence that the drugs being singled out as the “bad drugs” are often those being used by low-status families. Policies must address the personal beliefs and characteristics of the actual helpers and other providers of service. Team case management can best handle issues of culture, past use, and past family history.

*Increase capacity.* A review of existing data suggests that, although a high percentage of parents in the welfare and child welfare systems need alcohol- or drug-related treatment, these services are provided to only a fraction of them. Even some biological parents who receive a variety of services are not able to have their children returned to them, due to the relatively short length of the delivery of the services compared to realistic drug treatment time frames (Linares, 1998).

*Collaboration and Blending of Services.* Different systems need to resolve the separate and conflicting services they deliver to a family or individual. Purposes, goals, philosophies, time frames, staff education, funding streams, values and legal mandates all need review and consistency over the many systems in order for a continuum of services to be effective with families (Azzi-Lessing & Olsen, 1996; Young & Gardner, 1998; Colby & Murrell, 1998). These services should be from a broad spectrum of fields, including: public and private agencies, AOD treatment, mental health, health care, education, housing, vocational and employment, child welfare.

Laura Feig (1998) describes several components that need to be present in a true collaboration across systems. These components require system changes of a large nature.

- joint system training
- team staffing
- joint funding
- joint goal setting
- jointly sought treatment milestones and outcomes
- improved family risk assessments
- delivery of services as a single package
- use of a parenting focus to treatment and to child welfare services
- integrating child development services into treatment
- provide long-term services
- do prevention work with the children while the caregiver is in treatment

With the passage of ASFA, cross-disciplinary training curriculum must include information about ASFA timelines, how decision-making timeframes have changed, and the implications for practice and treatment. It also might include effective parenting and family interventions, engagement and retention of clients in treatment, relapse management, and post-treatment support. Some sources of cross-disciplinary training curricula include:

**Multidisciplinary training curricula from Children's Bureau grantees:** In 1997, the Children's Bureau of the U.S. Department of Health and Human Services issued 10 three-year grants to universities affiliated with public child welfare agencies to develop and implement interdisciplinary training curricula. The curricula were designed to enhance the capacity of public child welfare workers and their supervisors to respond effectively to child abuse and neglect, with particular emphasis on families experiencing problems related to substance abuse, mental illness, and domestic violence. The grantees (listed below) provide their curricula as a tool to other states or localities interested in implementing cross-systems training.

- Fordham University, Children and Families Institute for Research, Support and Training
- San Diego State University School of Social Work, Public Child Welfare Training Academy
- State University of New Jersey—Rutgers
- University of California at Berkeley, School of Social Welfare
- University of California at Los Angeles, School of Public Policy and Social Research
- University of Michigan, School of Social Work
- University of Southern Maine, Muskie Institute
- University of Utah—Salt Lake City
- University of Washington School of Social Work, Northwest Institute on Children and Families
- University of Wisconsin at Green Bay

**Maryland's curriculum:** Under Maryland's Title IV-E waiver demonstration program, the University of Maryland's School of Social Work provides a five-day interdisciplinary training to child welfare and substance abuse agency staff. The curriculum addresses the prevalence of substance abuse among the child welfare population; screening for substance abuse involvement; the concept of addiction as a disease, including how addiction and withdrawal affect an individual's body, behavior, and perception; the strategic use of authority to leverage parental compliance with a treatment and reunification plan; strategies for child welfare staff to work with parents in early recovery, e.g., the first 6 to 12 months; and steps for helping the parent commit to the joint goals of abstinence and safe parenting.

Contact: Ron Zuskin, LCSW-C, LCADC  
 Director of Training  
 School of Social Work  
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 (410) 706-3637

**Illinois's curriculum:** The Illinois Department of Children and Family Services (DCFS) developed the Substance-Affected Families Policy and Practice Training: The Path to Safety and Recovery to present DCFS' policy and practice for dealing with substance-affected families (SAFs) and substance-exposed infants (SEIs). The training consists of five modules directed at DCFS caseworkers and investigators, purchasers of services, personnel from the Office of Alcoholism and Substance Abuse (OASA) and Public Health, guardians ad litem, and judges. At the end of the five modules of training, participants should be able to use the SAF/SEI policy guide and protocol documents to understand how parental substance abuse affects child safety and parental functioning; determine the risk level and make a safety plan for the child, assess family needs and make a collaborative treatment plan; provide best practice clinical services during the intervention phases of the service plan; work with collaborators to provide continual evaluation of safety and treatment progress; and provide appropriate and timely case closure and aftercare plans. The five modules of the training are SAF/SEI Protocol Overview, the first 30 days—

engagement, assessment and the family meeting, family intervention, evaluating progress in placement—reunification cases, and preparing for the termination of parental rights.

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### **Content of Shared Information**

Treatment providers' progress notes and clinical files should clearly describe the demonstrable signs of treatment progress that child welfare agencies and courts can use to inform child welfare decisions. In addition, treatment providers should provide notes that correspond with key case junctures, such as the court review timelines established by ASFA. Both agencies should agree ahead of time on the format and content of updates to ensure its usefulness.

