Michigan

Substance Abuse /Child Welfare Protocol

For

Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR)

December 2009

By the Michigan
Substance Abuse/Child Welfare
State Team

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Michigan Substance Abuse/Child Welfare State Team Mission Statement

Our mission is to utilize collaboration to strengthen safety, permanency, and well-being for children by engaging families affected by substance use disorders and moving them through the process of recovery.

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All sections and tools in this document may be reproduced.

Michigan Substance Abuse/Child Welfare Protocol for Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR)

TABLE OF CONTENTS

I. Collaborating for Success..... 5

II. Developing and Implementing Collaboration.....6

III. Family Drug Treatment Court Principles.....8

IV. Screening: Presence and Immediacy.....11

V. Assessment: Nature and Extent.....17

VI. Engagement and Retention..... 22

VII. Aftercare and Recovery Services..... 31

APPENDICES:

Appendix I: Collaborative Values Inventory 35

Appendix II: Michigan Pathways of Communication Model.....46

Appendix III: Sample Memoranda of Understanding

Eaton County Substance Abuse Protocol 50

Saginaw County Protocol 53

Baraga County Substance Abuse/Child Welfare Protocol.....57

Baraga County Workgroup Basic Tenets.....60

Appendix IV: Screening Instruments 61

Appendix V: Collaborative Capacity Instrument.....67

Appendix VI: A Guide to Compliance with the Indian Child Welfare Act.....84

Appendix VII: Michigan Tribal Courts.....95

Michigan Substance Abuse /Child Welfare Protocol for Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR)

I. Collaborating for Success

The strong association between child abuse and neglect and substance use disorders is well known. National and local contemporary samples indicate that up to 80% of the adults associated with a child welfare case have substance use disorder problems that contribute to the abuse or neglect of children.[1] If Michigan is to effectively impact the issue of child abuse and neglect related to parental substance use disorders, community partnerships must be developed among the Family Division of Circuit Court (Family Court), the Department of Human Services (DHS) and private child welfare agencies, Substance Abuse Coordinating Agencies and their prevention and treatment provider network.

While alcoholism or drug addiction has no direct cause-and-effect link to child abuse and neglect, research indicates that substance abuse is an issue in an estimated 40% to 80% of the families with confirmed cases of abuse or neglect.[2] The behaviors of adults while under the influence can have a life-long impact on children – regardless of whether it is one or both parents, a parent's partner, or another caregiver in the home. Most states identify substance abuse as one of the top two factors involved in child abuse and neglect.[3]

The Adoption and Safe Families Act of 1997 (ASFA), requires timely permanency for children. ASFA emphasizes the need for a collaborative process to provide services to children and families. A decision regarding a child's permanency plan must be made within 12 months of the child's entry into care. In most cases, if the child has been placed out of the home for 15 of the last 22 months, a petition for the termination of parental rights must be filed.

In many Michigan counties, Native American tribes may operate parallel child welfare, substance abuse, and tribal court systems. Awareness of the federal protections provided for certain Native American religious practices that may involve controlled substances needs to be maintained across all systems. Protocols recognizing the sovereignty of tribes and the necessity of honoring and enforcing tribal court orders, judgments, records, and subpoenas in state courts are important to address child abuse and neglect in families with substance abuse issues. Please see Appendix VI for contact information for specific tribes.

The Michigan Substance Abuse/Child Welfare Protocol provides a set of principles, standards, and behaviors to guide daily practice. It is intended to serve as a tool to improve practice and enhance collaboration between systems involving substance abuse treatment, child welfare, and family courts.

The protocol addresses interactions identified by the Michigan Substance Abuse/Child Welfare State Team as most important to the provision of effective services to children

and families with substance abuse involvement. Each section of the protocol includes a table of “practice elements” with specific recommendations for the child welfare system (CWS), substance use disorders system (SUDS) and family court. Each system represents multiple entities that are integral to the complex system serving children and families in child welfare experiencing substance use disorders. The family court system, for example, includes the prosecutor and other attorneys practicing in that court.

II. Developing and Implementing Collaboration

When a social issue affects multiple systems, effective service response requires the coordination, endorsement, and support of all involved agencies. Cohesive principles, standards, and behaviors across all systems are important in providing interventions and services that work. Three major systems are involved with abused or neglected children whose parents are affected by substance use disorders: the family court, child protection system, and substance use disorder service providers. It is important to engage all three systems in planning for systemic change. This section of the protocol provides recommendations for how each system can work collaboratively.

Collaboration requires family court, child welfare, and substance use disorder professionals to rethink their respective roles in order to focus on integrated methods that address the needs of children and families. These systems share a common set of core values despite systemic differences. One way communities can begin the collaborative process is to adopt a set of principles that reflect tenets common to all three systems.

Additionally, there are a number of concurrent issues related to substance use and child abuse and neglect. They may include domestic violence, mental health, childcare, job training, housing, and transportation. In order to effect long term permanent change, it is imperative that these and similar needs are addressed.

The primary focus of this protocol is to structure a model collaborative approach between substance use disorder services, child welfare and family court systems. However, in order to effectively serve children and families, other community partners and professionals must be included.

The Michigan Substance Abuse/Child Welfare State Team developed the following principles to guide its work. These principles may be helpful to communities in developing their own working collaboration model.

