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Substance Abuse Specialists in Child Welfare Agencies and Dependency Courts

Considerations for Program Designers and Evaluators



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Administration for Children and Families
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Substance Abuse Specialists in Child Welfare Agencies and Dependency Courts - Considerations for Program Designers and Evaluators

Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
And
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau

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Introduction

For more than a decade, studies have suggested that a sizable majority of the families involved in child welfare services are affected by parental substance use disorders. With the passage of the Federal Adoption and Safe Families Act (ASFA, Public Law 105-89, 1997), the complex issues of parents with a substance use disorder who are involved with the child welfare system have become the focus of increased attention. Under ASFA, parents have limited time to comply with reunification requirements, including attaining and demonstrating recovery from their addiction and safely care for their children, or face permanent termination of their parental rights. Given the historical low rates of reunification and extended duration of foster care placements for families with substance use disorders, these families are likely to compose most of the families affected by this legislation.^{1,2} In addition, since substance abuse treatment can be a lengthy process and the recovery process often takes longer than is allowed under the ASFA timelines, it is important that substance-abusing parents be engaged in treatment as soon as possible. As a result, finding effective ways to address concurrent substance use and child maltreatment problems in families has taken on renewed importance.

Historically, a lack of coordination and collaboration has hindered the ability of child welfare, substance abuse treatment, and family/dependency court systems to support these families.^{3,4} Although the courts that have jurisdiction in cases of child abuse and/or neglect operate under various names (e.g., dependency, family, or juvenile), for the purposes of this paper they are referred to as dependency courts. The systems operate under different, even conflicting, mandates, priorities, timelines, and definitions of the primary parent, and each system has different goals and definitions of success. One of the primary emphases in discussions of how to best meet the needs of families affected by substance use disorders under ASFA has been on strengthening the collaborative relationships between the child welfare system, the substance abuse treatment agencies, and the courts. Coordinated efforts among child welfare caseworkers, treatment providers, and dependency courts are proposed as keys to timely access to appropriate treatment services, parent participation in child welfare and treatment services, and quality follow-up support.^{5,6}

Models of collaborative intervention vary widely in emphasis. They include such innovations as co-location of substance abuse specialists in child welfare offices or dependency courts, dependency drug courts, joint case management and planning, official committees to guide collaborative efforts, wraparound services, improved cross-system communication protocols, and cross-agency training of staff.

However, there are few empirical studies on the effectiveness of these collaborative models. Available research suggests that the collaborative process functions to provide a variety of supports to parents and has an important impact on service systems. A recent study by Green and colleagues⁷ found that successful collaboration helps to ensure that parents are not overwhelmed by the multiple demands and requirements of their case plans. In addition, collaboration indirectly supports parents by improving the ability of providers to work together on the

parents' behalf. This collaborative process includes such functions as providing a bigger resource base from which to offer needed services, helping providers to better monitor case progress, providing additional services and supports when parents are struggling, improving the coordination and timing of services, and holding providers accountable to each other. Successful collaboration has also been found to influence case outcomes by improving the ability of key stakeholders to make good decisions because of the availability of timely, comprehensive, and accurate information.⁸

To generate new knowledge about innovative and effective child welfare practices, Public Law 103-432 (authorized by Congress in 1994) introduced the concept of Federal waivers to child welfare programs. The introduction of Federal child welfare waivers mainly impacts Title IV-E, which is the Foster Care and Adoption Assistance Program. Since 1996, 17 States have implemented 25 child welfare waiver demonstrations. Four of those States (Delaware, New Hampshire, Illinois, and Maryland) were granted waivers to demonstrate new approaches to families with substance use disorders. Delaware co-located privately contracted substance abuse counselors with child protection managers in county child welfare offices. The substance abuse counselors were responsible for linking parents to treatment and for providing support services to parents while they awaited treatment. Through New Hampshire's waiver demonstration, licensed substance abuse counselors worked with child welfare workers in an advisory and supportive capacity and used their skills to provide training, assessment, treatment, and case management services. Illinois's demonstration focused on treatment retention and recovery for parents who lost custody of their children because of substance abuse disorders. The Illinois model incorporated a proactive intensive services model in which privately contracted case management specialists directly engaged families throughout the treatment process and provided post-treatment support. Maryland planned to implement a collaborative case management model in which privately contracted substance abuse specialists would work with child welfare workers, parent aides, and volunteer mentors to assess the needs of family members and to determine appropriate treatment options. The Maryland demonstration waiver was terminated before its full implementation because of various competing priorities and implementation issues. Table 1 at the end of the Appendix describes additional characteristics of the first three waiver demonstration sites, Delaware, New Hampshire, and Illinois.

Results from the Federal waiver demonstrations found that substance abuse-child welfare collaborations were most successful when backed by strong managerial support. Successful demonstrations were found to require careful service coordination and consistent communication between substance abuse specialists and child welfare staff. The mere co-location of substance abuse specialists in child welfare offices did not ensure that workers communicated about their cases. Successful collaboration requires the establishment of formal systems to share case information and to keep all staff informed about caregiver progress. In addition, adequate and appropriate substance abuse treatment resources need to be available to parents.

Purpose of This Paper

This paper focuses on one particular model of collaboration, the placing of substance abuse specialists in either child welfare offices or dependency courts. The purpose of co-locating substance abuse specialists is to ensure that parents are assessed as quickly as possible, to improve parent engagement and retention in treatment, to streamline entry into treatment, and to provide consultation to child welfare and dependency court workers.⁹ In addition to briefly describing substance abuse specialist programs and their various components, this paper includes findings from eight qualitative interviews of programs that place substance abuse specialists in child welfare offices or dependency courts. The interviews highlight ways in which early decisions about the program's collaborative structure influence other design decisions. Understanding how design decisions are related to one another can help jurisdictions to systematically create substance abuse specialist programs that best meet their specific needs and use resources most efficiently. This information is intended to provide those interested in creating a substance abuse specialist program with valuable data on programmatic and collaborative structures, lessons learned about program design, problems or challenges faced by these programs, and how the issues were resolved. Table 1 at the end of the appendix includes a summary of key components of the programs.

Programmatic and Collaborative Structures of Substance Abuse Specialist Programs

Co-located substance abuse specialist programs vary, each having their own unique programmatic and collaborative structures. The programmatic structure is based on a variety of underlying concepts and arrangements, such as the overall purpose of the program, the roles and responsibilities of substance abuse specialist staff, and the locations and settings of the programs. The collaborative structure includes concepts such as the underlying values and principles guiding the program; funding; staff development, training, and supervision; and joint accountability, outcomes, and evaluation. A more detailed description of each programmatic and collaborative structure follows.

Programmatic Structure

Purpose of the Program

The type of substance abuse specialist program that is designed and implemented varies depending on its purpose. Some programs are begun with the purpose of building linkages and improving communication and collaboration between systems. Other programs hope to improve parents' access to assessment and treatment, whereas others might design substance abuse specialist programs to improve the ability of child welfare and court staff to manage their caseloads. Some programs are designed with all three purposes in mind.

Roles and Responsibilities

The roles and responsibilities of the substance abuse specialist vary and depend on the purpose of the program. If the purpose is building linkages and improving communication and collaboration between systems, the substance abuse specialist often serves as a formal liaison and is responsible for building and enhancing the relationships between the systems. If the purpose is to improve parents' access to assessment and treatment, the specialist may serve as a treatment broker or as a front-line service provider. If the purpose of the program is to improve the ability of child welfare and court staff to manage caseloads in which substance abuse is a factor, the substance abuse specialist may serve as an advisor about the nature of substance use disorders as they relate to all parents and, at times, individual families.

Locations and Settings

Some programs have chosen to assign a substance abuse specialist to regional child welfare offices, for example Connecticut's Project SAFE (Substance Abuse and Family Education). This specialist, who is a child welfare employee, provides consultation and training to child welfare workers, as well as interventions with parents. Similarly, Delaware's Title IV-E Waiver Demonstration used Title IV-E funds to hire substance abuse specialists in each of its three child welfare offices. These specialists conduct substance abuse assessments, identify treatment options, monitor parent treatment entry to improve retention, and provide consultation to child welfare workers. In contrast, some programs place substance abuse specialists in units within the agency for specific functions. Examples of these arrangements include workers placed in child welfare investigation units.

Substance abuse specialists are also located in child welfare offices or dependency courts as full- or part-time substance abuse treatment agency employees or contract staff. This type of connection with the substance abuse treatment agency can facilitate the service integration and treatment referral process. As dedicated staff, the specialists are the direct linkage to treatment provider agencies that can strengthen relationships with treatment providers, facilitate ongoing case monitoring, and maintain cross-system professional relationships.

Collaborative Structure

Underlying Values and Principles

Each partner enters the collaboration with its own perspective and particular assumptions about the mission and mandates of the other partners. Agencies seeking a partnership often have different perspectives on whether substance abusers can

States' experience indicates that successful collaboration requires the establishment of formal systems to share case information and to keep all staff informed about caregiver progress. Adequate and appropriate substance abuse treatment resources also need to be available to parents.

be effective parents; whether the client is the parent, child, or family; and whether the goal is child safety, family preservation, or economic self-sufficiency. Unless these differences are identified and addressed, collaborative agencies may find it difficult to reach agreement on issues related to the program-structured elements. Often the values and definitional issues, such as who is viewed as the primary parent, affect the ways in which staff work across agencies' boundaries. Developing common principles of how the child welfare and substance abuse treatment agencies and staff will work together to best serve the parents in each of their caseloads is critical. Program designers must consider how they will secure each system's buy-in to a shared set of values and principles that drive the outcomes to be measured.

Funding

As jurisdictions move to create substance abuse specialist programs, professionals engaged in program design find that they are dealing with scarce resources. Contracting with a local substance abuse treatment provider may provide some cost efficiencies rather than having the specialist be employed by the child welfare agency. However, the financing strategies employed to provide the specialist program are often locally determined based on unique community influences. The strategies have included State funds, Federal child welfare and substance abuse treatment funds, and local investments.

Staff Development, Training, and Supervision

Child welfare, dependency court, and substance abuse treatment workers must address the complex needs and build on the strengths of their shared parents. To accomplish these goals, they need to continually improve their knowledge and skills through staff development and to receive ongoing interdisciplinary training and supervision. Conventional training in which professionals learn about their own roles and responsibilities without an appreciation for the cross-system roles and the ways to work appropriately in interdisciplinary teams may deepen any divisions between agency staff. Therefore, workers may participate in the cross-agency training program. For example, substance abuse staff may attend the child welfare New Worker Training. Staff supervision is also an important aspect of the programs, and various relationships have been implemented. Some programs have used a dual supervision approach with both agencies, others have contracted with service providers for supervision, and others use child welfare staff for supervision.

Joint Accountability, Outcomes, and Evaluation

Jointly developed outcomes are the best indicators that the agencies agree on the goals of their partnership and how to measure their progress toward achieving those goals. Agreement on accountability and outcomes means that the partners continue to measure their progress using their own, different measures of program success (e.g., treatment retention or child safety) while also agreeing to measure and report their collective effectiveness (e.g., family stability or reduction in re-occurrence of child neglect). The extent of focus on both the outcomes and the issues for data collection and monitoring varies significantly across programs.