### **Confidentiality**

Agencies are searching for ways to overcome the issue of confidentiality so they can share relevant client information on a consistent basis. For instance, substance abuse and child welfare agencies may establish Memoranda of Understanding (MOUs) to facilitate information sharing. Likewise, service providers may establish Qualified Service Organization Agreements (QSOAs) to assure that either agency can share information on behalf of their mutual clients—sometimes even without the consent of individual clients—pursuant to federal drug treatment confidentiality guidelines. As an example, the University of North Carolina at Chapel Hill developed a compact disc and online training on the Federal Confidentiality Regulations Dealing with Substance Abuse Patient Records (42CFR, Part 2). This electronic course offers interactive video, audio, text and testing technologies. It can be accessed at <http://unc.blueshoe.com/course.asp>

### **Joint Formal Policies, Procedures, and Protocols**

The child welfare agency and substance abuse service providers can establish policies, procedures, and protocols to improve working relationships. For instance, one critical protocol to support a child welfare/substance abuse collaborative would address the ongoing exchange of information—especially confidential information—about mutual clients, such as by establishing QSOAs. Confidentiality policies might establish the process to obtain consent from the client at the time of referral to share treatment information between the agencies. They also might address the circumstances under which the substance abuse treatment agency will notify the child welfare caseworker of a relapse. Another key protocol might provide guidance about when to return children to their families when substance abuse is involved. For instance, since early recovery is often a risky time for reunification, a protocol might establish which supports might be employed to address those risks.

Other policies and procedures might state that each system will receive a complete record of the family's history and current situation before making any permanent decisions; how each system will be involved in parent/child visitation; and who has responsibility for providing post-treatment supports for families and children at the community level (Blunt, 1999). The Illinois Department of Children and Family Services (DCFS) and the Office of Alcoholism and Substance Abuse (OASA) of the Illinois Department of Human Services have an interagency agreement that establishes how each agency will work with the other pertaining to child welfare clients with substance abuse issues. Through its Title IV-E waiver demonstration program, DCFS provides funds to OASA to pay community substance abuse treatment providers for services to DCFS clients. The interagency agreement establishes that DCFS clients receive priority admission and enhanced services in these community treatment agencies. In addition, the interagency agreement allows DCFS and OASA to use a jointly developed, standard release of information for sharing information on mutual clients throughout the life of a case. The interagency agreement also outlines the monthly reporting format for substance abuse treatment providers to submit information on mutual clients. A major future interagency effort in Illinois includes the creation of a joint database between DCFS and OASA to share histories on mutual clients.

### **Safety Planning**

With the parents, the child welfare and substance abuse agencies create a safety plan (potentially at a family conference or other early-in-the-case meeting involving all stakeholders) which addresses what steps the parent(s) will undertake to care for the children in the event of a relapse. Since relapse is probable—especially if a client never has attempted to become clean and sober before—child welfare and substance abuse agencies might create a relapse assessment tool to be incorporated into a safety assessment and plan (Blunt, 1999). In addition, since the period immediately following treatment is associated with increased risks to children returning home, professionals from both systems should focus on safety planning during this period. Concurrent planning may not explicitly mandate that addicted parents obtain treatment as a condition of reunification. Nonetheless, it requires that parents receive up-front, clear disclosure regarding the consequences of their lack of participation or progress in resolving the issues that led to the initial maltreatment.

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**CHILD WELFARE - RELATED**

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Child welfare practitioners should have several perspectives when attempting to assess and work with families of color they serve. Those perspectives include: competence in ethnically sensitive practice, differences in power, variations in role, and looking at alternative approaches for helping clients who have difficulties with alcohol or drug use (Rooney & Bibus, 1996).

**Title IV-E Waiver Demonstration Program States**

Under the Title IV-E waiver demonstration program, four states are addressing substance abuse within the child welfare population. In fiscal years 1998 and 1999, the U.S. Department of Health and Human Services gave priority consideration to demonstration approaches designed to improve the child welfare system's response to families with substance abuse problems. Four states currently implementing Title IV-E waivers to address child welfare and substance abuse are:

**Delaware:** One of the first child welfare agencies to receive a Title IV-E demonstration waiver, Delaware uses a multidisciplinary team model to address parental substance abuse as it relates to cases where children are placed in foster care or are likely to enter foster care. Specifically, contracted substance abuse counselors work with child protective services workers in each of the state's three county child welfare offices. Substance abuse counselors accompany child protective workers on initial visits, and together they assess the substance abuse problem and its effect on parenting. The counselor may conduct a substance abuse evaluation or arrange for one, and the counselor stays connected with the family throughout treatment. The substance abuse counselors participate in the Division of Family Services' (DFS) two-month new worker training, and then receive follow-up training throughout their tenure. In addition, child welfare caseworkers receive a three-day overview on the impact of alcohol and other drugs on individuals, as well as the indicators that a person may be abusing substances. Savings in foster care caseloads, pursuant to the waiver demonstration, pay for the counselors.