Michigan Child Welfare/Substance Abuse General Principles

SERVICES TO CHILDREN AND FAMILIES	▪ Families must be involved in their own treatment plan. ▪ Services to children and families must be comprehensive, family-focused, individualized, delivered within legal timeframes, coordinated with school and work demands while being available and accessible to the broad community, including rural areas. ▪ The opportunity for family preservation and child safety are enhanced when communities provide services for families in which substance abuse is a concern. ▪ The well being of children and families is improved when communities have knowledge of best practice models and have the capacity to use these models effectively.
ASSESSMENT, FAMILY ENGAGEMENT AND RETENTION	▪ There must be an active, family-focused approach to a coordinated screening and assessment process in treatment and prevention. ▪ It is the responsibility of all systems to support entry into, retention, completion and follow-through in the recovery process.
COLLABORATION	▪ The ability to engage families in a non-threatening, non-judgmental way on an on-going basis. ▪ There must be strong partnerships across systems (child welfare, substance use disorder services, and the family court) at both the state and local level in the areas of collaboration, staff education, and case management and treatment services. ▪ These partnerships must establish a set of common goals and approaches across disciplines. ▪ All agencies and organizations involved with at-risk children and families share responsibility to achieve the desired outcomes.
CONFIDENTIALITY AND EXCHANGE OF INFORMATION AND DATA	▪ Confidentiality issues among agencies need to be addressed so that necessary information can be shared and disclosed in a timely and safe manner. ▪ An effective service system requires standardized and shareable data accessibility across systems. The child welfare system, substance use disorder system and family courts must prioritize establishing a statewide database that provides access across integrated systems.
BUDGET AND PROGRAM SUSTAINABILITY	▪ To sustain best policy and practice, resources across systems need to be pooled and adequate funding streams need to be identified and sustained. Maximizing resources requires mutual, long-term commitments and joint planning efforts.

III. Family Drug Treatment Court Principles

Some Michigan communities have developed or are developing family drug treatment courts (FDTC) within their family court system. The purpose of family drug treatment courts is to better coordinate services and improve systematic response to children and families with substance use disorder issues who are involved with the child welfare system.

There are many ways family courts can facilitate collaborative partnerships regardless of whether capacity exists within a community to develop family drug treatment courts.

The Drug Court Planning Initiative of the U.S. Department of Justice developed 12 principles to encourage family courts to assume a proactive leadership role in their communities. The Michigan Substance Abuse/Child Welfare State Team believes that most of these principles are applicable to all family courts. These principles can be used to effectively facilitate substance abuse/child welfare collaboration. These principles are:

1. Place the safety and welfare of abused and neglected children above the needs of the parent(s).
2. Facilitate early intervention and treatment.
3. Utilize family courts based on the adult court model.
4. Take a comprehensive approach to strengthening family function.
5. Build customized case plans based on comprehensive assessments of the treatment, developmental, mental and physical health needs of the parents and their children.
6. Operate in a non-adversarial, team-oriented environment in which practitioners in all relevant specialties actively participate in case planning and monitoring.
7. Place parents in structured treatment programs that include mandatory, regularly scheduled court appearances, substance abuse treatment, drug testing, and training, education and counseling as required to meet their developmental needs.
8. Hold regular, scheduled staff meetings in conjunction with the court session, in which each client's progress, obstacles, and options are discussed individually, and case plans are updated as needed.
9. Hold parents accountable through the use of standardized sanctions and incentives.
10. Strive to maintain or reunify families according to the Adoption and Safe Families Act of 1997.

11. In cases where family reunification is not possible within ASFA timelines, conduct proceedings required to terminate parental rights and free children for permanent placement in a safe home.
12. Have family court judges perform a leadership role in the family court team.

Please visit http://dcpi.ncjrs.gov/dcpi/dcpi_family.html for more information on Family Drug Courts.

Practice Elements

Below are practice elements for collaboration for the three systems – child welfare, substance use disorder treatment, and family court. All three systems should evaluate the effectiveness of their current communication structure and partnering efforts. Each should take steps to strengthen identified areas that need improvement.

Step 1: Identifying partners

Child Welfare System (CWS)	Substance Use Disorder (SUD) Treatment System	Family Court System
Who are our CWS partners? Our CWS partners include ▪ public and private child welfare agencies and providers ▪ representatives from substance use disorder services and family court	***Who are our substance use disorder treatment partners?*** Our SUD partners include ▪ coordinating agencies ▪ assessment providers ▪ specialty treatment programs (including treatment for women and children) ▪ providers that represent a continuum of care ▪ representatives from child welfare services and family court	***Who are our Family court partners?*** Our Family court partners include ▪ judges ▪ referees ▪ court administrators ▪ lawyer guardians ad litem (L-GALs) ▪ parents' attorneys ▪ prosecutors, assistant attorneys general ▪ court appointed special advocates (CASAs) ▪ representatives from the child welfare system and substance use disorder services

Step 2: Value Assessment Our community has used a formal values assessment process with the child welfare system, substance use disorder services, and family court to determine how much consensus or disagreement we have about issues related to substance use disorder, parenting, and child safety. *One available tool is in Appendix I: **Collaborative Values Inventory**
Step 3: Shared Principles The child welfare system, substance use disorder services, and the family court have negotiated shared principles or goal statements that reflect a consensus on issues related to families with substance use disorder problems in the child welfare system and family court.
Step 4: Establishing Priority Our community has prioritized parents in the child welfare system to receive substance use disorder treatment services.
Step 5: Establishing Communication Protocol Our community has discussed and developed a communication agreement on what, how, where, when, and who to contact in order to effectively share information between systems. Policies, procedures, and specific content have been shared with all partners at all levels to facilitate communication bridges. *One tool to assist communication is in Appendix II: **Michigan Pathways of Communication Model**
Step 6: Collaborative Efforts The following key personnel hold collaborative meetings: ▪ Public and private child welfare system leaders ▪ Substance use disorder services assessment and treatment directors ▪ Family court judges, attorneys, court administrators, and court appointed special advocates

Community partners may decide to formalize the collaborative relationship through developing a memorandum of understanding (MOU). Examples of MOUs developed by Michigan counties are included in Appendix III.

Adapted from the Sobriety Treatment and Recovery Teams (START) Project in Ohio[4], the following may be useful in guiding objectives and content:

- Child abuse and neglect are frequently associated with substance abuse and addiction. To reduce the potential removal of children and possible termination of parental rights, it is critical to provide treatment services for the parent.
- Safety, permanency, and the well-being of children must always be maintained.