Programs Interviewed

There were seven programs included in our review: (1) Connecticut's Substance Abuse Specialists; (2) Massachusetts' Substance Abuse Regional Coordinators Program; (3) Washington's Substance Abuse Services Initiative; (4) Sacramento County's Early Intervention Specialists and Specialized Treatment and Recovery Services; and, programs that were Title IV-E Waiver Demonstrations; (5) Delaware's Substance Abuse Counselors Program; (6) New Hampshire's Project First Step, and (7) Illinois's Recovery Coach Program. These programs were selected for interviews because they are some of the Nation's most well-established substance abuse specialist programs.

Methodology

Qualitative interviews were conducted with key informants from the child welfare, substance abuse treatment, and dependency court systems. The key informants were those responsible for managing the substance abuse specialist program in their jurisdictions. Respondents were contacted by telephone and asked to participate in a 1-hour telephone interview.

The semi-structured interview was generally based on open-ended questions including a number of questions related to programmatic structure (i.e., purpose, roles and responsibilities, and locations and settings), collaborative structure (i.e., underlying values and principles; funding; staff development, training, and supervision; and joint accountability, outcomes, and evaluation), and lessons learned. Table 1, on page 45, provides a matrix of commonalities and differences among programs based on the programmatic and collaborative structures identified.

Results

This section describes the lessons learned in the sites with substance abuse specialist programs that were interviewed for this paper and examines 10 key areas or "critical factors" in the operation of the substance abuse specialist program.

1. Training: Understanding How to Use the Specialist

Child welfare offices and courts use the substance abuse specialist in a number of ways. In each program, the teams have determined the community's specific needs for the program. In some sites, the specialist provides initial screening to all new parents and then conducts follow-up evaluations as clinically indicated; other systems require that all parents participate in an evaluation by the specialist. In at least one program, the specialist is responsible for conducting face-to-face evaluations only for those parents who are referred by either the court or the child welfare system. It is important that the child welfare and court professionals who interact with the specialists clearly understand and receive training on how and when to access the specialist's expertise.

In many sites, substance abuse specialists work closely with a multidisciplinary team to assist the child welfare worker and/or the court in managing parent cases and ensuring that parents are receiving needed resources. Specialists may be involved in the day-to-day communication with the parent and often serve as content experts in child welfare investigations. Interviewees in two sites noted the importance of having the same substance abuse specialist involved with parents throughout the length of their cases. Regardless of the way in which the specialist is used, it is important that each program retain the flexibility to develop the system that works for its local community needs.

2. Training: Cross-Training Multisystem Staff

Cross-training the multisystem providers (child welfare professionals, court staff, and substance abuse coaches and counselors) is of vital importance to the success of the program. Cross-training supports team building, sets the context within which the providers are to operate, and establishes mutual expectations. This is separate from training child welfare and court professionals on the mechanics of how to use the specific services of substance abuse specialists. Cross-training promotes the success of a substance abuse specialist program because all cross-trained participants agree on joint accountability, outcomes, and evaluation. All team members also should have an overall understanding of ASFA and how the deadlines affect the treatment timeline, as well as their professional role in helping the parent navigate the timeline successfully. Cross-training for all team members generally includes providing information and promoting skills to work with trauma and its effects on women and children, as well as providing appropriate screening, assessment, and access to community resources.

3. Specialists' Background and Expertise

In addition to their high level of commitment to the position and to the multidisciplinary team, the skill set and attributes of the specialist are critical to the success of the program. It is important that each specialist have knowledge about, and respect for, the child welfare system and the court, including the institutional history and the core values of both partners. Interviewees also recommended that specialists receive specific ongoing training in their field of expertise. Personal characteristics of a successful substance abuse specialist included having a "never give up" attitude, expertise in substance use and related disorders, expertise in children and family issues including relevant laws, close ties to the community, and excellent communication and follow-through skills. One difficulty noted by interviewees from three sites was that hiring qualified specialists can be time consuming.

Interviewees agreed that the placement of a substance abuse specialist should not be a random assignment of counselors who are sent to conduct treatment assessments in the child welfare office or the court. Finding the right specialist who has a strong background in substance use disorders and its related conditions, and who possesses the preferred attributes described by these seven programs, can make a significant impact on the success of the programs.

4. *Support of Leadership Across Systems*

All of the seven program interviewees expressed the importance of having the support of top leadership across each of the agencies. Program success and sustainability requires that buy-in for the cross-system collaboration occur at all levels of each department and organization. This requirement was noted as especially important in the child welfare system. In most sites, the system administrators worked together to develop an overall framework for their staff to build on during program development, including a set of shared outcomes.

In addition to the top-level agency support, program coordinators ensure that their department supervisors stay informed about the work and utility of the substance abuse specialist. Regular communication between systems can ensure that the leadership understands the roles and responsibilities of the staff who are carrying out the day-to-day activities of the program.

5. *Collaborative Relationships*

Interviewees also stated that it is imperative that the systems involved in operating and monitoring a substance abuse specialist program develop a set of joint values and principles to formalize and guide the collaborative relationships. They found these joint values and principles were essential to the ongoing planning and implementation of the programs. Whenever possible, there were formal partnerships whereby agencies and community organizations have written agreements to collaborate and share responsibility for ensuring that parents have access to needed resources.

It is crucial to involve stakeholders such as the courts, domestic violence counselors, and other community providers in the process as early as possible and to engage them in the dialogue about cross-system collaboration. Involvement of the different systems that are typically needed by the target population, including mental health treatment agencies, child care, housing, and vocational and educational resources, is also important. Interviewees noted that generating the necessary buy-in from each of the different systems to develop joint values and principles and to formalize collaborative relationships can be a slow process. However, the result of this process sets the context within which substance abuse specialists and other providers are to operate and be successful.

6. *Space and Location of the Specialist*

The multisystem program development team often decides on the space and location of the substance abuse specialist. In many situations, the substance abuse specialist is co-located in the child welfare office and strategically placed in a visible location. In other situations, the specialist is co-located in the court and has a visible presence in the child welfare office on a regular basis. One interviewee stressed that the host office, generally the child welfare office, must be willing to take deliberate steps to incorporate the specialist into the office environment. These steps may include introducing the specialists and clarifying their roles

and responsibilities to supervisors and other staff members and disseminating information on how to access the services of the specialist.

7. Communication and Information-Sharing Protocols

Regular and effective communication between the substance abuse specialist, the child welfare staff, court staff and attorneys, and the other community providers is essential to the success of the program. The demands of the position should allow time for regular contact with other team members including time for information sharing through scheduled meetings, daily communication, and team building. In addition, clear understanding of the roles and responsibilities of the various team members, as well as a communication protocol, was suggested as essential for effective communication.

8. Sustainable and Flexible Funding Sources

It is important to ensure that there are adequate and reliable resources to operate the program and to create a strong sense of ownership in its ongoing success. Budgeting and sustainability planning for this type of collaboration should include representatives and funding from each of the systems involved.

There is a need to ensure sufficient stability in the program funding to attract full-time professionals who are passionate about their investment in the multidisciplinary team concept and in the target population they serve. Staffing the substance abuse specialist positions with either short-term funding allocations or grants will make it difficult to attract and hire well-qualified and motivated personnel. In addition, funding for the program needs to be flexible and allow for program revisions that arise as the needs of the system change over time.

9. Evaluation

Interviewees noted the importance of evaluation in two key ways. First, evaluation is critical to understanding the successes and challenges of the substance abuse specialist program and allows for program revisions as needed. Second, positive evaluation results justify the existence of the substance abuse specialist program and generate continued and additional support for the program.

Funding must include the resources needed to support data collection and outcomes management. Standardizing certain instruments, such as screening or evaluation, can reduce costs and provide valuable information necessary for a thorough evaluation. The evaluation of the substance abuse specialist program will provide a solid foundation for quality improvement and for building program sustainability.

10. *Access to Treatment Services*

Access to treatment services after the initial evaluation or assessment is a critical component for success. Interviewees described access as the general availability of appropriate treatment services in the community, and emphasized the role that substance abuse specialists can play in directly or indirectly facilitating parent screening, assessment, and engagement in services. In at least one program, eligibility periods for accessing the services of the specialists were extended from the first 90 days of the case to 6 months to allow for the establishment of relationships between the parent and the caseworker, and with multiple systems.

If planning and initial implementation of the substance abuse specialist program indicate a potential increased number of individuals accessing services, it is also important that treatment services have the resources and capacity to meet the potential increases. These treatment services also need to include ancillary services that address families' needs. Table 1 summarizes the substance abuse specialist programs across the sites interviewed for this paper.

Endnotes

¹ Lewis, M. A., Giovannoni, J. M., & Leake, B. (1997, June). Two-year placement outcomes of children removed at birth from drug-using and non drug-using mothers in Los Angeles. *Social Work Research, 21*(2), 81–90.

² Walker, C., Zangrillo, P., & Smith, J. M. (1991). *Parental drug abuse and African American children in foster care*. Washington, DC: National Black Child Development Institute.

³ U.S. Department of Health and Human Services. (1999). *Blending perspectives and building common ground: A report to Congress on substance abuse and child protection*. Washington, DC: U.S. Government Printing Office.

⁴ Young, N. K., Gardner, S. L., & Dennis, K. (1998). *Responding to alcohol and other drug problems in child welfare: Weaving together practice and policy*. Washington, DC: CWLA Press.

⁵ U.S. Department of Health and Human Services. (1999). *Blending perspectives and building common ground: A report to Congress on substance abuse and child protection*. Washington, DC: U.S. Government Printing Office.

⁶ Semidei, J., Radel, L. F., & Nolan, C. (2001). Substance abuse and child welfare: Clear linkages and promising responses. *Child Welfare, 80*(2), 109–128.

⁷ Green, B. L., Rockhill, A., & Burrus, S. (2008). The role of inter-agency collaboration for substance-abusing families involved with child welfare. *Child Welfare 87*(1):29-61.

⁸ Green, B. L., Rockhill, A., & Burrus, S. (2008). Ibid.

⁹ Austin, M. J., & Osterling, K. L. (2006, January). *Substance abuse interventions for parents involved in the child welfare system: Evidence and implications*. Berkeley, CA: University of California at Berkeley, School of Social Welfare. Available online at: http://cssr.berkeley.edu/bassc/public/EvidenceForPractice4_Substance%20Abuse_FullReport.pdf#search='austin%20%26%20osterling%20and%20substance%20abuse%20interventions

Appendix A: Case Studies

Connecticut: Substance Abuse Specialists

Background and Purpose

In 1989, a class action lawsuit [Juan F. v. O'Neill] was filed against the Connecticut Department of Children and Families (DCF) alleging that DCF was grossly underfunded and understaffed, child abuse complaints were not investigated, high caseloads overwhelmed social workers, and the dwindling supply of foster parents was underpaid and inadequately trained. Plaintiffs brought claims under the reasonable efforts provisions of Title IV-E, the Due Process Clause. The lawsuit resulted in a comprehensive consent decree in 1991 covering all areas of policy, management, procedures, and operation of the department's child protective services.