In addition, DFS and the Division of Substance Abuse and Mental Health implemented a joint Memorandum of Agreement (MOA) which requires substance abuse treatment providers who serve DFS clients to honor confidentiality issues; share information within the parameters of those rules; and follow a standard format for the content and submission of progress reports to both state agencies. The MOA also explicates that a provider must see a referral within 72 hours and provide written reports within two weeks. Finally, the MOA states that neither state agency can close a case without first meeting on the issues and clients' progress. Delaware's "one judge, one child" model also ensures judicial oversight and support of parents' treatment and progress in addressing the issues that brought them to the attention of the child welfare agency.

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**Illinois:** The Illinois Department of Children and Family Services (DCFS) contracts with a local treatment provider for addictions specialists called recovery coaches to assist families early in their treatment process, and to continue to provide support to families during and after treatment to prevent relapse and facilitate reunification. The process to link recovery coaches with child welfare clients begins long before a formal relationship develops. During the period when a DCFS caseworker first contacts a family, the DCFS workers implement a substance abuse screening of their clients; both DCFS and the Illinois Office of Alcoholism and Substance Abuse jointly developed this screen and trained caseworkers on its use to ensure it captures substance abuse issues pertaining to child welfare clients. If a screen indicates a parent has a problem with substance abuse, the caseworker documents this fact and refers the parent to treatment.

In addition to treatment, at the 90-day judicial hearing the court and the DCFS caseworker strongly encourage parents to obtain a more complete assessment of substance abuse issues; assessment providers are located in the same building as the Family Court to facilitate the transition from court to services. A recovery coach—certified by the Illinois Alcohol and Other Drug Addiction Professional Counselors' Association—is present at the assessment site and makes initial contact with the parents there. The recovery coach offers support services in addition to traditional child welfare and substance abuse treatment services. If the family accepts, then the recovery coach follows up in cooperation with the DCFS caseworkers and the family's treatment provider, with specific staffings among these stakeholders at every critical case juncture, e.g., six-month administrative case review or the period immediately before children are returned home. Once the children are returned home, the court may require that recovery coaches continue services to address associated stresses and the potential for relapse. To ensure that the recovery coaches and DCFS workers understand the services each provides, recovery coaches receive the same risk assessment training as DCFS caseworkers, and caseworkers receive AODA training.

The next stage of the waiver demonstration program will allow families in the second demonstration group to receive an enhanced array of services in addition to recovery coach services. Enhanced services include medically managed detoxification and withdrawal services, drug-free housing, graduated sanctions, reunification and concurrent planning consultation, and home visiting nurses.

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**Maryland:** The state is providing services to substance-abusing caretakers to prevent unnecessary out-of-home placement and expedite family reunification. Family support services teams, comprised of addictions specialists, local Department of Human Resources staff, treatment providers, parent aides, and mentors provide comprehensive, coordinated services to families of children at risk of foster care placement or who already are in foster care due to parental substance abuse. Upon referral and if the parents exhibit an interest in obtaining help with their substance abuse, an addictions specialist implements a modified Cage Questionnaire assessment tool to assess the level of parental substance abuse and its impact on child welfare.

Parents with substance abuse and child welfare concerns are then assigned to one of three community-provided treatment options: inpatient treatment for parents and their children; intermediate 28-day residential care; or intensive outpatient treatment. Treatment providers additionally provide wraparound services including case management; individual, group, and family therapy; obstetrical or gynecological care and family planning clinics; HIV education and testing; relationship groups; parenting skills training; domestic violence and sexual assault survivor groups; housing; employment; child care; and transportation.

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**New Hampshire:** The Title IV-E demonstration project in New Hampshire involves contracting with a licensed alcohol and drug abuse (A&D) specialist who also is certified in family therapy. The A&D specialists are stationed in each DHS field office and work with the child protection service workers on a consultant basis, providing training, information, and recommendations regarding treatment. Once a CPS worker identifies potential substance abuse issues in a family referred for abuse or neglect during the initial risk and safety assessment, she or he refers the family to an A&D specialist. The A&D specialist approaches the family, obtains their approval to proceed—along with the appropriate releases of information—and implements a modified version of the Substance Abuse Self-Evaluation Inventory (SASEI) to caretakers to determine the extent to which substance abuse impacts parental capacity to provide adequate care and supervision of the children. Furthermore, this assessment informs the Department of Children, Youth, and Families (DCYF) of the A&D specialist's recommendations regarding safety and case plans and current or future treatment needs once the court substantiates a case for abuse or neglect.