- Other behaviors and needs may be rooted within substance dependency. Services to the parent must focus on assessment and treatment of the addiction, in relation to substance abuse.
- A sober, supportive living environment is critical to successful recovery.
- Addiction, as a disease, requires abstinence. We acknowledge that relapse may occur which will require modified or intensified services.
- No single agency or system contains all of the resources and expertise to fully respond to the needs of the addicted parent who has abused or neglected his/her child.
- Policies and procedures that impede the family's cooperation with all service providers should be modified.
- All involved systems should utilize creative approaches to build family support systems, improving parenting skills, meeting childcare needs, and filling identified gaps in service.
- The goal is reunification of the family as quickly as the child's safety can be assured. A child deserves a safe and permanent home. If a parent is unable to sustain recovery, an alternative permanent home may be needed.

IV. Screening: Presence and Immediacy

Historically, each system screens for identified problems in its respective field: child welfare screens for abuse and neglect, substance use disorder systems screen for substance abuse or dependence, and courts determine statutory compliance.

Child welfare agencies need to screen families for potential substance use disorders and refer them for assessment and treatment when appropriate. Substance use disorder providers should assess the safety status of clients' children and make reports to children's protective services when appropriate.

Nationally, child welfare directors have reported that substance use disorder is one of the top two factors in child abuse and neglect. Consequently, child welfare workers must recognize the signs of substance use disorder as a significant indicator of potential child abuse or neglect.

The children's protective services or foster care worker should screen for substance use disorder by:

1. Observing the environment and behaviors

Observing the environment and behaviors includes examining the home for indications that substance use disorder may be an issue. (Is there drug paraphernalia on the table, or does the refrigerator contain alcohol but lack food?)

2. Asking screening questions

Screening for substance use disorder should always be part of a safety assessment conducted in response to a report of abuse or neglect. If screening indicates substance use disorder, a referral to formal substance use disorder services assessment must be made.

3. Making collateral contact within the extended family and community

An important part of screening and assessment is ascertaining whether a substance use disorder may be an issue in the home. Questions should seek information to facilitate family assessment of needs and strengths. Collateral contacts can provide an invaluable source of information on family function.

4. Performing a criminal history assessment

Reviewing and assessing the criminal history of a person may provide information that there is a substance use disorder issue. Crimes involving controlled substances, breaking and entering, theft, and others need to be assessed as part of the screen for substance use disorder.

Without a formal assessment for substance use disorder involvement, the severity of the use and its impact on the parent's functioning and family may be underrated. Often, other serious issues of abuse or neglect are related to substance use disorders and unless the needed treatment is provided, services have little chance of long-term success.

Ultimately, attempts to work on other behaviors may fail if the substance use disorder is not addressed.

Child Welfare System (CWS)	Substance Use Disorder (SUD) Treatment System	Family Court System
PHASE I – Adult Assessment		
Step 1: Always assess for substance use disorder as a factor in abuse or neglect using **the Risk Assessment or the Family Assessment of Needs and Strengths** (FANS) in confirmed cases. **Step 2:** Directly refer all individuals with an identified need in substance abuse on the Risk Assessment or FANS for a formal Substance Use Disorder (SUD) assessment. **Step 3:** Obtain appropriate consent to receive findings from the substance use disorder assessment. **Step 4:** Share environmental and behavioral observations with substance use disorder assessment provider when referral is made. * Examples of substance use disorder screening questions can be found in Appendix IV.	**Step 1:** Always ask whether or not children are in the home of treatment clients. **Step 2:** If you suspect that children are at risk of neglect or abuse file a report with CPS. *Examples of screening tools can be found in Appendix IV **Step 3:** If changes in circumstances occur, reassessment of risk to children in the home is necessary. *Examples of screening tools can be found in Appendix IV.	**Step 1:** Ask if a substance abuse screen has been conducted in every case. **Step 2:** Require a screen be conducted with parents and other adult caregivers to rule out substance use disorder as a factor. (This includes relatives who serve as placement or potential placement for children.) **Step 3:** Ensure that individuals with an identified need in substance abuse are referred for a formal assessment. **Step 4:** Include information presented on substance use disorder when determining imminent risk and making decisions about removal of children and a finding of reasonable effort.

Child Welfare System (CWS)	Substance Use Disorders (SUD) Treatment System	Family Court System
PHASE II – CHILD ASSESSMENT		
Step 1: Ensure that all children are assessed using **Child Assessment of Needs and Strengths** (CANS) to ▪ identify needs, ▪ make referrals or ▪ provide services **Note:** It is important to ▪ determine the impact of parental substance abuse and ▪ assess older children for their own substance use **Step 2:** Results should be documented in each child's case plan. **Step 3:** Partner with substance use disorder services agencies to ensure that ▪ services for Children of Substance Abusers (COSAs) are available and ▪ Children are linked to the support services that they need.	**Step 1:** Develop a plan of intra-system intervention and communication to address children's needs and treatment issues using qualified experts. **Step 2:** Results of children's needs should be documented in each parent's files. **Step 3:** Link children of clients to supportive services to improve well-being of children.	**Step 1:** Require children be assessed to determine as appropriate: ▪ impact of parental substance abuse, and ▪ that appropriate services for the child are obtained and ▪ whether missing information from case files due to either inaction or oversight should be ordered through court action **Note:** For older children (8+ years old), if indicated, ensure that children are screened for substance use themselves. **Step 2:** ▪ Enter current and Court status findings into the records of both parent and child ▪ Determine if further action is required. **Step 3:** Ensure children are provided timely and appropriate services, consistent with identified needs that resulted from parental substance abuse.

Substance Use Disorder Services

Most substance use disorder (SUD) service providers have not routinely incorporated questions about child safety, permanency, and well-being in their service planning. SUD service providers do obtain other relevant family information as part of their client's social history. It is important that they begin to specifically examine and note in the substance use disorder assessment the potential for child abuse and neglect.