Connecticut addressed these issues by, in part, developing and implementing Project SAFE (Substance Abuse and Family Education) in 1995 to improve the child protection system. Project SAFE provides a direct link between the child protection system and the adult substance abuse treatment system statewide. The program provides centralized intake procedures and priority access to substance abuse evaluations, drug screenings, and outpatient treatment services. Because of this collaborative program, direct-line social work staff in DCF have the ability to secure timely substance abuse evaluations and screenings for cases in which substance abuse issues are identified.

At the time Project SAFE was created, DCF began hiring substance abuse specialists to serve as consultants and provide expertise and training to its social workers.

Roles and Responsibilities

Substance abuse specialists provide consultation, expertise, and training to child welfare workers to improve the workers' practice and to provide brief interventions for families. The roles and responsibilities vary to meet the different needs of the population served in each area of the State. Examples of roles and responsibilities include (1) home visiting with child welfare workers, (2) collaborating with adolescent and adult treatment providers, (3) interpreting drug screening results for the child welfare workers, and (4) consulting with the workers about referrals to treatment providers. Specialists were involved in 70–80 percent of the 1,978 DCF neglect cases in 2006 for which substance abuse treatment was indicated.

Connecticut has been exploring Illinois' recovery coach model as a way to better engage clients and provide more outreach. This exploration arises from concern about how to help more DCF clients engage in and complete treatment. Currently, child welfare workers and substance abuse specialists work together to provide clients with treatment referrals, but subsequent treatment entry is not ensured.

Locations and Settings

Connecticut is a State-administered child welfare system comprising 15 area offices, divided according to towns, cities, and population clusters. Each area office director determines the number of substance abuse specialists needed for his or her area. There are eight to nine total substance abuse specialists in Connecticut. A specialist may serve more than one area.

In each area, the substance abuse specialist is one member of the Area Resource Group, a clinical team that includes a registered nurse and children's mental health professionals, including at least one clinical social worker and a psychologist.

Underlying Values and Principles

Under Project SAFE, a Memorandum of Agreement between DCF and the Department of Mental Health and Addiction Services (DMHAS) was developed that provides policy-level guidance for specialists and child welfare workers when working with DMHAS-funded treatment providers. Through the agreement, DCF clients receive assistance from the specialists and workers with gaining access to drug tests, evaluations, and outpatient treatment.

On the practice level, however, philosophical differences may remain in whether the client is the parent, child, or family, and whether the goal is child safety, family preservation, or parent recovery. Because of the differing values, some child welfare workers avoid substance abuse specialists, whereas others have productive relationships with them. Successful collaborations result in child welfare workers and substance abuse specialists working on cases together, focused on the children's needs, the family's needs, and the parents' treatment needs.

Funding

Because of the consent decree, the State of Connecticut allocates funds to DCF to pay for 67 unionized clinical specialists with expertise in clinical social work, nursing, substance abuse, children's mental health, and family and clinical psychology. Specialists' salaries range from \$45,000–\$68,000 plus benefits negotiated in the collective bargaining agreement.

Substance abuse specialists are hired by DCF and are employed by the State of Connecticut. DCF pays the specialists from the State allocation. Specialists have the same job class as clinical social workers and are members of the health care union.

Staff Development, Training, and Supervision

DCF State substance abuse specialists must be licensed clinical social workers with additional licensure or certification in alcohol and other drug counseling. The requirement for additional certification can be waived if the candidate has experience working with the substance abuse treatment system. Statewide, there is a shortage of licensed professionals who are qualified to fill these positions, which has led to DMHAS and treatment providers hiring staff without substance abuse credentials.

When substance abuse specialists were first introduced in the early 1990s, child welfare workers and providers experienced a learning curve on how to use the specialists appropriately. The specialists provided cross-training to child welfare workers and providers to help them understand the role and functions of the specialists. Today, many DCF area offices view the worker, provider, and specialist as a "treatment team." In addition, DCF is moving toward a model of training that will provide child welfare workers with an understanding of substance use disorders, treatment, and recovery.

Specialists report to their respective DCF area office director, who is responsible for determining the specialist's responsibilities. The DCF area office directors supervise the specialists, which includes providing ongoing training, coaching, improving knowledge and clinical skills, and providing other necessary support to improve clinical outcomes for children and families. Specialists are required to maintain their licensure and certifications.

Joint Accountability, Outcomes, and Evaluation

Since introducing substance abuse specialists, DCF has collected activity data including the number, frequency, and type of consultations provided by the substance abuse specialists on each case. In addition, DCF collects data on triage, case conferencing, tracking, and case management.

Each area office collects data at the area level. However, the data are not standardized and are therefore difficult to analyze on a statewide, aggregate basis. To address this challenge, DCF has implemented the use of the Global Assessment of Individual Needs - Short Screener (GAIN-SS), a standardized screening for co-occurring disorders to be conducted by child welfare workers. Substance abuse specialists train child welfare workers to use the GAIN-SS instrument. Recently, DCF began providing specialists information on the extent of GAIN-SS usage and the training and technical assistance needs among workers in specific area offices.

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Delaware: Substance Abuse Counselors Program

Background and Purpose

In 1996, the U.S. Department of Health and Human Services granted the Delaware Department of Services for Children, Youth, and Their Families' Division of Family Services (DFS) approval to implement a Title IV-E Waiver Demonstration Project. The purpose of Delaware's 5-year waiver demonstration was to reduce the cost of out-of-home care by focusing on early identification of parental substance use disorders and substance abuse treatment service referrals. Before the demonstration project, DFS had limited access to substance abuse counselors. DFS applied for the waiver demonstration with the intent of using the expertise of substance abuse treatment counselors to reduce removals of children from the home or facilitate reunification of families with substance use disorders.

Although all child welfare workers received 3 days of training related to substance abuse, they had limited hands-on experience in working with these issues. The substance abuse counselors, however, were familiar with the treatment network, both within and outside of Delaware (e.g., Philadelphia and Maryland), had contacts in an array of treatment agencies, and understood the variety of programs offered by each agency (e.g., perinatal, methadone, and adolescent). With the support of the substance abuse treatment counselors, parents were provided with referrals that better reflected their individual and treatment needs.

In addition, child welfare workers experienced difficulty in negotiating the managed care system that governs a significant portion of the substance abuse treatment network. One of the biggest challenges was navigating Medicaid and managed care preauthorization specifications regarding treatment length and coverage and determining which treatment agencies accepted Medicaid. The Title IV-E waiver provided an opportunity for DFS to use substance abuse counselors who were familiar with the managed care system.

In the evaluation results, the Waiver Demonstration Project was not cost-neutral, nor did it demonstrate cost savings. As a result, the demonstration project was terminated in December 2001. Although Federal funding for the project ceased, DFS, substance abuse treatment agencies, child welfare workers, and courts saw the value in using substance abuse counselors who could assess and connect clients to appropriate treatment in a timely manner. The juvenile court wrote letters to DFS praising the expertise of counselors in helping parents to complete treatment. DFS also received letters from clients testifying to the positive impact the counselors made on their lives. As a result, DFS decided to continue the Substance Abuse Counselors Program using non-Federal Title IV-E sources.

Roles and Responsibilities

The primary roles and responsibilities of the substance abuse counselors include providing consultation, evaluations, referrals, linkages, and case management services to adult DFS clients who may have a substance use disorder. Specifically, the substance abuse counselors fulfill the following responsibilities:

1. Collaborate with treatment units;
2. Provide consultation services to child welfare investigation units;
3. Identify clients with suspected or documented substance use disorders;
4. Conduct home visits with the DFS social worker or on their own;
5. Refer clients with suspected or documented substance use disorders to a substance abuse treatment agency for an assessment;
6. Link and monitor substance abuse treatment services provided by substance abuse treatment agencies;
7. Provide continued support to clients while the client is engaged in treatment;
8. Coordinate services and case monitoring with the DFS social worker;
9. Keep DFS informed of activities and status of the client;
10. Participate in child safety decisions;
11. Participate in case conferences and jointly develop case plans with DFS;
12. Enter notes summarizing client contacts into the DFS computerized case management system known as FACTS (Family and Child Tracking System);
13. Conduct or arrange random urine screenings for clients as needed (to be determined by either the substance abuse counselor or the DFS social worker);
14. Testify in court as needed (if proper subpoenas have been issued); and
15. Provide quarterly "brown bag" seminars to DFS staff to cover a variety of timely substance abuse issues. Recently, seminar topics have included how to recognize whether clients may be using methamphetamine or heroin. Attendance is voluntary; however, many DFS staff attend because of the useful information provided.

DFS and treatment unit supervisors emphasize the need for the counselors to work flexible hours to accommodate the child welfare aspects of the case (i.e., visitations and home visits). Substance abuse counselors consult with an average of 15 DFS caseworkers and carry caseloads ranging from 26–37 families.

Locations and Settings

Delaware has three counties and four regional child welfare offices—one office each in Sussex and Kent counties and two offices in New Castle county. There is one substance abuse counselor assigned to each region. DFS contracts with community-based substance abuse treatment agencies in each region to employ the substance abuse counselors and to provide clinical oversight. The DFS treatment program manager is involved in interviewing these potential substance abuse counselors.

The substance abuse counselors are co-located in the community-based substance abuse treatment and agency with DFS treatment staff in each of the four regional DFS offices. DFS provides each substance abuse counselor with office space, a computer, a telephone, and a State vehicle. By co-locating the substance abuse counselors with DFS staff, the counselors are available either to accompany DFS staff on home visits and to case conferences or to provide consultation to DSF staff. The counselors are considered part of their respective DFS treatment units and are included in all unit meetings.

Underlying Values and Principles

In 1998, DFS signed a Memorandum of Understanding with Delaware Health and Social Services, Division of Substance Abuse and Mental Health (DSAMH), to ensure that every DFS client is given priority status to receive a substance abuse assessment. Although this arrangement was made independently of the demonstration project, it provided the foundation for building shared values and principles between agencies.

Several aspects of the program design have helped build a shared set of values between child welfare and substance abuse systems. For example, new substance abuse counselors must complete a 6-month DFS New Worker Training protocol before they can carry a caseload. Through the DFS New Worker Training, the substance abuse counselors learn child welfare and safety issues as well as DFS policies and procedures. The counselors, having gone through New Worker Training, understand where differences in values can easily cause misunderstandings between the child welfare and substance abuse treatment systems. The DFS treatment program manager conducts trainings for all treatment agencies in the State on DFS's Child Protection Registry, child welfare timeframes (Adoption and Safe Families Act), substance abuse, treatment, and recovery.