Since so many cases in New Hampshire are unsubstantiated, the A&D specialists also may provide up to 60 days of intensive substance abuse services for child abuse or neglect cases that are referred but not substantiated to mitigate the potential for future risk. If a case is substantiated, the SASEI is part of the case record and thus the court also may use it to tie a client's substance abuse needs to treatment plans. In addition and implemented prior to the Title IV-E demonstration project, New Hampshire's court system and DYCF jointly created a protocol in which the court specifically states to the client the consequences of not meeting the terms of the case plan, including accessing substance abuse treatment.

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#### **Edna McConnell Clark Foundation's "Community Partnerships for Protecting Children" Sites**

The Edna McConnell Clark Foundation currently funds four Community Partnerships for Protecting Children sites that provide child protective and other services directly to the communities where they are located, including varying degrees of substance abuse treatment. The sites are:

**Jacksonville, Florida:** The Jacksonville Community Partnership for the Protection of Children program addresses four overlapping issues that are present in the majority of Florida's Department of Children and Family (DCF) child abuse and neglect cases. These issues include child abuse and neglect, substance abuse, mental illness, and domestic violence. When the DCF's CPS worker receives an allegation of child abuse and neglect, the worker assesses the potential for these four issues. If any are present, the worker refers the case to the Community Partnership for the Protection of Children to provide appropriate referrals and follow-up services. In July and again in October 2001, DCF workers joined staff from the

substance abuse, mental health, and domestic violence fields for cross-training on these issues as well as appropriate interventions.

With specific regard to substance abuse, the Jacksonville office of the Department of Children and Families deploys staff to the local substance abuse treatment agency, Gateway Community Services. This substance abuse professional accompanies the CPS worker to provide support to the family, and attends follow-up family team meetings to offer additional referrals and guidance on substance abuse treatment. Every person attending the family team meeting signs a form promising confidentiality; the form also provides a release of information to allow information sharing among the treatment agencies providing services to the family. Florida has adopted the Community Partnership for the Protection of Children model and currently is replicating it in five additional DCF sites in Jacksonville, as well as other sites around the state. The original local Community Partnership site is assessing whether it will incorporate with the new DCF sites, or if it will create a stand-alone nonprofit agency.

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**Louisville, Kentucky:** In Louisville, the Clark-funded Community Partnership for Protection of Children (CPPC) site is named UJIMA. It is here that a substance abuse case manager has been co-located with CPS staff to provide services. Some of the duties performed by the substance abuse case manager are assessments, screenings, and referrals to appropriate treatment modalities and services for clients who meet certain criteria. It may be determined through an initial screening that a client may not need services provided by a substance abuse case manager for substance abuse treatment but may require other social services help. This outcome of the assessment is communicated to the referral sources and follow-up case management or monitoring is provided as prescribed.

If a client is referred to treatment, a treatment plan or service plan is developed to assist the client and family. Within the framework of the plan, we identify client strengths and barriers to recovery. The case manager helps the client with issues regarding maintaining abstinence, child care, housing (transitional and permanent), transportation, employment, vocational rehabilitation, medical issues, and legal problems. The case manager collaborates with other service providers in meeting client and family needs. The case manager provides advocacy for the client (e.g., attending family court sessions to facilitate reunification of parent and children once the client is viewed as stable) and will report to the referring agency if the client is noncompliant with the treatment or service plan. The case manager maintains involvement until the client no longer seeks services or no longer complies.

The substance abuse case manager at UJIMA participates in outreach undertakings and events within the community such as health fairs and other type of forums. Staff are also available to consult with faith-based or other social service entities to include substance abuse related curriculum in their endeavors to reach others affected by substance abuse. Staff also collaborate with other CPPC components such as a domestic violence prevention and community resources team to help in their efforts. The case manager attends regular Neighborhood Place UJIMA, CPPC, and other related meetings and is cochair of the family focus work groups. The manager also takes part in all forums and services sanctioned by the CPPC. The case manager provides education and consultation in the areas of substance abuse treatment and recovery to all UJIMA staff and community members who desire it.

The substance abuse case manager will also facilitate any referrals for family members to services when warranted. The staff encourages clients and family members who are affected by addiction to seek support through Alcoholics Anonymous, Narcotics Anonymous, ALANON, or NARANON as recovery is an ongoing process. The staff also promotes any positive activity that supports the emotional, spiritual, physical, and mental well-being of clients and family—church, exercise, education. UJIMA features an on-site program for 6-12 year olds that helps children understand dynamics of addiction and recovery and lets them know they are not alone. The program is called Children of Addicted Parents Program (CAPP) and runs concurrently with NA meetings at UJIMA.

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**Cedar Rapids, Iowa:** In response to the prevalence of prenatal exposure to illegal substances, staff at area hospitals, the Iowa Department of Human Services (DHS), and community agencies created the independent Children at Risk Task Force. The task force is funded by the Partnership for Safe Families, Iowa's self-titled program funded by the Clark Foundation's

Community Partnership for the Protection of Children grant. The task force consists of administrators from the Iowa Department of Human Services and two hospitals, and local treatment providers, including the Heart of Iowa, a residential treatment program for mothers at risk of losing their children due to substance abuse. The task force meets monthly to coordinate services for newborns who test positive for illegal substances, and it meets every other month to address community issues related to child welfare and substance abuse. DHS makes all referrals of child welfare clients with substance abuse problems to community treatment programs, some of which employ community family support workers under the rubric of the Partnership for Safe Families.