Child Welfare System (CWS)	Substance Use Disorder (SUD) Treatment System	Family Court System
PHASE II – CHILD ASSESSMENT (cont.)		
Step 4: Consistently monitor cases for indications of substance abuse and impact of caregivers' use on children.	**Step 4:** Consistently monitor and refer cases for clinical implications for children.	**Step 4:** Require that a substance abuse assessment be conducted in all cases where a screen has shown a potential substance use disorder. Review services provided and encourage participation of caregivers and children at all court hearings.
Step 5: Routinely share with SUD system and family court information collected regarding children and parental substance use disorders.	**Step 5:** Routinely share with child welfare and family court systems the information collected regarding children and parents or other adult caregivers.	**Step 5:** Use authority and leadership to assure linkages among systems.

If the client is currently involved with the child welfare system, the information should be shared with the child's caseworker. If there is no child welfare system involvement in the case, but abuse or neglect is suspected, the SUD professional should make a report to the children's protective services agency.

Children's protective services will determine whether or not an investigation for abuse or neglect is warranted and whether or not the child can safely remain in the home or must be temporarily placed with relatives, in foster care, or in some other temporary living arrangement.

Michigan law does not require direct observation of child abuse or neglect. In Michigan, mandated reporters are required to make a report if the individual "has reasonable cause to suspect child abuse or neglect," MCL 722.623(1)(a).

Child welfare and substance use disorder service systems initially screen to obtain front-end data to determine the next appropriate phase of their respective systems. Once cross-systematic issues are identified, a single system approach is no longer sufficient. In order to facilitate appropriate assessment and services, systemic collaboration is necessary.

Child Welfare System (CWS)	Substance Use Disorders (SUD) Treatment System	Family Court System
PHASE II – CHILD ASSESSMENT (cont.)		
Step 6: Consistently collect results from drug tests and use data for monitoring treatment provided and program planning at the local level. **Data should include:** ▪ Whether drug test results was administered ▪ Drug test results ▪ Observational notations	**Step 6:** Collect data on clients with children and child welfare status and use for program planning at the local level. **Data should include:** ▪ Number of children ▪ Number of children with past and present child welfare system involvement ▪ Pertinent characteristics including past and present history of child welfare system involvement	**Step 6:** Ensure that data regarding children of substance use disorder treatment clients and results of drug test results are consistently recorded and monitored and are used for program planning (including workloads) and resource allocation at the local and statewide level.

Family court is encouraged to take a proactive role to ensure 1) caseworkers consider substance use disorder as a possible factor, 2) appropriate screening has occurred, and 3) the case has moved into the assessment phase, if indicated. The family court can provide leadership to ensure that linkages between systems and services occur.

Child Welfare System (CWS)	Substance Use Disorders (SUD) Treatment System	Family Court System
PHASE II – CHILD ASSESSMENT (cont.)		
Goal To actively develop and participate in a multi-disciplinary team conducting comprehensive family assessment including other co-existing issues.		

V. Assessment: Nature and Extent

Screening indicates whether a comprehensive assessment or evaluation is necessary; however, it is never diagnostic in and of itself. Assessment collects detailed information to determine whether an individual has a condition or meets the diagnostic criteria for a given disorder. It may also determine appropriate treatment plan and level of care.

In the SUD system, assessment is used in conjunction with an investigation of abuse or neglect in child welfare and diagnosis. This cross-system assessment helps answer questions like, "What is the nature of the substance use disorder? What is the nature of the child abuse/neglect issue?" and, "What is the extent of the substance use disorder or child abuse/neglect issue?"

Child Welfare System (CWS)	Substance Use Disorders (SUD) Treatment System	Family Court System
Phase III – CROSS-SYSTEM COMMUNICATION		
Share case information with substance use disorder services agency upon referral using standardized forms. ▪ Ensure that signed consents for disclosure comply with 42 CFR Part II. ▪ Share precipitating events in the child welfare cases. ▪ Results of child welfare observations and assessments are communicated.	Share diagnostic information with child welfare system within 7 days of assessment using a standardized form to make information sharing uniform. ▪ Ensure that the child welfare system has provided consent forms signed by the parent that meet 42 CFR Part II requirements so that "no shows" can be communicated. ▪ Include information on level of care needed and diagnostic impression.	Ensure that substance use disorder diagnosis and results of multi-dimensional assessment are submitted in all cases where a positive drug test was confirmed. ▪ Ensure that the child welfare system and substance use disorder services have shared information about this family and are working collaboratively.

In both systems, assessment is a cumulative, information-gathering process. Workers examine information from a number of sources: interaction with family members, other service providers and feedback from assessment tools.

The more comprehensive the exchange of information among engaged systems the more complete and beneficial the assessment process will be for the client. Information sharing is an important factor in developing the case plan (treatment plan to substance use disorder services providers) and in working with the parents and children.

Family courts can facilitate the process by ordering assessments and requiring the results to become part of the court-ordered case plan. Family courts can aid in obtaining needed information by ordering an assessment be conducted and the results become part of the court-ordered case plan.

Child Welfare System (CWS)	Substance Use Disorders (SUD) Treatment System	Family Court System
Phase IV – GENERAL ASSESSMENT		

To determine extent of child welfare issue(s) in confirmed cases, the CPS or foster care worker will:
 	
Conduct a Family Assessment of Needs and Strengths (FANS) to determine the extent of the issue within 30 days of receiving CPS complaint or child's entry into foster care.
 	