Funding

DFS contracts with these substance abuse agencies to hire the certified substance abuse counselors. DFS transfers funds to the agencies in exchange for their employment, training, and supervision of counselors. Since DFS funds the Substance Abuse Counselors Program, DFS establishes the terms and conditions of contracts with the agencies. When the Title IV-E Waiver Demonstration Project ended, DFS reallocated funding from other treatment contracts to continue the Substance Abuse Counselors Program.

DFS spends approximately \$150,000 annually on the substance abuse counselors' salaries, health insurance, Federal Insurance Contributions Act taxes, association dues, conference fees, and urinalysis screenings. The contracts between DFS and the substance abuse treatment agencies are the cost-reimbursement type. As such, the agencies submit invoices to DFS each month to cover monthly expenses incurred by the substance abuse counselors. The substance abuse counselors have access to a State vehicle; DFS absorbs the cost of State vehicle use.

Staff Development, Training, and Supervision

Substance abuse counselors must maintain a current certification in drug and alcohol counseling (CDAC) and must receive clinical supervision by a credentialed supervisor. The treatment agencies that employ the counselors have their own desired qualifications and requirements based on the populations they serve.

As discussed previously, new substance abuse counselors must complete the DFS New Worker Training protocol. The DFS treatment program manager provides opportunities for additional in-service training as well. All counselors must maintain their CDAC certification, and some treatment agencies require additional training.

Delaware uses a dual supervision model to train and supervise counselors. The substance abuse treatment agencies provide a credentialed supervisor to conduct ongoing clinical supervision and training of the counselors. DFS provides supervision for the child welfare aspects of each counselor's cases. The DFS treatment program manager and the DSAMH director of drug and alcohol services coordinate and facilitate quarterly meetings with all parties involved in the Substance Abuse Counselors Program (DFS, DSAMH, treatment agencies, and counselors). At the quarterly meetings, these parties review and discuss any systemic issues and concerns and develop programmatic improvement strategies.

Joint Accountability, Outcomes, and Evaluation

Since 1996, the DFS Treatment Program Manager has collected data monthly, from the substance abuse counselors, summarizing their caseload and the status of each client. The data collected are as follows:

- Date each case is referred by child welfare to the substance abuse counselor;
- Date of the counselor's first contact with the client;
- Whether the client was referred to a treatment agency;
- Whether the client attended treatment/scheduled appointments;
- Duration of treatment episode;
- Existence of co-occurring mental health disorders and domestic violence issues;

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- Whether the client was in substance abuse treatment at the time of referral;
 - Whether the children were placed in out-of-home care;
 - Identified barriers to success; and
 - The client's current prognosis.

In evaluating a client's current prognosis, the counselors select one of the following choices:

- Excellent: Client connected to treatment, consistent negative urines, and improvement in functioning noted;
- Good: Client attended evaluation, appears to be motivated toward treatment, mostly negative urines, and little improvement in functioning noted;
- Fair: Client attended evaluation, little motivation toward treatment, some negative urines, and little improvement in functioning noted; and
- Poor: Client did not attend evaluation, no motivation toward treatment, no negative urines, and no improvement in functioning noted.

If a counselor gives a client a prognosis of "fair" or "poor," the counselor will increase efforts to engage the client through more frequent contact and potentially increasing the level of structure in the substance abuse treatment program for the parent.

DFS's budget does not allocate money for an independent program evaluation. Thus, given limited evaluation resources, the first analysis of the post-demonstration project data was completed in 2006 by a graduate student/research assistant. The results indicated that in 2005, 24 percent of parents working with the substance abuse counselors completed a treatment program. Because of the evaluation, DFS, the treatment agencies, and the substance abuse counselors are developing strategies to improve the treatment retention rates among DFS clients. For example, peer mentors have been suggested as a possible additional component of the program.

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Illinois: Recovery Coach Program

Background and Purpose

The Recovery Coach Program in Illinois emerged from a history of collaborative efforts focused on improving services for substance-affected families in child welfare. In 1986, the Department of Children and Family Services (DCFS) and the Department of Human Services (DHS), Division of Alcoholism and Substance Abuse (DASA), launched Project SAFE (Substance and Alcohol-Free Environment.) This pilot project was launched to learn whether DCFS and DASA could increase the number of women with substance use disorders engaged and retained in treatment if their unique needs, such as child care, transportation, and lack of insurance for treatment, were met.

In 1998, DCFS launched a second pilot project, the Intact Family and Recovery Program, in Cook county. The cornerstone of the project is the collaboration between child welfare workers and alcohol and other drug abuse (AODA) workers in serving mothers of prenatally exposed infants. This collaboration allows the engagement of mothers into treatment immediately after the birth of their child with the goal of keeping the family intact. This pilot project revealed that there was a further need for cross-training of child welfare and AODA workers and that these workers needed the ability to address clients' co-occurring issues (i.e., domestic violence and mental health issues). The project also revealed that clients benefited when they had an advocate to assist them in progressing through treatment.

When presented with an opportunity to apply for a Title IV-E Waiver Demonstration, DCFS believed that its experience in addressing substance abuse issues among child welfare clients would help the agency create and implement an effective waiver demonstration program. The waiver demonstration program began in April 2000 in Cook county (Chicago and suburban areas) and continued until June 2005. The purpose of the waiver demonstration program in Illinois was to test a model of intensive case management in the form of a recovery coach. The use of a recovery coach was intended to increase access to substance abuse services, improve substance abuse treatment outcomes, shorten the length of time in out-of-home care for the child, and affect child welfare outcomes, including increasing rates of family reunification and decreasing the risk of continued maltreatment.

At the conclusion of the demonstration program, an independent evaluator determined that the program met all of its intended outcomes. The program also provided a cost savings of \$5.6 million over the 5 years of the demonstration, which DCFS was able to reinvest in State child welfare services. As a result, DCFS received a 5-year extension to expand the program into the southern, more rural, part of the State, including Madison and St. Clair counties. The new project began in December 2006 and will end in December 2011. The purpose of the current Title IV-E waiver project continues to be the use of a recovery coach.

Roles and Responsibilities

The role of the recovery coach is to be an advocate for DCFS clients in working with their child welfare workers, the courts, the substance abuse treatment agencies, and their family members. As an advocate, the recovery coach assists the parent in obtaining benefits and in meeting the responsibilities and mandates related to the parent's child welfare case and recovery treatment plan. Recovery coach services are provided for the duration of the case and may be continued for a period of time after the child welfare case closes.

Recovery coaches engage DCFS clients in all activities related to the substance abuse aspects of a case, including comprehensive clinical assessments, service planning, outreach, and case management. The following paragraphs describe some of these activities.

The clinical assessments focus on a variety of problem areas, such as housing, domestic violence, parenting, mental health, and family support needs. Recovery coaches also conduct urinalysis to help demonstrate to the court whether the client has tested negatively for substance use.

In service planning, recovery coaches coordinate DCFS and other services. They also arrange for the appropriate level of care and ensure that there are no gaps in service.

In conducting outreach, recovery coaches work with substance-abusing families in their community. The coaches improve communication between the child welfare worker and substance abuse treatment facilities to ensure a seamless delivery of services. Recovery coaches also transport clients to appointments and court hearings, arrange and attend meetings with families and treatment providers, and make joint home visits with child welfare caseworkers and/or treatment agency staff. At least one recovery coach is always on call during evenings, weekends, and holidays to respond to any emergencies that may arise. Recovery coaches engage in information sharing with child welfare, treatment providers, and juvenile court personnel. The information sharing is intended to help inform permanency decisions. To ensure recovery, child welfare workers and treatment providers contact recovery coaches if they sense a client is about to relapse.

Locations and Settings

The offices of recovery coaches are located in a Treatment Alternatives for Safe Communities (TASC) office, the organization initially responsible for providing recovery coach services to clients in the demonstration group. This office is close to the Cook county juvenile court, a location found to be effective, particularly if the recovery coach is unable to locate a client. Thus, if the client appears in court, Juvenile Court Assessment Project (JCAP) professionals are able to identify his or her recovery coach and immediately re-link the client to that recovery coach. Recovery coaches, however, often spend most of their time in the field.

Clients receiving recovery coach services meet the recovery coach liaison at JCAP immediately after their substance abuse assessment. DCFS contracts with Caritas, a central intake service organization, to perform the initial JCAP assessment, make a treatment recommendation, and set up an intake appointment at one of the treatment agencies participating in the interagency agreement between DCFS and DASA.

There are four recovery coach teams that each focus on clients and/or specific issues (e.g., men, women, or co-occurring disorders). Each team has one supervisor and four to five recovery coaches and each team includes outreach workers, sometimes known as trackers, who are responsible for finding clients who have become difficult to locate at some point during the recovery process. There are two trackers in Cook County, and one of the team supervisors works with both trackers.

Underlying Values and Principles

Since 1995, DCFS has had in place a formal interagency agreement with DHS and DASA. Periodically, DCFS, DHS, and DASA review this interagency agreement to ensure that DCFS clients continue to receive priority treatment admission. DCFS contracts with approximately 60 private agencies (such as Catholic Charities and Lutheran Social Services of Illinois) to provide child welfare case management for about 80 percent of Illinois families with open child welfare cases. The contracts and interagency agreements with private agencies outline DCFS policy and procedures for serving substance-affected families. The agreements clearly outline procedures for working productively and collaboratively with child welfare workers and recovery coaches. In addition, the DCFS contracts with TASC and Caritas specify DCFS' expectations for assessment, referral, recovery coach services, and data collection.

Funding

DCFS spends approximately \$2.2 million annually on the Recovery Coach Program, including costs for the JCAP services, the computer-based data collection integrated system, and the recovery coaches. Recovery coaches receive the same benefits as TASC employees. Recovery coaches are required to use their own vehicle, but they receive the Federal rate allotment for mileage reimbursement.

Staff Development, Training, and Supervision

Recovery coaches must be either a Certified Alcohol and Drug Counselor (CADC) or a Certified Assessment/Referral Specialist (CARS). Recovery coaches have 1 year after hiring to obtain the required certification. Supervisors are required to have a master's degree as well as experience in the child welfare and substance abuse treatment systems. Caritas and TASC are responsible for hiring, training, and supervising recovery coaches. DCFS contracts with TASC to provide supervision and training of recovery coaches. Recovery coaches are required to participate in a variety of DCFS and DASA trainings that cover various topics, including addiction, relapse prevention, the *Diagnostic and Statistical Manual of Mental Disorders*

(Fourth Edition), the American Society of Addiction Medicine, fundamentals of assessment, ethics, service hours, client-tracking systems, service planning, case management, and counseling.

Since the first waiver project, DCFS personnel have provided training on the role of recovery coaches to child welfare agencies and substance abuse treatment providers. DCFS emphasized to child welfare agencies that the recovery coach was not to replace the child welfare worker, but would instead provide a bridge to the client and the treatment community regarding all substance-related aspects of the child welfare case. The intention of the training was to emphasize the expertise of the recovery coach in assisting the parents through the recovery process.

In addition, the DCFS AODA Waiver coordinator provides cross-training to ensure collaboration between JCAP, Caritas, TASC, and other collaborating agencies. DCFS has also extended its training into courts to inform judges about the recovery process and the role of recovery coaches.