The community family support workers provide such support services as parenting skills, homemaker services, and money management. DHS caseworkers collaborate with community family support workers, and both types of worker can implement a safety plan with a client family. Either type of caseworker may refer families to the task force for family team meetings to address substance abuse and safety issues. In July 2001, the task force held a substance abuse and child welfare cross-training for 97 staff from DHS, the Partnership for Safe Families, the Task Force for At-Risk Children, and treatment provider agencies not already included in those groups. DHS also uses a multidisciplinary team agreement with any agency involved on the task force to facilitate information sharing and address confidentiality issues regarding mutual clients. The agreement is signed at the beginning of a case and amended as new agencies enter the service spectrum.

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**St. Louis, Missouri:** The primary goal of this community partnership program is to provide CPS workers with the tools they need to recognize and help their clients address alcohol and drug abuse issues. The site employs a high-level CPS worker who also is an A&D specialist. This specialized staff person is housed in the hotline to provide front-end technical assistance workers who suspect that a referred client has substance abuse issues who present risks to his or her children. Ongoing workers also may access the services of the A&D specialist. In addition, the A&D specialist attends all 72-hour family team meetings where caretaker substance abuse is suspected. There, the specialist is a resource to the family, referring them to treatment or counseling as their case plan allows.

The A&D specialist also provides training for child welfare staff and community partners on addressing substance abuse with child welfare clients. In addition to co-locating the cross-trained A&D specialist in the child welfare agency, Missouri's departments of Mental Health and Social Services bring together their staff working with clients with substance abuse, child welfare concerns, developmental disabilities, and mental illness for a one-day interdisciplinary training. This training focuses on sharing information on each division's role and responsibilities in serving mutual clients, and offers job-shadowing opportunities so that peers can directly experience another's job. To provide immediate information to child welfare workers on community-based substance abuse treatment services, St. Louis' Neighborhood Network is creating an Internet-accessible database of available treatment slots for child welfare clients. Finally, in November 2001, St. Louis implemented its first Family Drug Court to leverage compliance with treatment and to provide intensive supervision and incentives for continued progress.

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## ALCOHOL AND OTHER DRUG - RELATED

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### Promising Models, Approaches and Steps Forward

<http://www.cwla.org/programs/bhd/promisingAODmodels.htm#top>

From a broad base of research and service delivery experience, there is a common theme: promising family strengthening initiatives should begin a dialogue with professionals and caretakers from many different disciplines, which will lead to innovation in policies, programs, and practices at the local level. Collaborative, coordinated, culturally competent, community based services are more likely to emerge when the professionals and caregivers in a community possess a common base of knowledge about child welfare concerns and AOD problems (Wingfield, 1998). In public hearings around

the country in 1999, the Center for Substance Abuse Treatment heard the same themes of coordinating assessments and providing a continuum of care that is family-focused with an array of "wraparound" services and aftercare programs (CSAT, 1999). In these hearings, there was also clear support for providing culturally relevant, gender relevant, and alternative forms of treatment.

A recent report to the United States Congress echoed this same theme in numerous parts of the report (HHS/SAMHSA, 1999). Specifically, the report recommended that prevention and intervention strategies must be:

- Comprehensive, integrating the contributions of social service, legal, law enforcement, health, mental health and education professionals;
- Neighborhood-based, strengthening the neighborhood and community by encouraging and supporting local improvement efforts, including self-help programs, that make the environment more supportive of families and children;
- Child-centered, protecting the safety and personal integrity of children and giving primary attention to their best interests; and
- Family-focused, strengthening families, supporting and enhancing their functioning, providing intensive services when needed, and removing children when such action is appropriate.

*Diversify treatment.* Treatment specific to the needs of women, pregnant women, different cultural groups, and home-based would improve access and appropriateness in matching client needs with treatment options.

McMahon and Luther (1998) recommend that we open our minds to new options of meeting the needs of substance abusing parents and their children. They recommend seven structural components to a family-oriented drug abuse treatment program:

- 1) Prenatal intervention,
- 2) Child care services,
- 3) Family therapy,
- 4) Parent intervention (education),
- 5) Child development services,
- 6) Specific interventions for children, and
- 7) Interagency collaboration.

Issues of culture, gender, age of the children, parent drug of abuse, and the treatment setting all need to be considered in the actual services to be delivered. A network of agencies, co-located, with multiple points of entry should be part of the design of such a treatment program.