▪ Reassessment is done quarterly, using standardized forms.
▪ Shared information is provided in a written report within 30 days that includes:
  ▪ Criminal and civil court history
  ▪ Prior child abuse/neglect reports and substantiations
  ▪ Substance use disorder by significant other or other adults in the home
  ▪ Information about home environment, including past or present family violence and domestic violence
  ▪ Parent's involvement in CWS as a child
  ▪ Parent's mental health history (and results of psychological evaluation) Indian Child Welfare Act (ICWA) or Interstate Compact on Placement of Children (ICPC) involvement
  ▪ CWS drug testing requirements and results
  ▪ Parents perception of issue
  ▪ Extended family, family strengths, connections to community, culture and available resources
  ▪ Children's assessments
	To determine the extent of substance use disorder:
	
	▪ Conduct a bio-psycho-social assessment within 30 days of entry into SUDS.
	▪ Share results with child welfare system within 7 days.
	▪ Shared information is provided in a written report delivered to CWS using standardized forms that include:
	  ▪ Frequency of use
	  ▪ Impact of drug toxicity
	  ▪ Parent functioning resulting from use (e.g., blackouts)
	  ▪ Level of impairment (*Is parent's ability to meet child's basic needs impaired?*)
	  ▪ Family connections, strengths, extended family
	  ▪ Employment/education status
	  ▪ Parents' trauma history
	  ▪ Assessment of motivation and engagement level
	  ▪ Substitute care for child during parental substance seeking behavior
	  ▪ Parent's perception of relationship between substance use and their parenting
	  ▪ Treatment recommendations (i.e., level of care, length of time in treatment, can children remain with parent, parent-child visitation in treatment
	  ▪ Other family changes (e.g., marriages, deaths, moves)
	  ▪ Additional services needed
		Ensure reports from **CWS** and **SUDS** include:
		
		▪ Information on treatment recommendations.
		▪ Level of care determination.
		▪ Culturally relevant assessments and recommendations.
		▪ Effect of substance use disorder on child.
		▪ Assessed potential for reunification (best practice would dictate ADS to provide information directly to the court accompanied with an appropriate release.
		▪ What if court orders record?
		▪ What if person is ordered into treatment?
		▪ Other recommendations to the court.

Child Welfare System (CWS)	Substance Use Disorders (SUD) Treatment System	Family Court System
Phase IV – GENERAL ASSESSMENT		
▪ Other case issues that impact parents, family, or child	.	

Child safety and risk of future maltreatment must be assessed on an ongoing basis by the child welfare worker. When children remain in the home with a parent, the level of risk of future harm to the children in the family is initially assessed, then reassessed quarterly to determine the level of intervention by CPS.

The decision to request the court to authorize emergency removal of children from their home must be based on conditions which immediately threaten the child's health or welfare, i.e., safety. When children are placed out of the parent's home, the child welfare worker assesses and reassesses the barriers preventing reunification with the parent. If the barriers are addressed adequately, a safety assessment is completed to determine if the children can be returned home with protective interventions.

Child Welfare System (CWS)	Substance Use Disorders (SUD) Treatment System	Family Court System
Phase V – MONITORING /CASE CONTROL		
Complete the Family Risk Assessment, the Family Assessment of Needs Strengths and/or the Reunification Assessment and the case service plan quarterly.	Treatment plan review and share every 60 days	Ensure that case service plan is amended to reflect current re-assessment information and services needed.

Child Welfare System (CWS)	Substance Use Disorders (SUD) Treatment System	Family Court System
Phase VI - CROSS-SYSTEMIC INVOLVEMENT		

SCOPE OF DISCUSSION:

- Assessment results
- Cross-system planning of services
- Case service plan/ treatment plan development

STAKEHOLDERS:

- Family
- Attorneys
- Child Welfare Service (CWS)
- Family Court
- Substance Use Disorder System (SUDS)
- Other supportive entities

Meetings are conducted in a manner that is comfortable for families in regards to language, culture, etc.

Substance use disorders also occur on a continuum, generally classified as “use”, “abuse”, and “dependence.” Dependence is also commonly known as “addiction.” It is important to realize that a parent does not need to be addicted to alcohol or drugs to place the child at risk of abuse or neglect. The table[5] below defines the continuum and highlights implications for risk to children based on parental substance use, abuse, or dependence.

Alcohol and Drug Use Continuum	Implications for Child Welfare Examples of Risk to Children
USE of alcohol or drugs to socialize and feel effects. Use may not appear abusive and may not lead to dependence; however, circumstances under which a parent uses can put children at risk of harm.	▪ Driving with children in the car while under the influence. ▪ Use during pregnancy can harm the fetus.

Alcohol and Drug Use Continuum	**Implications for Child Welfare** Examples of Risk to Children
ABUSE of alcohol or drugs includes at least one of these factors in the last 12 months: ▪ Effects have seriously interfered with health, work, or social functioning; ▪ Person has engaged in hazardous activity on a recurring basis, such as driving or operating machinery under the influence; ▪ Person has experienced use-related legal problems; ▪ Person has continued use despite ongoing or recurring problems caused or exacerbated by use—this includes a maladaptive pattern of use, such as binge drinking.	▪ Children may be left in unsafe care—with an inappropriate caretaker or unattended—while parent is entertaining. ▪ Parent may take children to location where parent or others party or get high. ▪ Parent may neglect or sporadically address the children's needs for regular meals, clothing, and cleanliness. ▪ Even when the parent is in the home, the parent's use may leave children unsupervised. ▪ Behavior toward children may be inconsistent, such as a pattern of screaming insults then expressing remorse.
DEPENDENCE, also known as addiction, is a pattern of use that results in three or more of the following symptoms in a 12 month period: ▪ Tolerance: needing more of the drug or alcohol to get high. ▪ Withdrawal: physical symptoms when alcohol or drugs are not used, such as tremors, nausea, sweating, and shakiness. ▪ Uncontrolled use: a strong craving or compulsion to use and an inability to limit use. ▪ Alcohol and/or drug(s) increasingly become the focus of person's life at the expense of all other areas, including family, work, social, and recreation. ▪ Continued use despite ongoing or recurring physical or psychological problems caused or exacerbated by the alcohol and drug use.[6, 7]	▪ Despite a clear danger to children, the parent may engage in addiction-related behaviors, such as leaving children unattended while seeking drugs. ▪ Funds are used to buy alcohol or drugs, while necessities, such as buying food, are neglected. ▪ A parent may not be able to think logically or make rational decisions regarding children's needs or care.

