



# **Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Drug Services With Child Welfare**

## **Executive Summary**

*Of Technical Assistance Publication (TAP) Series 27*

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## Background

In the Spring of 2000, the Center for Substance Abuse Treatment (CSAT) supported the development of a Technical Assistance Publication (TAP) on Substance Abuse and Child Welfare Services. Children and Family Futures (CFF), a California-based consulting firm, was asked to prepare the TAP and to provide descriptions of seven sites from around the nation that have implemented programs to address the issue. This document is a brief summary of the program models that will be published in the near future by CSAT.<sup>1</sup> The sites selected for inclusion as case studies were:

- \$ The State of Connecticut
- \$ Sacramento County, California
- \$ Jacksonville, Florida
- \$ The Dependency Court San Diego, CA
- \$ The State of New Jersey
- \$ Cuyahoga County, Ohio
- \$ The Dependency Court Miami, FL

## Methods

Site visits were conducted during March and April 2000, and each site was asked to respond to a series of questions in ten specific areas. These areas were developed by Children and Family Futures as a framework, combining the five domains of action highlighted by DHHS in its 1999 Report to Congress, *Blending Perspectives and Building Common Ground*,<sup>2</sup> and the framework that had been used in CFF's prior work for the Child Welfare League of America. Out of this project, a ten-part self-assessment measure was developed and piloted with the County Alcohol and Drug Program Administrators Association of California and the Children's Committee of the County Welfare Directors Association of California. The assessment tool reviews agencies' capacity to work as partners in addressing the alcohol and other drug (AOD) needs of parents in the child welfare system and can be downloaded from the CFF website. The ten major elements of the instrument are:

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

Why are these elements so important to a partnership between AOD and child welfare agencies?

1. *Underlying values* must be addressed in partnerships, because the partners are very likely to come to the table with different perspectives and assumptions about their agency's mission. Unless these differences are out in the open, the partners will be unable to reach agreement on surface issues that are commonly cited as barriers between the systems, if they diverge widely on the underlying ones.
2. Daily practice in the areas of *AOD screening and assessment* must be addressed in partnerships, as it is in these first contacts with the client that agencies must begin the process of determining what kind of AOD problem these parents have, and what mode of treatment can best respond to the problem, and what information needs to be communicated among workers.
3. Daily practice in *engaging and retaining parents* must be addressed in partnerships as new time limits demand the best possible efforts to keep clients on track in meeting their parental goals while balancing the many obstacles often confronting chemically-dependent parents and their children.
4. Daily practice in *services to children* must be addressed in partnerships, as treating the parents alone ignores the effects of AOD problems on the children. In a family where caretakers are substance-abusing or addicted, there is the risk that without intervention a new generation may repeat the same patterns in which they were raised.
5. *Joint accountability and shared outcomes* must be addressed in partnerships, because jointly-developed outcomes are the best test of whether a collaborative relationship has achieved interagency agreement on desired results. Without such an agreement, each of the partners is likely to continue measuring its own progress as it always has, using only the outcomes that the agency is accustomed to.
6. *Shared information systems* must be addressed in partnerships, because these are the prerequisites for joint accountability. Without such information systems, which can be used to determine whether joint outcomes are achieved, the partnership will have no guideposts to gauge its programs' effectiveness.
7. *Budgeting and program sustainability* must be addressed in partnerships, because tapping the full range of funding resources available to a state or community is the only way to develop multi-year stability for innovative approaches.
8. *Training and staff development* must be addressed in partnerships, because without cross-training efforts, conventional practice will deepen the division between agency staff, who are oriented to think separately, rather than collaboratively in serving shared clients.
9. *Working with the courts* must be addressed in partnerships, as the role of the courts is critical in enforcing time limits and making judgments about parental progress. Decisions will be made by the courts unilaterally, unless these entities are faced with a joint stance by the two sets of agencies.
10. *Working with other agencies and community members* must be considered in partnerships, because many parents with AOD problems also require assistance from services other than

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AOD and Child Welfare to address the multiple, complex issues impeding the functioning of families affected by AOD-related problems.