### **Models That Show Promise**

*The Opportunity to Succeed (OPTS).* This treatment model (Rossman, 1998) was developed in a multi-site demonstration program that helped addicted ex-offenders break the cycle of recidivism and become contributing members of their communities. The program served felons (who were not convicted of rape or murder) who received substance abuse treatment while incarcerated and assisted them in re-establishing their ties to their communities, families and jobs. The core of the program was the close relationship between the participant, the community-based case managers and the parole or probation officer. Local case management ensured that participants received continuing drug treatment, family counseling, medical and mental health care, assistance in finding housing, and employment training; virtually everything they needed to make the transition to community life. The program was operated in St. Louis and Kansas City, Missouri; Tampa, Florida; and West Harlem, New York by a public/private partnership of correctional and social service agencies.

Another successful approach to this population is using contingency management to enhance client motivation (Silverman, 1999; Higgins & Silverman, 1999). Using a combination of positive and negative reinforcements and positive and negative punishments, studies have found that reinforcements are generally more effective in motivating change than punishments. The well-established principles of operant learning are highly applicable to client elimination of drug self-administration. Program elements recommended include: 1) make the program and consequences very clear; 2) use a foolproof system to detect use; 3) aim at relatively brief periods between consequences; 4) use a consequence controlled by the helper; and 5) make the consequences numerous, initially small, and predictable. The study further found that while contingency management can help a person gain a long period of abstinence, it is no better than other interventions in preventing relapse. It does, however, give the person more time in abstinence to develop other relapse prevention strategies. A variety of studies using contingency management have shown significant positive effects in getting and keeping IV drug users in treatment, helping pregnant women stay in treatment at higher rates, having longer periods of abstinence in alcohol and cocaine abusers and those with co-occurring mental health disorders. "A challenge for contingency management

practitioners . . . may be to change prevailing concepts of what treatment is, of how it is delivered, and of how one searches for optimal treatments."

*CASAWORKS.* In January 1999, The National Center on Addiction and Substance Abuse at Columbia University (CASA, 1999) launched CASAWORKS for Families, a three-year demonstration to help drug and alcohol addicted mothers on welfare achieve self sufficiency. CASAWORKS combines in a single concentrated course of treatment and training: drug and alcohol treatment, literacy and job training, parenting and social skills, violence prevention, health care, family services and a gradual move to work. The program is being tested at 11 sites in nine states, including New York and California, and will serve more than 1,100 women and their children. While the effort is too new to show any results, it does blend a wide array of services into a single "service", which addresses many of the difficulties in separate systems working, at times, at cross purposes with each other.

*La Bodega de la Familia.* This is a program in New York City that includes the addicts' families in the drug treatment process (DOJ, 1998). In response to evidence that substance abusers supported by a caring family are more successful than others in completing treatment, the city opened this program. It uses family case management, with a focus on the whole family and helping friends, not just the addict, building on their strengths. La Bodega identifies the most appropriate treatment and other providers for referral and coordination, and many of the services are provided in the homes and neighborhoods of the participants. They assist the families with access to the Internet, and information about health, housing, mental health, job training, housing and employment services.

*CSAT Model Program.* The Center for Substance Abuse Treatment has developed a comprehensive treatment model for AOD abusing women and their children. In summary, it establishes both program structure and administration, as well as clinical interventions and other services to be provided. It is prepared in a manner to allow for local adaptation.

*Sobriety Treatment and Recovery Teams.* The Cuyahoga County (Ohio) Department of Child and Family Services operates START, an adaptation of a similar program in Hamilton County, Ohio, called ADAPT. START is an attempt to meld together what is known about addiction services treatment, good child welfare practice and family preservation practice into a model that can work with the special needs of these families. The population targeted for this program is crack cocaine-using women with children in the Child Welfare system. A set of tenets for blended work with these families is included in Appendix B. Unique to this program is the pairing of a Child Welfare Social Worker and an Advocate who is a former substance abuser, and often a parent in the child welfare system. These two share the traditional child welfare roles, with smaller caseloads (15 families maximum) and a great deal of cross training in child welfare, AOD treatment and family preservation. Equally involved are several drug treatment providers, who also receive the cross training. Health and mental health care providers, housing programs, family and friends, and other supports are part of the family team to support the successful outcomes of the unified plan for the mother. (Annie E. Casey Foundation, 1998).

One part of this network of treatment agencies includes the program called Miracle Village. This is a recovery community for addicted women and their children in a public housing environment. After 4 years of operation, 63% of the women who completed initial treatment are sober and living in the area.

*Strategies for Family Change.* This is a Sacramento County (California) Department of Health and Human Services response to the population of substance abusing child welfare families. Building on an existing substance abuse treatment initiative, SFC conceptualized a network of formal and informal supports surrounding families to keep children safe. Formal and informal supports are located within the neighborhood, where various disciplines are housed together, and work together. Help is available before problems continue to escalate in severity. Two existing neighborhood centers began the effort, with a third being added in 1999. Each center was different, including the array of services existing in the neighborhood. See Appendix C for a description of and picture of the SFC model. (Annie E. Casey Foundation, 1998A).