VI. Engagement and Retention

Once child abuse or neglect is confirmed and a substance use disorder is diagnosed, the next step includes the following queries:

- Are the case worker and service provider creating a supportive environment even if the client is not actively progressing in treatment?
- Is the family benefiting from existing services?
- What other services are needed for the parents and the children?
- What is the response by the child welfare system, substance use disorder services, and the family court system?
- What is the historical record of interaction of each individual system with the client?
- Are there other issues of concern identified in the family?
- What are the goals of the treatment plan/case plan?
- What strengths are identified in the family? Can any of these strengths be utilized to address needs identified in the preliminary assessment?
- Does the parent face barriers to access needed services? Is there a plan to overcome these barriers?
- What is the proposed cross-system action plan? (Has the future plan of action been coordinated so that all systems are aware of all aspects of implementation?)

The Role of Motivation

Motivation for change is an important component of engagement and retention in both the child welfare and substance use disorder services systems. The Prochaska and DiClemente[8] model of change may provide a useful framework for the child welfare, substance use disorder services, and family court systems for understanding the process of change.

Six stages describe the progression of change that individuals experience in changing behaviors or working to resolve problems. The six stages of change are:

1. Pre-contemplation
2. Contemplation
3. Determination
4. Action
5. Maintenance
6. Relapse

In both the child welfare and substance use disorder service systems, it is important to identify in the parent 1) an ability to recognize problematic behaviors; and 2) a readiness to accept change. Some may feel ambivalent. Ambivalence may exist because parents view their behavior as normal and functional. They may be comfortable with a passive role (e.g., “someone else must fix it for me”), or feel it would be too difficult to change.

Ambivalence is viewed positively because it opens the door to examination of other options. It should not be confused with rationalization intended to justify and maintain the status quo. With the Adoption and Safe Families Act (ASFA) requirements for timely permanency, engaging and arranging services for parents, even if motivation is lacking, is of the utmost importance.

There is a difference between lapses; a brief return to use usually triggered by a stressful event, and relapse; a return to previous behavior patterns. Lapses and relapses are not unusual and do not necessarily mean that the child’s welfare is at risk. An assessment of the child’s well being should dictate action in each case as well as patterns of the adult’s behavior.

Drug testing is not to be used punitively. The worker must evaluate the risk of leaving the children in the home without the benefit of this monitoring tool. If the risk is determined to be substantial, a petition to family court should be considered to remove children or make the children temporary wards in their own home.

Either the child welfare or substance use disorder system can request a drug test. Regardless of which system requests the test, information is shared across systems.

Motivated change and motivational interventions go hand-in-hand with the change process and personal readiness to incorporate it into daily life. The child welfare worker, SUD counselor, the judge, and significant persons in the life of a substance-abusing parent can promote and support motivation to change. The table below describes the stages of change and identifies motivational tasks to address with the substance-abusing parent.

Please see the complete Motivational Task Table on following pages.

Parent's Stages of Change		Motivational Tasks for Child Welfare Worker and Substance Abuse Counselor
	Description	
PRE-CONTEMPLATION	No perception of having a problem or need to change.	**Goal:** Increase parent's perception of the risks and problems with their current behavior. Raise parent's doubts about behavior. **A worker may say:** ▪ *When you get high, who takes care of your children?* ▪ *What would happen if one of your children was hurt and needed you?* ▪ *How does your use affect your ability to be a good parent?* ▪ *How does your alcohol/drug use affect your judgment?*
CONTEMPLATION	Initial recognition that behavior may be a problem and ambivalence about change.	**Goal:** Foster and evoke reasons to change and the risks of not changing. Tip the balance toward change. **A worker may say:** ▪ *Children's protective services must assess how safe your child is in your home and if there is a future risk of harm to your children.* ▪ *Treatment will help you maintain sobriety and reduce the risk that your children will be removed.*
DECISION TO CHANGE	Makes a conscious decision to change. Some motivation for change identified.	Help parent identify best actions to take for change. Support motivations for change. **A worker may say:** ▪ *Your decision to enter intensive outpatient treatment and attend four Narcotics Anonymous and Alcoholics Anonymous meetings a week is a strong indicator to the judge of your commitment to regain custody of your children.*

Parent's Stages of Change		Motivational Tasks for Child Welfare Worker and Substance Abuse Counselor
	Description	
ACTION	Takes steps to change.	Help parent address barriers, implement strategies and take steps. **A worker may say:** ▪ *You have a treatment program lined up, our agency has arranged transportation to and from treatment, and you will be able to visit your children once a week – what else do you need to consider in order to meet your goals?*
MAINTENANCE	Actively works on sustaining change strategies and maintaining long-term change.	Help parent to identify triggers and use strategies to prevent relapse. **A worker may say:** ▪ *Spending the holidays with your family sounds very stressful. What are some things you could do to reduce this level of stress and reduce the possibility of relapse?*
LAPSE OR RELAPSE	Lapses from a change strategy or returns to previous problem behavior patterns (relapse).	Help parent re-engage in the contemplation, decision, and action stages. **A worker may say:** ▪ *Let's re-examine the reasons why you think treatment is a good decision for you.* ▪ *What are some of the benefits of sobriety?* ▪ *What are some of the benefits of continuing to use?* ▪ *What actions will help you to become reunited with your children?*

Table Adapted from: *Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers*

With the family's involvement, child welfare and substance use disorder services systems develop intervention plans that address the services needed for desired change. Services are provided and monitored through individual treatment plans (substance use disorder services) and case service plans (child welfare services) and through the development and monitoring of outcome measures.

In Family Court, the case is guided through the issuance of a court order and the monitoring of compliance with that order.