The DCFS AODA Waiver coordinator meets monthly with supervisors from TASC, JCAP, and Caritas to discuss the recovery coach program and any data collection issues. Cross-training about the various roles in the collaboration also occurs during these monthly meetings.

Joint Accountability, Outcomes, and Evaluation

DCFS contracts with Caritas to coordinate a computer-based data collection integrated system called TRACCS (Treatment Record and Continuing Care System). Caritas collects data from child welfare workers, recovery coaches, and treatment agencies. The database includes a variety of client (e.g., demographics and placement history) and social service (e.g., placement records) information.

The current waiver demonstration project requires that an independent evaluator determine whether the project has met its outcomes and whether the project is cost-neutral. The Children and Family Research Center at the University of Illinois at Urbana-Champaign School of Social Work analyzes the collected data to measure whether the following outcomes are being met:

(1) increased rates of reunification; (2) shorter lengths of stay in foster care; (3) a reduction in reallegations of child abuse and neglect; and (4) higher success rates for completion of parental substance abuse treatment among demonstration group participants. According to the Center's January 2006 evaluation report, DCFS has achieved its first three outcomes, with statistically significant differences between the control group and the demonstration group. Although no comparison was available for the fourth outcome, beginning in April 2004, 22 percent of clients in the demonstration group had completed treatment.

DCFS realized a cost savings of \$5.6 million over the 5-year span of 2000–2005, which it reinvested in State child welfare services.

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Massachusetts: Substance Abuse Regional Coordinators Program

Background and Purpose

In 1998, the Massachusetts Department of Social Services (DSS) Child Welfare Department created a strategic plan entitled "The Project on Addressing Substance Abuse," in collaboration with the Massachusetts Department of Public Health's (DPH) Bureau of Substance Abuse Services (BSAS). The plan included six recommendations for improving substance abuse services for child welfare clients.

One recommendation was to establish a Substance Abuse Unit to focus exclusively on building child welfare's capacity and expertise in responding to substance abuse allegations. In 2000, DSS and DPH created and co-funded a managerial position at the child welfare central office. The two departments also hired the first substance abuse director with the agreement that DSS would be responsible for administrative oversight. In 2001, DSS and DPH used additional funding to create a central office assistant to the substance abuse director.

From 2001–2004, the substance abuse director and the assistant were responsible for training, policies, and projects related to substance abuse, including drug testing policies and procedures. In 2004, because of budgetary constraints, DPH could no longer co-fund the director position. The resulting budgetary considerations for DSS led to staffing changes that presented an opportunity to reflect on the strengths and weaknesses of the Substance Abuse Unit's activities and to configure a new program design and staffing plan.

Several factors led to DSS's continued support of the Substance Abuse Unit, including

(1) the Substance Abuse Unit had demonstrated the value of and demand for its services to DSS; (2) governmental leadership, including the support of the DSS commissioner at the time, for integration and system changes in child welfare and substance abuse was in place; and (3) the Massachusetts Child and Family Services Review, completed in fiscal year 2001, highlighted the need for DSS to improve substance abuse services.

However, two issues were highlighted for program and staffing revision. First, standardized drug testing services provided from 2002–2004 demonstrated that child welfare workers needed more training and support for cases in which substance abuse is a factor. During this timeframe, all drug testing was provided at one laboratory location, and results were reported to child welfare. Child welfare workers, partially from a lack of knowledge about when testing is appropriate, were unnecessarily referring large numbers of cases for drug testing. Second, with responsibility for all six regions, the two-person Substance Abuse Unit struggled to provide services in the field. There was a need to add and reconfigure staff to allow the Substance Abuse Unit to provide services on a regional level. For example, each of the six regions had received a mental health specialist in 2001.

With funding from DSS, the Substance Abuse Unit created six regional positions in 2004 and called the effort the Substance Abuse Regional Coordinators Program. The purpose of the program is to build child welfare's capacity and expertise to address substance abuse, create linkages between child welfare and the substance abuse provider community, and collaborate with colleagues in mental health and domestic violence.

Roles and Responsibilities

The roles and responsibilities of the coordinators were developed by the DSS substance abuse director. In developing coordinator roles, the director wanted to exclude responsibilities that would involve coordinators in extensive clinical work, which would hinder their ability to focus on system-level change, promote interagency collaboration, and build caseworkers' capacity and expertise to address substance abuse in their cases. Thus, case management and home visiting were intentionally excluded from the coordinator's role, though the coordinators regularly consult and provide expertise and guidance to DSS staff regarding substance abuse-related cases. Coordinators also attend multidisciplinary meetings and case staffing to provide their expertise and to ensure that DSS workers are adequately supported to address substance abuse.

Within these boundaries, DSS was intentionally broad in developing the various possible roles for the coordinator. Central administration wanted to give regional administration shared power to prioritize the various roles. Although central administration wanted to provide overall expertise and a common language and purpose among coordinators, the regional administrators could determine which roles would best serve the needs of the clients and caseworkers in that particular region. DSS also intentionally established common responsibilities between coordinators. For example, the substance abuse director planned to hold weekly meetings with all the coordinators, providing a venue for coordinators to learn from one another's experiences.

The roles and responsibilities listed in the coordinator job description are as follows:

- Conduct a capacity needs assessment on substance abuse for the assigned region and its corresponding area offices;
- Develop and implement substance abuse capacity building and action plans. Provide resources, support, and training to increase the level of substance abuse expertise in the assigned region;
- Implement regional and area objectives outlined in "The Project on Addressing Substance Abuse," in conjunction with regional leadership;
- Provide case consultation to assigned area offices as needed;
- Monitor ongoing pilot project efforts on substance abuse within assigned regions;

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- Participate in regional and area team meetings, including continuous quality improvement teams, family group conferencing, and other clinical meetings;
 - Work with community-based substance abuse providers to establish working relationships between the provider and the local DSS area office. This work includes improving communication with the provider and developing protocols to improve DSS clients' access to services and to streamline service provision;
 - Participate in regional and area interagency or community-based substance abuse or child welfare meetings;
 - Collect regional and area data on substance abuse when needed; and
 - Participate on regional and statewide projects and committees as needed.

DSS works with approximately 20,000 families on any given day. The coordinators do not work directly with families in their case consultation role, but conduct a total of 50–75 consultations with the child welfare worker per month.

All the coordinators have a substance abuse treatment background, which has been invaluable as they build relationships with treatment providers. Their treatment background is also a challenge for the program, because the coordinators enjoy and may prefer to focus on the case consultation part of their work. Although the coordinators understand their role in promoting system change, most do not have a background in building interagency relationships. They also face the challenge of frequent misperceptions about their role from within both DSS and BSAS. For example, people often assume the coordinators are to be directly involved with cases. When the coordinators become involved in casework, as many DSS and BSAS staff believe is the coordinator role, keeping system change and capacity building at the forefront becomes a challenge.

Locations and Settings

Massachusetts child welfare services are State administered. DSS provides services through six regions and through area offices within each region. The DSS Substance Abuse Director works with each regional director to select the coordinator. The positions are known technically as regional positions (not central administrative office positions). There is one substance abuse coordinator for each region, working in his or her respective regional office while also providing services to area offices.

Underlying Values and Principles

A joint value for interagency collaboration between DSS and DPH/BSAS predated the Substance Abuse Regional Coordinators Program. The collaboration was developed during the creation of the 1998 strategic plan to address substance abuse and continues to exist in the Massachusetts Family Recovery Collaboration (MFRC). MFRC is an effort launched in 2006 to develop an integrated, coordinated

system of care for families in which parental substance use disorders result in the maltreatment and/or neglect of children or increase the risk of such maltreatment or neglect. Its goal is improved well-being of children and strengthened families. MFRC is governed by a Memorandum of Understanding between DSS, DPH/BSAS, the Administrative Office of the Trial Court Juvenile Department, and the Wampanoag Tribe of Gay Head Aquinnah. The memorandum specifically explains joint values and principles for those involved in the MFRC collaboration.

The substance abuse director's weekly meetings with coordinators also reinforce the program's purpose and underlying values and principles. In the program's first 6 months, the leadership from the substance abuse director and weekly meetings were critical to help the coordinators form relationships with the child welfare workers and substance abuse treatment providers. The meetings continue to be important for helping the coordinators lead their regions to continue building their own capacity to address substance abuse.

Funding

The Substance Abuse Unit created six regional positions in 2004. Since the coordinators are technically regional positions, DSS allocates State funds to the regions to cover the coordinators' salaries, workspace, travel, and parking. The coordinators are State union positions, not funded by grants or legislative allocations. The DSS Substance Abuse Unit, however, does not have a program budget for other aspects of the program, such as purchasing equipment or funding conference participation.

Staff Development, Training, and Supervision

Each coordinator is required to have at least a bachelor's degree in human services, social work, or a related field. Licensed professionals are encouraged to apply. Four years of full-time or equivalent part-time professional experience in social work, social casework, health care administration, public health, program administration, hospital administration, or program management is also required. However, either a bachelor's degree holder with 2 years of experience or a master's degree holder with 1 year of experience is also qualified.

Massachusetts has filled all six positions. All have master's degrees (one is in nursing, two are in social work, and two are Licensed Mental Health Counselors), and one has a Ph.D. It was difficult to find the right candidates for these positions for several reasons. These positions require professionals who are able to meet the relatively new challenge of working across governmental systems (including navigating the politics). And DSS strongly believed that the program's success depended on identifying candidates who have a background in working with families.

New coordinators participate in the 1-month-long child welfare New Worker Training, which is the key to understanding how child welfare operates. They typically receive a basic introduction to the program and job responsibilities from the substance abuse director. New hires also shadow experienced coordinators.

The director hosts a weekly meeting of the coordinators in which they are able to learn from one another's experiences. In the initial implementation of this program, these weekly meetings provided coordinators with support and direction as they worked to become integrated into the child welfare system. They gained a mutual sense of belonging and trust and built relationships with substance abuse treatment providers. Coordinators have recently started arranging meetings between themselves, representatives from the child welfare offices where they work, and local substance abuse treatment providers to build relationships and initiate cross-training.

Under a matrix-management model for supervision, the primary supervision for each coordinator is at the regional level. The DSS substance abuse director provides clinical supervision and technical support. Two factors may influence the supervisory relationships in the future. First, Massachusetts intends to hire a co-director of integrated practice for substance abuse and mental health, who will take over management of the program. Second, at the regional level, new clinical managers have recently been put into place, and some have substantial substance abuse experience.

Joint Accountability, Outcomes, and Evaluation

The program does not track outcomes, but there are ways in which DSS is evaluating progress. In the weekly meetings, the substance abuse director can consistently gather information about coordinators' success. The director uses the following indicators to determine whether the purpose of the Substance Abuse Unit and the Substance Abuse Regional Coordinators Program is being effectively carried out:

- High utilization of the coordinator by caseworkers and external providers;
- Stronger linkages between child welfare and substance abuse treatment providers; and
- Increased capacity of child welfare to address cases in which substance abuse is a factor.