## **Brief Synopsis of the Sites and Program Models**

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

### *The State of Connecticut*

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

DCF, which handles child welfare, children's mental health, juvenile justice and adolescent substance abuse treatment programs in Connecticut, instituted a substance abuse screening questionnaire to be used by child welfare workers system wide. The screening tool was developed to cast a wide net in order to screen in parents and potential caregivers for further assessment. To provide the assessment of substance abuse conditions, DCF entered into a services contract with a nonprofit organization, Advanced Behavioral Health, Inc. (ABH). ABH is a state-wide consortium of non-profit behavioral health agencies. The initial DCF contract involved drug testing, substance abuse assessment, and outpatient treatment for DCF-referred biological parents and caregivers from abuse and neglect investigations and/or on-going services. At-risk Healthy Families program participants and those being considered for subsidized guardianships were added later. By November 1999, over 23,000 unduplicated referrals were made from DCF to substance abuse services under this contractual arrangement.

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

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

By mid-1999, DCF recognized the need to form a closer relationship with the state's DMHAS, as it is the major state agency for managing adult behavioral-health issues, including services for persons with AOD problems. A primary goal in seeking to improve the linkage between the two state agencies was to better tap existing AOD assessment and treatment resources—both funding and expertise—through the publicly-funded AOD service network. The Commissioners of DCF and DMHAS, together with their Deputy Commissioners of Addiction Services and Child Welfare, met on several occasions to develop a joint approach. The Commissioners agreed upon A15 Guideposts® for their working relationship and the development of cross-department strategies.

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

### *The State of New Jersey*

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

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

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Services, jointly expanded the bed capacity for women diagnosed with a substance abuse disorder. This agreement included development of procedures for granting priority access to mothers of DYFS-supervised children.

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

### *Sacramento County*

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

The Department, under the leadership of then-Director Robert Caulk, and with assistance from the Annie E. Casey Foundation, developed a multi-faceted initiative focused on changing the child welfare and other systems through training and making AOD assessment and intervention part of the responsibility of every worker. The clear and ambitious goal was to provide direct AOD treatment on demand. From the inception of the project, a core set of values was part of the project's direction. These values and principles included prioritizing high-risk clients, expanding treatment and support service capacity within existing resources, and viewing the client as integral to successful intervention. Additional, and equally important goals, were to increase staff's level of knowledge, understanding and sensitivity to issues of addiction, recovery and relapse, as well as to enhance their skills and capacity to respond appropriately to AOD problems. These basic premises included an explicit recognition that the great majority of workers in the child welfare system and in the treatment agencies did not know enough about alcohol and drug abuse to work effectively across systems. However, project staff knew that working across systems was necessary to produce better results. The current outcome of their value- and data-driven system is reflected in the County's treatment access numbers. While the State of California treatment-access statistics show that women received 35% of available treatment resources, in Sacramento County 52% of resources were accessed by women.

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

Specific procedures were developed by AODTI and other relevant departmental policies for Child Protection Services (CPS) social workers to conduct alcohol and other drug screenings and assessments. According to the policy, every case that entered the Child Welfare System would have a

comprehensive substance abuse assessment to rule out or identify the severity of the AOD problem as an essential component of the risk assessment and case planning process. However, the deaths of two young children, who were involved in the CPS system and the resulting public reaction, caused significant increases in child welfare caseloads. Due to the increase in caseloads, the policy of having social workers complete AOD assessments was suspended in August of 1997.

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

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

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

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## *Cuyahoga County*

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

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

A second major value underlying START is that the program relies heavily upon the strengths of the family advocates who work directly with clients. These workers provide a wide base of knowledge about addiction and recovery to the child welfare staff. The advocates typically have been in recovery for at least three years and are participating in twelve-step programs. Supporters of the program acknowledged that the advocates see the clients differently than the social workers and are able, at times, to see the signs of continuing use and abuse that may not be uncovered by traditional staff. The demands on the advocates are heavy, due to the emotional drain of being involved with a troubled family's crises on a day-to-day basis. Efforts had been made to match social workers and advocates, since the working relationship between them is of great importance.