*Maternal Addiction Program.* MAP is a combination residential and day treatment program, in Miami, developed to meet the needs of a largely African American, inner city, indigent female population who are pregnant (Calley & Murell, 1998). In this program, the women start in residential treatment for 28 days, and then go into day treatment for a period from 6 to 12 months, depending in needs. The services target drug use with benefits to the mother and children for reaching and maintaining abstinence. They coordinate with child welfare, social services, legal and other community resources, childcare, transportation and parenting programs. A cross-trained multidisciplinary team, with the mother, develops the specifics of a tailored intervention plan.

*Prevention.* The Center for Substance Abuse Prevention has developed a booklet describing the eight most successful drug abuse prevention programs (CSAP, 1999). Some of these programs are aimed at children and youth, and often based in school settings. Others are community-based, in churches or other community-based organizations, and target families. One is a program targeted to youth in residential placements. The National Institute on Drug Abuse (NIDA, 1997) developed a guide with prevention principles to help in the development of prevention programs that are community-based, school-

based or family-based. This same guide describes other successful prevention programs around the country. These two sources provide a wide range of ideas and models for alcohol and drug abuse prevention.

### Frontline Practice Level

In this section, we will discuss specific approaches, methods and tools, which have been found to improve family functioning and reduce AOD abuse and child abuse.

*Client-Worker Relationship.* Interview data from mothers in substance abuse rehabilitation who were regaining custody of their children were analyzed to identify social worker and agency characteristics that facilitated their recovery and family reunification (Akin and Gregoire, 1997). Findings were grouped into three categories: 1) the addiction experience, where the worker understood the omnipresent and overwhelming impact of drug use, even when the person really wants to be clean; 2) lack of the usual system shortcomings-changing the paternalistic actions by workers that reinforce parent powerlessness, cynical agency attitudes and unrealistic expectations; and 3) system successes that encouraged addiction knowledge, provided direction, shared power between parent and worker, and built a relationship based on trust and availability. Implications for practice include the importance of developing a supportive and helpful client-worker relationship and that the worker uses the power of the system to help the family, not to coerce it.

Empathy on the part of the interviewer is a high predictor of positive outcomes in treatment (Fiorentine & Hillhouse, 1999). Accurate empathy has been known for many years to be the most important characteristic of the helper in the helping relationship (Miller, 1992).

*Social Support.* A body of research and writing describe the importance of social support for women to enter, remain in and follow-up to treatment. One study found that increased social support was significantly associated with increased self-esteem, a key factor in moderating depression and in successful treatment outcomes (Dodge & Potocky, 2000). They recommend that increased social support be a component of treatment and follow-up care.

*Family Strengthening, Self-Efficacy Building.* Family strengthening refers to efforts that engage the individual and family in the planning and implementation of services, particularly those services which build on existing family strengths and meet their particular needs. In one study, the quantity of services, which matched the clients' belief that the services were relevant to their situation, was a statistically significant predictor of length of stay in treatment; moreover, length of stay in treatment correlates positively with improved treatment outcomes (Dilonardo, 1998). The results may suggest that an additional important pathway to improving treatment outcome is meeting client's perceived needs.

A node-link map is a cognitive-behavioral visual representation and communication technique (Newbern, et. al., 1999). It increases motivation and self-confidence (self-efficacy) to employ behavioral skills cited as outcomes of positive treatment. It also increased the ability of the client to use oral and written communications while in treatment. Findings suggest that substance abuse treatment is enhanced by service delivery that incorporates clients' perspectives and addresses their interrelated drug abuse problems (Quimby, 1995).

Parenting is often the only role women see as legitimate in their life, and that their children are a stabilizing influence (McMahon & Luther, 1998). Their child abuse or neglect can also lead them to feelings of guilt, shame and failure due to their substance abuse. Programs that work to maintain the parent-child relationship can use this parent role strength to help in raising motivation to address the drug use. The acquisition of the parent role was linked to reduced drinking on the part of women in one study (Crum, et. al., 1998). When the child welfare system places children, it should be for only enough time to get treatment started. Returning the children, with the proper supports and services, can actually help the mother maintain the progress made. Without the proper supports and services, the added stress of the parent role can have a deleterious effect.

*Culture and Gender Considerations.* Women in early recovery often experience problems related to parenting, to trauma resulting from physical or sexual abuse, or to mental illness. Recovery will be more likely successful if these other issues, which precipitate or relate to the abuse of alcohol or other drugs, are attended to. Remaining drug free is very difficult if the woman remains in an abusive relationship, if she has no coping skills to deal with her children, if she has no access to counseling, is in unsafe housing, or her and her family's basic needs are not being met. Ongoing counseling, self-help and other supports, and accessibility to other available resources are almost required in order to maintain recovery (HHS/SAMHSA, 1999).