<table>
<tr><th>Child Welfare System (CWS)</th><th>Substance Use Disorders (SUD) Treatment System</th><th>Family Court System</th></tr>
<tr><td colspan="3">Best Practice:

Partners (including family) develop family-driven case plans with shared objectives.</td></tr>
<tr><td colspan="2">Fundamental Practice:

Substance use disorder services and the child welfare system have input into development of each other's case plan with shared ownership of objectives.</td><td>Fundamental Practice:

Communication and shared knowledge between substance use disorder services, the child welfare system and family court orders.</td></tr>
<tr><td colspan="2">Plans include the following:

▪ Joint child welfare system-substance use disorder services ownership of goals.
▪ Ensure that child welfare system activities, objectives and service strategies do not conflict with substance use disorder treatment services.
▪ Court interventions are used therapeutically with families.</td><td>Court orders reflect the following:

▪ Family court supports child welfare system-substance use disorder services goals.
▪ Treatment is court ordered.
▪ Family court oversees integration of timelines within the Adoption and Safe Families Act (ASFA) framework.
▪ Court interventions are used therapeutically with families.</td></tr>
</table>

Relapse

It is important to remember that relapse is not the same as treatment failure. During the phases of engagement and retention, the child welfare system and substance use disorder services system must work closely together and maintain regular communication. It is essential to re-engage the parent in treatment as soon as possible if a relapse or slip occurs.

Reports to the family court need to reflect the parent's participation and compliance so that the power of the court can be used to support continued recovery or encourage the parent to re-engage in treatment.

Recurrence of a substance use disorder can happen at any point in the recovery process. Child welfare workers in concert with a SUD counselor can assist parents to view a relapse episode as a means for learning to identify what triggers desire or cravings to use.

<table>
<tr><th>Child Welfare System (CWS)</th><th>Substance Use Disorders (SUD) Treatment System</th><th>Family Court System</th></tr>
<tr><td colspan="3">Establishing Communication Protocol</td></tr>
<tr><td colspan="2">STAGE I

SHARE qualitative and quantitative information at critical incidents and standardized intervals regarding:
▪ compliance with court orders
▪ ability of parent to meet treatment objectives with substance use disorder services and family court

DISCUSS best use of drug tests (i.e., when and how to handle results) with substance use disorder treatment provider.

DETERMINE who will conduct drug tests (if any) and how results will be communicated across systems.

PLAN for cross-system response to relapse on an individualized case basis.

REVIEW together whether additional family court hearings can facilitate parent's recovery and retention in treatment.</td><td>▪ <u>Review</u> progress of the parent and results of drug tests during review hearings.
▪ <u>Support</u> joint child welfare system and substance use disorder treatment plan for effective use of drug tests.
▪ <u>Recognize</u> positive strides made by the parent.
▪ <u>Encourage</u> commitment or a recommitment to recovery and treatment if slips or relapse has occurred.
▪ <u>Support</u> the bond developed between parent and treatment provider and between parent and child welfare worker.
▪ <u>Reinforce</u> parent's motivation to change through immediate and timely consequences (e.g., spending a day in jail).</td></tr>
</table>

Child Welfare System (CWS)	Substance Use Disorders (SUD) Treatment System	Family Court System
Establishing Communication Protocol		
STAGE II **MONITOR** treatment compliance. **SHARE INFORMATION** across all systems (including family court) about: ▪ Number of drug tests required and results of tests. ▪ Progress in achieving and maintaining recovery. ▪ Number of group and individual sessions required and attended. ▪ Treatment goals and progress toward treatment goals.		▪ **Review** treatment compliance. ▪ **Utilize** the power of the court for therapeutic intervention or support of recovery.
STAGE III **CONTINUALLY ASSESS** movement through stages of change: ▪ Use positive drug tests as motivation for return of child – a therapeutic tool to re-engage parent through the child welfare and court system. ▪ Use negative drug tests as reinforcement of success. ▪ Include parent's self report. ▪ Ensure drug tests are updated and shared across systems.		▪ **Support** parental motivation for return of child as a therapeutic tool for re-engaging the parent in treatment.
STAGE IV **INCORPORATE** children into parent's treatment: ▪ Older children may benefit from meeting with parent's therapist. ▪ As parent progresses in treatment, increase parenting time through more frequent and longer visits with child. ▪ Find out whether SUD provider observed parenting time during treatment.		▪ **Reinforce** a parent's progress and continued commitment to treatment by supporting increased parenting time with children.

Family and Domestic Violence

Domestic violence in a home presents considerable threat to children. More than half of the men who assault their partners are also physically abusive to their children,[9] and as many as 90% of the children of abusers witness the abuse.[10] Children can experience detrimental effects, including somatic, behavioral, and emotional problems in response to being battered or witnessing the battering of a parent.[11]

When domestic violence and substance use disorder are present, "substance abuse treatment alone is unlikely to stop the violence."[12] In fact, as a woman progresses in treatment and asserts more independence in behaviors regarding visitation or reunification with her children, she may be at increased risk of being battered.

Many victims are coerced by their partners into using alcohol or drugs as a mechanism of control, and the abusive partner often actively sabotages recovery efforts.[13] Interventions for the abusive partner and for the battered parent must be individualized. Case service plans and treatment plans must address both ongoing family safety needs and the abusing partner's behavior.

Family therapy, couples or marriage counseling, or other programs in which the victim and abuser must cooperatively participate should not be required of families in which there is domestic violence.[14] Local domestic violence prevention programs, shelters, and batterer intervention programs should be involved in assessing needs. They should develop case service plans for the battered parent and the batterer. Specific steps should be taken to assess the impact of domestic violence on the children. Two screening instruments for domestic violence are included in Appendix IV.