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

## *Jacksonville, Florida*

Relative to the other case study sites, Jacksonville is a more recently-developed program in its efforts to address AOD and child welfare issues. The essential element of the project is the use of TANF funds

(under the WAGES program in Florida) to outstation AOD counselors with specific child protective services investigation units. The program was implemented in early Spring of 2000. The primary role of the AOD counselors is to assist CPS workers in assessment, treatment referral, and engagement of parents in substance abuse intervention programs.

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

Jacksonville also benefitted from the involvement of the Child Welfare League of America (CWLA), which assisted in conducting a Think Tank training session held in February, 2000. Philip Diaz, the current director of Gateway Community Services, (the largest community treatment agency in NE Florida), was a consultant on AOD issues for the CWLA. Gateway had been an active player in the Community Partnership, first under its prior director, Dr. Virginia Borrok, and currently under Mr. Diaz. State child welfare officials in the Jacksonville area, who are in the Department of Children and Families (DCF) gave Gateway substantial credit for initiating contacts from the AOD side. As the original community governance unit for the Community Partnership did not include AOD representatives, Gateway successfully sought membership in the group, allowing the agency to become active participants in the Partnership.

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

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

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

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

Faster engagement in the treatment process is a key effort of the out-stationed AOD staff members. This is accomplished through a joint endeavor made possible by the Gateway staff's relationship with his/her assigned CPS unit. CPS workers, within that unit, refer and consult with AOD staff members regarding the families that are assigned to the unit. Drug testing is used as an integral part of the assessment and treatment monitoring process, and is continued after treatment discharge. As part of early recovery services, relapse is monitored by Gateway staff as they meet with DCF staff on a regular basis.

### *San Diego County*

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

The goal of the DCRP is to achieve a reunification or permanency plan as soon as possible—in essence, to observe the law, with 6 months to placement for children under 3, and 12 months for older children. While there were other issues, such as sexual and physical abuse, domestic violence and mental health,

Usually drugs and alcohol were the triggers that took the inhibitions off, causing a problem. Treatment was, thus, often seen as a prerequisite to working on other issues.

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

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

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

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

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

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

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

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

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

As a result of these changes, the majority of CPS clients in San Diego do not pass through the Dependency Drug Court, but do receive the benefits of the SARMS process. As of December 1999 there were 808 dependency parents actively participating in the SARMS program, with 79% in compliance with their Recovery Services Plans, including negative drug testing and completion of other treatment plan requirements.

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

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

It has taken an extensive modification in the culture of parents' attorneys to accept these changes. One of them noted that she felt parents, under the prior system, had been giving up on reunification if they had AOD problems. She also pointed out that San Diego had historically been a "very litigious system" prior to the DCRP. At present, she said it has been possible to re-allocate resources more effectively with the results of the DCRP. "We are on a diet from litigation," she remarked. "There is a definite

benefit to parents in the SARMS program, since a stronger case can be made on their behalf that they are complying with the reunification process and they do not carry the burden of having to prove their case@.

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

### *Miami, Florida*

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

As a result of Judge Cohen's prior work with DUI offenders, she had developed positive relationships with community mental health and substance abuse treatment providers. These relationships, and her experience working with alcohol-and drug-abusing individuals, became the foundation for initiating the Dependency Drug Court.

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

Prior to setting up the Dependency Drug Court, Judge Cohen negotiated agreements with DCF to dedicate three case workers to the DDC. She obtained funding from the Florida state legislature to fund

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three positions for addiction specialists, including a program administrator. The funds were submitted through the Administrative Office of the Courts and constituted a recurring budget item. In addition, TANF monies funded two additional addiction specialists. The addiction specialists serve as the link between the court, the parents, and the treatment providers. The addiction specialists conduct the initial screening for AOD and mental health problems. The screenings included the ASI, ASAM- Patient Placement Criteria, Beck Depression Inventory, and Readiness to Change Scales.