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New Hampshire: Project First Step

Background and Purpose

During the late 1990s, New Hampshire's Statewide Automated Child Welfare Information System, known as New Hampshire Bridges, documented a number of co-occurring issues facing child welfare clients, including substance abuse. Both the data and the opportunity to apply for a Title IV-E Waiver Demonstration Project led professionals from the New Hampshire Department of Health and Human Services (HHS), including representatives from the Division for Children, Youth and Families (DCYF) and what is now the Division of Alcohol and Drug Abuse Prevention and Recovery (DADAPR), to come together to determine how to better address the needs of families affected by substance use disorders who are involved in child welfare services. DCYF adapted Delaware's Substance Abuse Counselors Program, also funded as a Title IV-E Waiver Demonstration (see page 15).

In May 1998, New Hampshire DCYF received approval to run its proposed Title IV-E Waiver Demonstration Project, known as Project First Step. New Hampshire implemented its demonstration project in two of the State's most populated district office areas, which serve the majority of Hillsborough county. The waiver allowed New Hampshire to demonstrate whether spending the funds to increase capacity to provide parents with substance abuse treatment could improve reunification and other family permanency and safety outcomes for children from substance-affected families. HHS involved the University of New Hampshire (UNH) Family Research Lab, as well as field supervisors, caseworkers, and stakeholder groups, to provide its expertise during the program design phase.

Four factors influenced the demonstration project design in New Hampshire:

- Compared with many other States, the rate of substantiated child abuse and neglect referrals is relatively low. This factor is due, in part, to the State's stringent due process requirements for substantiation of allegations of child abuse and neglect. New Hampshire's Child Protection Act provides for a relatively long, 60-day assessment before substantiation. Substance abuse screening is conducted before substantiation, which has documented that one-fifth to one-fourth of all reports assigned for face-to-face assessments have an identified substance abuse issue. However, since 1996, just 10–11.5 percent of all DCYF cases have been substantiated. Upon investigation, 50 percent of those substantiated assessments that resulted in temporary removal or in-home services had parental substance abuse identified;
- Although heroin use is substantial in some areas, alcohol is the primary substance used by clients;
- New Hampshire is involved with most referrals on a short-term basis, but repeatedly (sometimes for a few months out of a year, over a period of years); and

- The program designers made an assumption that with children being removed from homes in only about 10 percent of cases, the actual number of children who would be traditionally eligible for Title IV-E funding in New Hampshire's demonstration project would be relatively small. Most families would be receiving in-home services.

HHS decided to co-locate Licensed Alcohol and Drug Counselors (LADCs) in two Child Protective Services (CPS) district offices, one in Nashua and the other in Manchester. From November 1999 through December 2004, reports that DCYF accepted for assessment were randomly assigned to experimental (enhanced services) or control (standard services) groups. Child Protective Service Workers (CPSWs) and LADCs were mutually assigned to families in the experimental group. Families in the control group received standard child protection and community-based assessment and treatment services.

By July 2003, a total of 435 families had enrolled in the demonstration, with 222 families in the experimental group and 213 in the control group. Children from families in the enhanced services group were more likely to remain with kin and had fewer foster care placements than children from families in the standard services group. Further, the average number of foster care placements for enhanced group children was significantly lower than the average number of similar placements for standard group children. Those children in the enhanced group who could not be safely reunified, reached the concurrent goal identified by Termination of Parental Rights sooner than those in the standard group. Regardless of substantiation of placement, children and their parents in the enhanced group demonstrated improved outcomes in the area of well-being.¹

At the conclusion of the demonstration project, New Hampshire found that the cost of the enhanced LADC/CPSW services to families remained constant, so the project did not demonstrate savings in Title IV-E funds. Nevertheless, the addition of LADCs improved reunification and permanency rates and allowed the CPSWs to focus on all aspects of their cases by having a better connection with substance abuse treatment and recovery. By 2004, DCYF viewed the project as extremely important and genuinely believed that approaches like Project First Step were necessary to meet the needs of its clients. Thus, Project First Step was allowed to continue its efforts to increase clients' access to quality assessment and timely treatment and to encourage child protection, substance abuse treatment, and community services to create a system of integrated services.

The demonstration had two lasting effects that contributed to the program's continuation. First, families in the enhanced services group experienced improved kinship care as an alternative to foster care placement. In identified cases, LADCs worked with kinship caregivers to increase their awareness of the dynamics of addiction and recovery. LADCs also served as mediators between parents and kinship caregivers to obtain mutual support of the visitation and reunification plan.

¹ Bluhm, B. (2007). *Project First Step: Approaches to co-occurrence of child maltreatment and substance abuse*. Unpublished. 1.

Second, these counselors were able to engage parents in the enhanced group with the understanding that information shared with LADCs was subject to State and Federal confidentiality laws. Thus, parents were more open to the notion that the services of the LADCs would be helpful.

Roles and Responsibilities

During the Title IV-E demonstration, LADCs worked with CPSWs in an advisory and supportive capacity by providing training, assessment, treatment, and case management services. LADCs conducted an initial drug and alcohol assessment concurrently with the CPS maltreatment investigation and were involved from the outset in the risk and safety assessment to facilitate better decisions regarding child safety and out-of-home placement. LADCs could provide direct outpatient treatment or facilitate treatment access, thereby improving the timeliness of access to substance abuse treatment services and increasing the likelihood of positive treatment outcomes. In addition, LADCs had the option to continue working directly with parents for an additional 2 months after completion of the maltreatment assessment or CPS case opening.²

After the demonstration project concluded in 2004, DCYF expanded the duties of the LADCs. LADCs are now involved with all referrals in their respective district offices where substance abuse is indicated as a contributing factor. LADCs are involved as consultants with CPSWs, or they become involved directly with parents or caretakers when assessment and family service supervisors determine that substance abuse is a contributing factor to alleged or substantiated child abuse or neglect. If there are primary indicators of significant parent or caretaker substance abuse, LADCs may provide a direct substance abuse assessment and initiate referrals to community-based treatment.

LADCs help CPSWs reduce such barriers as access to treatment facilities and provide direct individual treatment for parents or caretakers who are receptive to treatment, but have not yet accessed treatment. LADCs currently train CPSWs to incorporate substance abuse screening questions in all abuse and neglect assessments to help clarify the existence or extent of substance abuse. During the assessment process, LADC services result in enhanced community-based family support. In open DCYF cases, LADCs are involved, both as substance abuse treatment case managers for parents and caretakers and as readily available consultants for CPSWs and supervisors. For cases that involve in-home services, LADCs provide services consistent with family preservation. For those cases in which children are in temporary out-of-home care, LADC services help to expedite reunification or placement into kinship care, consistent with services attributed to time-limited family reunification.

² Children's Bureau. (2007, June 5). Profiles of the Child Waiver Demonstration Project: New Hampshire – Services for caregivers with substance use disorders. Accessed August 1, 2007, from http://www.acf.HHS.gov/programs/cb/programs_fund/cwwaiver/2007/newhampshire.htm

For those situations in which the concurrent permanency plan is adoption, LADCs continue to be consultants in the case-planning process and to provide direct service to parents or caretakers if treatment resources are not available.³

Locations and Settings

In New Hampshire, the State HHS manages all child welfare and substance abuse services through district offices arranged by population and accessibility (e.g., ease of transportation). During the Title IV-E demonstration, LADCs were located in the Nashua and Manchester offices (one per office), serving most of Hillsborough County, the most populated area in New Hampshire. Today, Project First Step is expanding to a third office. Placing the LADCs in district offices allows LADCs to work directly with CPSWs in the field. DCYF would like to add more LADCs to increase the project's capacity.

Underlying Values and Principles

DCYF expected ongoing, respectful discussion and disagreements between the LADCs and the CPSWs, particularly with regard to determining the primary client and the goals. There was a learning period during which CPSWs developed an understanding that LADCs were bound to Federal confidentiality laws and that certain information could or could not be shared. Over time, the nature of discussions surrounding each case has changed from debating whether children should be removed from the home to what can be done to provide clients with integrated treatment. CPSWs have become well-versed in treatment terminology, and they have come to trust that the LADCs are providing information relevant to the case while maintaining client confidentiality.

Funding

The demonstration project was funded by Title IV-E funds. Since 2004, DCYF has funded Project First Step with grants from the Promoting Safe and Stable Families (PSSF) program, which is supported by Title IV-B funds, and the Child Abuse Prevention and Treatment Act (CAPTA). A line item in DCYF's budget allocates Project First Step \$120,000–\$150,000 per year. The funding covers salaries, furniture, telephones, mileage compensation, and administration.

New Hampshire has very little State funding for early intervention and for cross-training to promote service integration. In expanding Project First Step, district office staff will not want to commit energy to the learning curves necessary to develop such a program without knowing it will exist for at least 3–5 years. To expand Project First Step to areas outside Hillsborough County, for example, DCYF had to assure the district office new to the program that funding would be available for at least that long.

³ Bluhm, B. (2007). *Project First Step: Approaches to co-occurrence of child maltreatment and substance abuse*. Unpublished. 1.

Staff Development, Training, and Supervision

LADCs are certified to provide substance abuse counseling and mental health treatment. LADCs are self-employed, and the State considers them to be independent treatment providers. This arrangement helps DCYF to identify LADCs who are well-educated in the substance abuse and mental health treatment fields and who can consistently provide this perspective to CPSWs.

New Hampshire's HHS certifies LADCs as treatment providers and hires them. Local district office CPS supervisors select and interview candidates with oversight by the DCYF clinical social worker and the Project First Step program manager. LADCs provide their services for a flat hourly rate that covers assessment, direct service, and case management (no billable hours). To be consistent with the integrated service model, LADCs must also be certified counselors. Health insurance and typical fringe benefits can be built into the hourly rate. So far, LADC services in each district office approximate full-time hours.

DCYF has developed a coordinated system for supervising LADCs that involves workers, mentors, supervisors, and administrators. Regarding their clinical practice, LADCs are required to arrange for their own clinical supervision. LADCs also are included in supervision sessions by district office CPS supervisors, ideally with CPSWs who are jointly assigned to specified cases. This approach provides an opportunity for essential discussions about child safety, stability, permanency, and well-being in the context of the parent's substance abuse and recovery. LADCs provide regular reports to the Project First Step program manager, specifying the quantity and types of interventions and treatment recommendations resulting from the CPS cases referred to them. CPS supervisors and LADCs from each district office come together on a regular basis to present progress resulting from Project First Step.

LADCs participate in the child welfare core New Worker Training, which includes shadowing child welfare staff. They also participate in trainings on case planning and permanency planning. With this training, Project First Step LADCs can better facilitate clients' compliance with both their treatment plan and child welfare case plan, as well as facilitate collaboration between treatment providers and CPSWs.

Project First Step LADCs provide ongoing education at district office staff meetings for CPSWs to learn when and how to use the LADCs effectively. They also provide education on community issues. In Nashua and Manchester, they have conducted sessions on the growing heroin use, and in Nashua, the LADC has educated CPSWs on how to recognize and approach clients who may be using methamphetamine. LADCs and CPSWs also can evaluate how they handled past cases and discuss how they can improve service delivery for future cases.