Gender and ethnic congruity between client and interviewer increases client disclosure; however it does not necessarily increase client retention in treatment or treatment outcomes (Fiorentine & Hillhouse, 1999). The helper must also have empathy skills, to help the family members build their sense of hopefulness and ability to succeed with their goals.

Specialized AOD treatment programs have been developed in the recent past for women (Grella, et.al., 1999A). These women-only programs differ from traditional mixed-gender programs in a number of areas: inclusion of children, treatment

that is focused on relationships, addressing past trauma from abuse, sexual abuse and domestic violence. Further, since so many of the women have been unemployed, job readiness is often an included service. The process and duration of the treatment itself is more flexible with this population. Many of these programs allow the (young) children to be with the mother, in both outpatient and inpatient programs.

## COURT- RELATED

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### PRACTICE IMPROVEMENTS PIONEERED BY MODEL COURTS

*“Model Courts: Improving Outcomes for Abused and Neglected Children and Their Families* published by the National Council of Juvenile and Family Court Judges, Reno, Nevada.” ©2004, National Council of Juvenile and Family Court Judges.

- Establishment of one judge/one family calendaring.
- More substantive preliminary protective hearings.
- Scheduling hearings at a specific time (“time certain”).
- Implementation of strict no-continuance policies.
- Copies of orders disseminated to all parties at the end of each hearing.
- Setting the date and time of the next hearing at the end of the current hearing.
- Development of “dedicated” attorneys.
- Improved advocacy for children and representation for parents.
- Development of data information systems specifically focused on dependency case processing.
- Faith community involvement.
- Development of family group conferencing and dependency mediation programs.

### IMPROVED OUTCOMES ASSOCIATED WITH MODEL COURTS

In Chicago, the backlog of children under court jurisdiction in out-of-home, long-term foster care was reduced from an estimated 58,000 to fewer than 20,000 during a three-year period. The number is now less than 16,000 children. The implementation of improved practices in the juvenile courts reduced the length of time a child remained under the jurisdiction of the juvenile court by 50% and reduced the time children remained in out-of-home care from 400 to 178 days. The savings were estimated at \$5 million.

In Des Moines, through the utilization of mediation programs, the number of contested removal hearings has been reduced by more than 50 percent. “Parties come to court less polarized, having already developed a working relationship with providers and agency workers prior to court involvement,” states Lead Judge Connie Cohen.

In Alexandria, the Model Court is cooperating with the Virginia Director of Court Improvement to establish “Best Practice Courts” throughout Virginia. There are currently 19 courts participating. Each court is using the *RESOURCE GUIDELINES* and the examples of the Model Court to engage their communities and agencies in making changes to impact the lives of children and families.

In Salt Lake City, utilization of the same best practices has produced similar results, and children are able to have safe, permanent homes in a shorter time.

In San Jose, the adoption rate doubled. San Jose also created one of the first child welfare mediation and family group conferencing programs in the United States; the San Jose program is now a nationally recognized model and is an expected part of best practices.

## REFERENCES

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American Public Human Services Association (APHSA): <http://www.aphsa.org>

Annie E Casey Foundation: <http://www.aecf.org>

Center for Substance Abuse Treatment (CSAT): <http://www.csat.samhsa.gov/>

Child Welfare League of America (CWLA) - <http://www.cwla.org/programs/bhd/promisingAODmodels.htm#top>

Connecting Child Protective Services and Substance Abuse Treatment in Communities: A Resource Guide – 75 pg guide available online at <http://www.aphsa.org/Policy/Doc/cpsubabuse.pdf>

National Center for Substance Abuse and Child Welfare - <http://www.ncsacw.samhsa.gov/>

This website contains resources and publications pertinent to the issues of substance abuse, child welfare, tribes, and family judicial systems, including the following:

- Safe & Sound: Models for Collaboration Between the Child Welfare & Addiction Treatment Systems
- Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection
- Healing the Whole Family: A Look at Family Care Programs
- No Safe Haven: Children of Substance-Abusing Parents
- Foster Care: Agencies Face Challenges Securing Stable Homes for Children of Substance Abusers
- Responding to Alcohol and Drug Problems in Child Welfare: Weaving Together Practice and Policy
- Linking Child Welfare and Substance Abuse Treatment: A Guide for Legislators, August 2000, National Conference of State Legislators.

National Council of Juvenile and Family Court Judges - Permanency Planning for Children Department

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- Resource Guidelines: Improving Court Practice in Child Abuse and Neglect Cases (170 pg guide)
- Adoption and Permanency: Improving Court Practice in Child Abuse and Neglect Cases (152 pg guide)
- Community and Cultural Considerations in Child Abuse and Neglect Cases: National Judicial Curricula Series – Court, Agency and Community Collaboration
- Court, Agency and Communities Working Together: A Strategy for Systems Change National Judicial Curricula Series-Court, Agency and Community Collaboration

*Opportunities for Collaboration Across Human Services Programs*, published June 2003, discusses the interdependence of major human service programs administered at the state and local level. 79-page report can be found online at:

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