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

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

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

In May 2000, DDC graduated its first class of 13. All the graduates except one were female. Presently there are four fathers in DDC. The Judge pointed out that failure to comply with DDC was also a success, if lack of commitment and dedication is determined early, and the children can be moved to permanency expeditiously. DDC plans to enroll 100 parents in DDC during 2000-01.

In preparing the Tap and reviewing the experiences of these seven programs, Children and Family Futures developed the matrix which is included in this packet to specify elements of cross-system linkage from a developmental perspective of stages of improved system collaboration. A Self-assessment@questionnaire was also created to allow communities to assess their progress in each of these linkage arenas, which may be found on the CD included in the packet distributed to workshop participants and our website [www.cffutures.com](http://www.cffutures.com).

## **Models of System Linkages - Examples are not a comprehensive listing of sites**

### **1. Worker Linkages**

- \$ Pair CPS and AOD Worker - *Delaware*
- \$ Outstation AOD Worker in Juvenile Court - *San Diego; Orange County; Los Angeles*
- \$ Outstation AOD Worker in Child Welfare Sites - *New Jersey, Jacksonville*
- \$ Home Visitation Models - *Cleveland; Orange County California, Cook County Illinois*
- Multi disciplinary Teams for Joint Case Planning and Sharing Outcomes - Multiple Sites, Generally Related to Prenatal Exposure

### **2. Child Welfare - AOD - Para Professional and Community Member Linkages**

- \$ Linking Community Members and AOD Providers with Child Welfare Worker - *Jacksonville*
- \$ Pair a Person in Recovery@Para-professional with a Child Welfare Worker - *Cleveland*
- \$ Community Partnerships for the Protection of Children - *Jacksonville, Cedar Rapids, Louisville, St. Louis*

### **3. System Improvements**

- \$ New and Revised Screening and Assessment Protocols - *Sacramento, Connecticut*
- \$ Management Information System Linkages and Improvements - *Sacramento, Connecticut*

### **4. Training Initiatives**

- Multiple Sites, Comprehensive Curriculum Developed for child welfare - *CWLA and Sacramento:*
- \$ Child Welfare Trained in AOD
  - \$ AOD Providers Trained in CWS
  - \$ Court System Trained in AOD & New Child Welfare Initiatives
  - \$ Informal Training Through Out-stationing

### **5. Court Initiatives**

- \$ Family Drug Court - *Reno, Pensacola, St. Louis, San Diego, Miami, New York, Napa County*
- \$ Child Welfare - Juvenile Court/Probation Prevention Programs - *Sacramento, San Diego*

### **6. Funding Innovations**

- \$ Re-defining A Needy Families@ - *Florida*
- \$ Using TANF as CW prevention - *El Paso County, CO*
- \$ CW Purchasing AOD Treatment - *Connecticut, Illinois, Arkansas*
- \$ Title IV-E Waivers - *Delaware, New Hampshire, Illinois, Maryland, West Virginia*

## **7. Safe and Transitional Housing**

- \$ Housing Authority - *Key West*
- \$ Housing Initiative - *Connecticut*
- \$ Closed Military Bases - *Monterey, California; Merced, CA*
- \$ Purchased Apartment Complexes - *Los Angeles*
- \$ Recovery Communities - *Louisville, Minneapolis*

## **8. Improving Services to Children**

- \$ Children and Substance Abuser Groups - *Connecticut*
- \$ Targeting of Prevention Funding

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<sup>1</sup> The full report, *Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Other Drug Treatment with Child Welfare Services*, is currently under review by the Center for Substance Abuse Treatment and the Administration on Children, Youth and Families. The opinions expressed in this summary are solely those of the authors and do not reflect opinions or approval of the draft or this summary by the federal agencies.

<sup>2</sup> The Full Report to Congress can be downloaded at [www.acf.dhhs.gov/programs/cb/](http://www.acf.dhhs.gov/programs/cb/).