Joint Accountability, Outcomes, and Evaluation

To evaluate the Title IV-E Waiver Demonstration Project, HHS secured a 5-year contract with UNH. The contract allowed the university to have access to CPSWs and their files, including notes from confidential interviews. The contract covered all DCYF policies and procedures. Additionally, UNH and DCYF professionals consulted with each other to develop a mutual understanding of evidence-based evaluation and child welfare practice.

Given DCYF involvement with families often entails several short-term interventions, the evaluation of the Title IV-E Waiver Demonstration Project included a longitudinal component. UNH was able to track families longitudinally, over a 5-year period, even during the times when DCYF was not involved. The university secured families' participation by providing stipends. The research indicated that children in the enhanced group slept better, experienced less mobility, and had greater declines than children in the standard group in the following categories: anxiety and depression, withdrawn/depressed, somatic problems, attention problems, aggressive behavior, thought problems, and rule breaking.⁴

Since the random assignments and control and experiment groups were concluded in 2004, DCYF has not contracted UNH to do continued analysis. Since 2004, LADCs have been reporting data to their DCYF supervisors. LADCs are to answer the same set of questions for each client in a Microsoft Excel spreadsheet. Questions include the following:

- How quickly the LADC was involved with the client;
- When the client received an assessment;
- What services were recommended to the client;
- Had the client been served by the LADC in the past; and
- Percentage of males versus females served.

DCYF uses the data from these reports to shape the future applications of Project First Step to other regions in the State and to justify the use of PSSF and CAPTA grants to support the program. Also, the information is aiding in the design of other community-based treatment models being developed by the New Hampshire HHS.

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⁴ Bluhm, B. (2007). Ibid.

Sacramento County: Early Intervention Specialists and Specialized Treatment and Recovery Services

Background and Purpose

In 1995, Sacramento County implemented the Alcohol and Other Drug Treatment Initiative (AODTI) in response to evidence that substance abuse was a problem for a large number of families served by county agencies. The AODTI was enacted to ensure that substance abuse services would be an integral part of the health and human services system. The goal of the AODTI was to develop the ability of child welfare social workers, public health nurses, eligibility workers, and neighborhood-based services staff to provide systematic screening and intervention services to clients with substance use disorders. The AODTI planned to accomplish this goal by enhancing the workers' understanding of substance use, abuse, and dependence.

Because of the AODTI, five system-wide reforms were subsequently instituted throughout Sacramento County: (1) a comprehensive cross-system joint training program, (2) a substance abuse treatment system of care, (3) a dependency drug court, (4) Early Intervention Specialists (EISs), and (5) specialized treatment and recovery services. The comprehensive cross-system joint training program involves training all child welfare workers on substance use disorders and ways to access treatment resources. This program also involves training substance abuse treatment providers on the child welfare and dependency court systems. The substance abuse treatment system of care includes a managed wait list, expansion of group services, implementation of pre-treatment groups, and prioritization of child welfare clients for immediate access to substance abuse services (after Federally mandated priority access to clients).

The EIS workers and the Specialized Treatment and Recovery Services (STARS) workers are the two ways that Sacramento County provides substance abuse specialists in connection with the Sacramento County Dependency Drug Court (DDC). EIS workers ensure timely assessment and treatment authorization for families at the initial detention hearing. STARS workers are recovery management specialists who assist parents in entering and completing substance abuse treatment and other court requirements.

Roles and Responsibilities

A preliminary step in the court procedure involves the identification of parents who meet the DDC admission criteria at the time of the initial child detention hearing. The EIS worker reviews intake petitions from Child Protective Services (CPS) and identifies petitions alleging neglect or abuse related to parental substance use, including cases in which a child tested positive for drugs at birth. The EIS worker administers a preliminary substance abuse assessment to parents. From the results of the preliminary assessment, the EIS worker provides the county's authorization for treatment payment and makes a referral to the appropriate level of care.

The EIS workers and STARS workers employ Motivational Interviewing (MI) techniques to initially engage parents and motivate them to enter treatment. The EIS worker refers parents to the STARS program, which provides specialized recovery case management. The EIS worker develops a preliminary substance abuse recovery plan, reflecting the appropriate level of care, in consultation with the STARS worker. Each parent who is referred to STARS is matched with a recovery specialist who assists the parent in accessing substance abuse treatment services, develops a liaison role with CPS and other professionals, and provides monitoring and accountability for the parent in complying with treatment requirements. The STARS program provides immediate access to substance abuse assessment and engagement strategies, intensive management of the recovery aspect of the child welfare case plan, and routine monitoring and feedback to CPS and the court.

The primary responsibility of the STARS worker is to maintain a supportive relationship with the parent, emphasizing engagement and retention in substance abuse treatment while providing recovery monitoring for CPS and the DDC. Optimal caseloads are 18–20 clients per STARS worker. The STARS worker monitors urine testing, substance abuse treatment, and self-help group compliance and provides regular compliance reports to the court, social worker, and minor’s counsel. Drug testing is administered on a random basis, and collection is observed by the STARS worker. The STARS worker provides regular compliance reports regarding drug testing, treatment participation, and self-help group attendance. Compliance reports are sent to CPS, legal counsel, and the DDC twice each month.

Through a supportive relationship based on MI strategies, the STARS worker supports the parent’s adherence to the case and treatment plans and court orders. The STARS worker helps the parent integrate learned rehabilitation skills into his or her daily life. The STARS worker also acts as a liaison between the court, client, and recovery center and provides referrals to self-help meetings that are close to the parent’s home and appropriate to the parent’s needs. In addition, the STARS program provides aftercare services and follow-up to families to decrease the probability of relapse. Aftercare services ensue when the parent has completed formal treatment and continue for as long as CPS has an open case with the family.

Locations and Settings

CPS and Alcohol and Drug Services (ADS) jointly employ EIS workers. These workers are out-stationed at the dependency court, where they administer the preliminary substance abuse assessment at the time of the detention hearing, make a referral to an appropriate level of substance abuse treatment, and refer parents to the STARS program.

The STARS program is operated by a local, non-profit, community-based organization that provides treatment services through a contract with Sacramento County. The recovery specialist attends DDC hearings and acts as a liaison with community-based treatment to ensure linkages to treatment recovery and supports. STARS program service contacts are conducted in a variety of locations, including in the home, at substance abuse treatment agencies (residential,

outpatient, and intensive outpatient), in hospitals, and at community agencies. The parent is initially required to meet with his or her STARS worker at least twice each week. Based on the parent's progress, the intensity is then lowered to one contact per week and then decreased to once every 2 weeks.

The STARS program also is located close to the court, which reduces the number of clients who may get "lost" on their way from court to the program. The program in Sacramento is located right across the street from the court house.

Underlying Values and Principles

The Juvenile Dependency Drug Court Steering Committee meets twice each year to discuss evaluation results and any changes recommended to the DDC. A Memorandum of Agreement (MOA) was signed by key court, CPS, STARS, and evaluation staff. This MOA emphasizes the collaborative nature of the DDC and allows the evaluation team access to client records to conduct evaluations and research and to ensure client protection.

Funding

Original resources used to develop and begin implementation of the system improvements involved one-time grant funds. When presented with evidence of cost-effectiveness and efficiencies by the administration, the Sacramento County Board of Supervisors has consistently acted in support of these efforts. The EIS worker position is funded through CPS. The STARS program is funded through local tobacco litigation settlement funds (30 percent), which are used to match State and Federal Title IV-B and case management funds (70 percent).

Staff Development, Training, and Supervision

EIS workers are master's level social workers with training and experience in substance abuse services and motivational enhancement therapy. CPS supervises these workers.

STARS workers must possess an alcohol and drug counselor certification and are trained in motivational enhancement therapy as well. Three supervisors within the STARS program closely monitor the STARS workers. In addition, every STARS worker meets weekly with the clinical director, who is a licensed clinical social worker.

Since 1995, all child welfare workers have been required to participate in joint training with substance abuse treatment provider staff on substance abuse, child welfare, and the courts. The training is provided by a professional trainer. This comprehensive cross-system joint training began with three levels of training: (1) 4 days of required basic information on substance abuse for all child welfare staff; (2) 4 days of required information on substance abuse screening, brief intervention, motivational enhancement, and substance abuse treatment for all child welfare workers with cases; and (3) 4 days of required group treatment skills for all

substance abuse treatment provider staff. The group intervention training was voluntary for any CPS staff.

This comprehensive cross-system joint training is provided at all levels (administrators, managers, and supervisors) to clarify training goals and practice expectations. Training supervisors reinforce change in practice and quality assurance.

Recently, the training program was revised to meet the changing needs of CPS and substance abuse treatment provider staff. The 8 days of training for child welfare staff has been consolidated into 4 days of core training, and mandatory 2-day training on MI was added. The group intervention training was renamed "co-facilitation," and Sacramento County now offers voluntary 4-day training on adolescent mental health and substance abuse.

Joint Accountability, Outcomes, and Evaluation

Sacramento DDC program outcomes are assessed in two primary areas: parental treatment status and child placement outcomes. Analyses are conducted to examine differences between comparison and treatment cohorts for parental treatment participation: length of stay in treatment, treatment modality (residential versus outpatient), and satisfactory completion of treatment. Analyses related to child placement outcomes are conducted including child placement type (reunification versus other permanency outcomes) at various time points after the child's initial placement in out-of-home care, time to reunification among those who reunified, and total time in out-of-home care. A separate follow-up analysis among those children who were reunified is conducted to examine rates of reentry into out-of-home care. In addition, analyses are conducted on the relationship of the parent's primary drug to both treatment completion and the child's placement.

Evaluation results are reviewed twice each year to assess the program's continued success. The most recent evaluation report includes information on six groups of parents and children, a comparison group, and five cohorts of DDC participants. Comparison participants are those who entered the dependency system before EIS and STARS implementation (January through May 2001) and met the criteria for DDC. This group received standard CPS and ADS Division services. Court-ordered participants are those who entered the dependency system from October 1, 2001, through September 30, 2007, and who received EIS and STARS services and were court-ordered to receive DDC supervision.

The DDC program produced substantial cost savings from increased 24-month reunification rates of court-ordered children relative to the comparison group. The cost-savings estimate takes into account the reunification rates, time of out-of-home care, time to reunification, and cost per month of out-of-home care. The 24 month reunification rate for the comparison group was 27.2 percent. The 24 month reunification rate for the court-ordered group was 46.1 percent, which accounted for 962 children.

If we assumed a reunification rate of only 27.2 percent for the court-ordered group, then 394 fewer children would have reunified. By deducting the time to reunification for the court-ordered group (9.22 months) from the average length of out-of-home care for the comparison group (33.1 months), we find a 23.88 month difference. The savings due to the estimated additional 394 children who reunified through the DDC program totals \$17,572,290 (394 children multiplied by 23.88 months multiplied by \$1,867.66 out-of-home care costs).

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Washington: Substance Abuse Services Initiative

Background and Purpose

In 2005, the Washington State Children's Administration (Children's) became increasingly aware that a relatively high percentage of its clients needed substance abuse and mental health treatment services. Children's was also aware that a relatively low percentage of its clients received those needed services. In fiscal years 2004–2005, 31 percent of dependency cases filed involved substance abuse as a contributing factor, whereas only 6 percent of the parents completed treatment.

However, 31 percent was understood to be an underestimate because it was based on information obtained during the initial investigation phase. Children's ongoing caseworkers anecdotally estimate the number of cases in which substance abuse is a factor to be 75–80 percent.

The identified issues were parents not following through on substance abuse assessment recommendations and being unable to engage sufficiently in the treatment process.

The situation provided Children's with the motivation to seek increased collaboration with the Division of Alcohol and Substance Abuse (DASA). Both Children's and DASA are part of Washington's Department of Social and Health Services (DSHS). The collaboration effort is called the Substance Abuse Services Initiative (SASI). The Chemical Dependency Professional (CDP) program, as part of the overall collaborative effort, provides substance abuse specialists.

In 2005, DSHS appealed to the Washington legislature to allocate funding to the CDP initiative. DSHS received funding through Senate Bill 5763, the Omnibus Treatment of Mental and Substance Abuse Disorders Act of 2005, for 22 full-time employees statewide. These substance abuse specialists, or CDPs, help social workers by providing case management services to parents who are in need of substance abuse services. CDPs focus on case management to enhance clients' motivation to engage in the treatment process through treatment completion.

Roles and Responsibilities

The Washington legislature and the SASI oversight committee established the roles, responsibilities, and qualifications of the CDPs. The legislation's full list of potential CDP roles is as follows, with the italicized roles being those that the SASI oversight committee recommends:

Conducting on-site chemical dependency screening and assessment, facilitating progress reports to department social workers and staff on substance abuse issues, in-service training of department social workers and staff on substance abuse issues, referring clients from the department to treatment providers, and providing consultation on cases to department social workers.

Washington's DSHS system has six regions and thirty nine counties that vary considerably. For example, one region has thirteen small counties, but another has just one large county. Each region also has varying characteristics in population and access to services. Some are urban and have high population density, whereas others are rural with small populations.

Because of these regional differences, the SASI oversight committee provided some local flexibility for counties to determine the exact roles and responsibilities of CDPs. Although conducting assessments can be a component of a CDP's role, SASI did not recommend assessment as a primary role for CDPs because of the identified need for case management services. Case management includes referring clients for assessment, helping clients to access services, and bridging gaps in service systems. CDPs can conduct assessments, however, in situations when the assessments cannot be conducted in a timely manner by a local treatment agency. In rural areas, where there are fewer treatment agencies, for example, a CDP might focus on conducting assessments. In urban areas, where there are comparatively more treatment agencies, CDPs are more likely to provide case management services.

Locations and Settings

Currently, Washington funds 22 full-time Children's CDP positions. In essence, the CDPs are stationed in local Children's offices, but are hired and clinically supervised by local treatment agencies. The SASI oversight committee approves job descriptions and contracts.

DASA contracts with counties to provide State-licensed treatment services. Counties subcontract with local treatment agencies to hire and clinically supervise CDPs. The county and Children's management jointly identify and hire the CDPs. The county hiring authority announces the position and conducts interviews of candidates. Children's management participates in the interviews.

CDPs are stationed in local Children's offices. The positions were distributed based on client population. Each county Children's office is responsible for establishing a workspace for its CDP. Typically, the Children's office determines the most appropriate location for the CDP.

Underlying Values and Principles

The SASI oversight committee, made up of professionals from both Children's and DASA, meets every 2 months to administer and oversee the CDP initiative. SASI was made formal in 2005 after more than a year of planning and development. The collaboration is guided by a Memorandum of Understanding (MOU), which outlines joint values and principles. The MOU is useful in motivating all agencies involved to work together despite traditionally varying principles between child welfare and substance abuse systems. On the practice level, however, philosophical differences may remain in such areas as whether the client is the parent, child, or family; whether the goal is child safety, family preservation, or parental recovery; and the appropriate timelines for meeting those goals.

Beyond these incentives to work together that are outlined in the MOU, the agencies also collectively recognize that investing in the collaboration supports clients through treatment completion. Parents who complete treatment are more likely to reunify with their families. The prospect of reunifying with children can be a strong motivator for parents to complete treatment. In addition, the legislature's funding for mutual clients is influenced by the development and success of these collaborative efforts.

Funding

Washington Senate Bill 5763, mentioned previously, provided expanded funding for substance abuse treatment of approximately \$32 million for adults and \$6.7 million for youth. The State legislature allocates funding authorized in Senate Bill 5763 to Children's for 22 full-time employees statewide.

Washington spends \$1.144 million per year on CDPs' salaries and benefits. This total does not cover the full costs to support the program. DASA and Children's contribute additional dollars from other sources to supplement training, travel, and administrative costs. In addition, the agencies alternate funding the substance abuse program manager, who acts as a liaison between the agencies and is responsible for implementing the initiative.

Children's had 10,873 total clients (including children and youth) involved with DASA treatment services at some level in fiscal years 2004–2005. As SASI increases its ability to identify and refer clients in need of treatment, treatment capacity issues arise. Accessibility to treatment services varies from county to county. Treatment capacity is augmented by the treatment expansion funds allocated under Senate Bill 5763, as well as discretionary grants from the Federal Government, such as Access to Recovery (ATR) funds. The State of Washington ATR initiative provides vouchers for substance abuse treatment and/or recovery support services to low-income individuals who are involved with child protective services, shelters and supported housing, free and low-income medical clinics, and community detoxification programs. The target areas are Snohomish, Clark, Pierce, Yakima, King, and Spokane counties. The SASI oversight committee also identifies and seeks ways to meet funding challenges.

Staff Development, Training, and Supervision

Each CDP must have completed an associate's degree, a chemical dependency certification, and 2,000 hours of clinical supervision. Currently, Washington State faces a shortage of qualified CDP professionals. DASA and the Department of Health, which handles the licensing and certification, are working to address this challenge.

Children's headquarters provides training for all new CDPs, but is still determining the best way to provide ongoing training and development. Ongoing cross-training is desired, but goals have to be negotiated between county-level needs and DASA as well as Children's statewide objectives.

The CDP reports to a designated manager in his or her county Children's office. The county office is responsible for developing workflow procedures and often does this in consultation with its CDP. Children's and county management jointly resolve employee disputes and conduct CDP evaluations.

Joint Accountability, Outcomes, and Evaluation

Oversight is provided by the SASI oversight committee, made up of professionals from both Children's and DASA. Children's and DASA are continuing to refine their roles in tracking and analyzing outcomes of the CDP initiative. As part of the treatment expansion funds allocated under Senate Bill 5763, for example, DASA documents how much money this program has saved the State by comparing the cost of substance abuse treatment with the costs clients typically incur without treatment. Children's, DASA, and the counties are also working on ways to improve information sharing and track clients across systems. The SASI oversight committee is helping to design and implement simple strategies for overcoming these challenges.

The attention of State legislators also provides for a certain level of accountability. State legislators have inquired about the program's effectiveness. DASA and Children's are preparing data to demonstrate that more clients have entered and completed treatment since the program's inception. If DASA and Children's are able to demonstrate the program's success, the program may receive more funding in the future.

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Table 1. Commonalities Matrix of Substance Abuse Specialist Programs

	Connecticut	Delaware	Illinois	Massachusetts	New Hampshire	Sacramento County	Washington
Background							
Year program began	Early 1990s	1996	2000	2004	1998	2001	2005
Number of specialists in program	8-9	4	20-24	6	2	25	22
Title IV-E Waiver Demonstration site		X	X		X		
Previous history of collaboration between systems			X	X		X	
Purpose							
Responds to Federal decree	X						
Reduces costs of out-of-home placements and/or reduces time of children in foster care		X	X		X	X	
Removes barriers and improves linkages between CWS and AOD to better serve parents		X	X	X	X	X	X
Improves the capacity of CWS to serve parents with AOD problems	X			X			X
Improves collaboration between systems	X	X	X	X	X	X	X

CWS = child welfare services; AOD = alcohol and other drugs

	Connecticut	Delaware	Illinois	Massachusetts	New Hampshire	Sacramento County	Washington
Employment and Licensing							
Employed by State or county CWS agency	X			X			X
Employed by community-based AOD treatment agency		X					
Employed by contracted service provider			X			X	
Self-employed and contracted by child welfare					X		
Unionized employees	X			X			
Licensed/certified AOD counselors	X	X	X	X (preferred)	X	X	X
Licensed Clinical Social Workers	X						
Specialists' Location (place of work)							
Area, regional, county, or district CWS offices	X	X		X	X		X
Contracted service provider's office, near juvenile court			X			X	

	Connecticut	Delaware	Illinois	Massachusetts	New Hampshire	Sacramento County	Washington
Roles and Responsibilities							
Case management		X	X		X	X	X
Screening and/or assessment		X	X		X	X	X
Referral to treatment	X	X			X	X	X
Facilitation of access to treatment		X			X	X	X
Urine testing	X	X	X			X	
Consultation to CWS	X	X	X	X	X		X
Training to CWS	X	X	X	X	X		X
Training to court			X				
Support to parents while in treatment		X	X			X	X
Home visits	X	X	X			X	
Information sharing with CWS and/or courts		X	X			X	X
Development and implementation of substance abuse capacity-building plans for CWS				X			

	Connecticut	Delaware	Illinois	Massachusetts	New Hampshire	Sacramento County	Washington
Underlying Values and Principles							
MOU or other agreement formally outlines joint values and principles for the program						X	X
MOU or other agreement outlining joint values and principles influences the implementation of the program (but was not specifically developed for the program)		X		X		X	
MOU or other agreement outlines systems' and/or other programs' roles in program implementation	X	X	X				X
Other factors influence ongoing development of joint values and principles	X	X		X	X	X	
Funding							
State funded	X	X		X			
Federal funds (i.e., CAPTA, Title IV-E, Title IV-B)			X		X		
Multiple sources (i.e., partial State funding, tobacco settlement, and agency budget reallocation)						X	X

MOU = Memorandum of Understanding; CAPTA = Child Abuse Prevention and Treatment Act

	Connecticut	Delaware	Illinois	Massachusetts	New Hampshire	Sacramento County	
Staff Development, Training, Supervision							
Supervised by CWS	X				X	X	X
Supervised by contracted service provider			X			X	
Receives dual supervision		X		X			
Attends regular meetings to maintain program purpose and/or foster collaborative relationships		X	X	X	X	X	X
Receives CWS New Worker Training		X		X	X		
Participates in cross- training	X	X	X	X	X	X	
Joint Accountability, Outcomes, and Evaluation							
Regularly collects data	X	X	X		X	X	
Collects standardized data			X		X	X	
Regularly analyzes and reports data			X			X	

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