Child Welfare System (CWS)	Substance Use Disorders (SUD) Treatment System	Family Court System
STAGE V **ASSESS** for domestic violence and other mental health, behavioral and environmental issues that present barriers to compliance with the case plan. **ADDRESS** linkages to joint services.		▪ **Ensure** that the family's other needs and issues are explored and addressed in order that reunification may occur including: ▫ domestic violence ▫ mental health ▫ behavioral health ▫ environmental health

Addressing Other Needs and Barriers

In almost all cases, parents and other caregivers have other issues and considerations that must be addressed before treatment can be effective. For example, in order for a parent to be fully focused and engaged in treatment, housing, reliable transportation and

other basic needs must also be met. When child welfare workers seek treatment for substance-abusing mothers, gender-specific components are important considerations. If barriers and other service needs are not identified and addressed, we fail our vulnerable children and parents.

In addition to substance use disorder counseling, education, and treatment services, a number of common barriers and cross-system needs are reflected in the list below (adapted from a comprehensive treatment model with three levels of services for women with substance use disorder issues):[15]

CLINICAL TREATMENT SERVICES:

- Detoxification
- Crisis intervention
- Case management
- Trauma specific services
- Medical care
- Mental health services
- Drug monitoring
- Continuing care

CLINICAL SUPPORT SERVICES:

- Primary health care services
- Life skills
- Parenting and child development education
- Family programs
- Educational remediation and support
- Employment readiness services
- Linkages with legal system
- Housing support advocacy
- Recovery community support services

COMMUNITY SUPPORT SERVICES:

- Recovery management
- Recovery community support services
- Housing services
- Family strengthening
- Child care
- Transportation
- Temporary Assistance for Needy Families (TANF) linkages
- Health insurance
- Employer support services
- Vocational and academic education services
- Faith-based organization support
- Culturally appropriate support, including Lesbian, Gay, Bi and Transgender support

Child Welfare System (CWS)	Substance Use Disorders (SUD) Treatment System	Family Court System
STAGE VI ▪ **INCORPORATE** children into parent's treatment and increase parenting time through more frequent and longer visits with child as parent progresses in treatment.		▪ **Reinforce** a parent's progress and continued commitment to treatment by supporting increased parenting time with children.

VII. Aftercare and Recovery Services

After a parent has demonstrated progress in meeting treatment objectives, the child welfare system, substance use disorder services provider, and family court must examine whether the family is ready for transition.

Aftercare and recovery services involve assessing an individual's ongoing recovery plan. The assessment includes a clear picture when and under what circumstances the children will be reunited with the parent.

Important questions to consider include:

- Is the family ready for transition?
- What are the results of a risk, safety and/or reunification assessment at this time?
- How soon can we reunify the child with the parent?
- How soon can the family safety be assessed and established?
- What additional interventions are needed to support the parent's recovery?
- What additional interventions or supports are needed to reinforce the reunification stability of the family and well-being of the child?
- What is the parent's assessment of needed supports for reunification?

Child Welfare System (CWS)	Substance Use Disorders (SUD) Treatment System	Family Court System
Identified indicators of capacity for families with substance use disorders to meet the needs of their children regarding safety, permanency, and well being in outcome measures.		
▪ Changes in family functioning, parent's recovery, and case plan success are the key indicators to determine transition plans.	▪ Changes in family functioning, parent's recovery, and child welfare goals are key indicators to determine treatment completion and aftercare plans.	▪ Family court reviews changes in family functioning, parent's recovery, and child welfare goals in developing court orders for reunification and determining when or whether the case should be dismissed.
▪ Collaboratively developed plans and timelines for reunification of child and family are shared with partners. ▪ **Note:** If reunification is indicated, the caseworker does not need to wait until the next scheduled hearing. Contact court to schedule an earlier hearing date.	▪ Communication and shared knowledge about parent's treatment and recovery assists in development of plans for reunification of child with the parents. ▪ On-going support may be necessary to prevent relapse and maintenance placement.	▪ Family court ensures that plans for reunification are developed from shared information between substance use disorder services, the child welfare system, and other community providers of services to the parents and children.

The child welfare system's transition plan for the return of the child parallels the substance use disorder services plan for aftercare. Aftercare or recovery support services are essential to sustaining treatment success, child safety and family well-being. They give the family an opportunity to anchor new behaviors, practice drug-free living and relapse prevention techniques.

Without aftercare services and community supports, relapse rates can be high, even after periods of long sobriety during treatment. Continuing care includes clinical treatment and community support, addressing individual needs identified in the parent's relapse prevention plan, and building a supportive net around the individual and his or her family to sustain recovery. The child's reactions must be carefully reassessed once reunited with a parent who is no longer abusing substances.

Child Welfare System (CWS)	Substance Use Disorders (SUD) Treatment System	Family Court System
Aftercare services are developed to ensure family stability. ▪ Additional services are provided as appropriate to support the parent's continuing sobriety and support for the child's needs. Information is shared across systems with the substance use disorder services partner on a continuous basis.	Aftercare services incorporate changes in the child's status (e.g., returned home) and the impact on the parent's recovery. ▪ Additional services are provided as appropriate to support the parent's continuing sobriety and support for the child's needs. ▪ Information is shared across systems with child welfare partner on a continuous basis.	Family court encourages and monitors continued collaboration between the child welfare system and substance use disorder treatment services to maximize support of the parent's continued sobriety and stability for the child.
▪ Child welfare system recommendations for case closure incorporate substance use disorder treatment aftercare service recommendations and acknowledge their importance for optimal long-term family functioning. ▪ Parent is linked to appropriate community supports to ensure success after case closure.	▪ Substance use disorder services aftercare incorporates child welfare goals and supports optimal long-term family connections.	▪ The court acknowledges the importance of substance use disorder aftercare services, their contribution to child welfare goals, and supports these continuing services.
▪ Cross agency and community-wide funding strategies are employed to sustain programs. .		
▪ Outcome results are used for program planning and resource allocations		

APPENDICES

Appendix I: **Collaborative Values Inventory**

Appendix II: **Michigan Pathways of Communication Template**

Appendix III: **Sample Memoranda of Understanding**

- Eaton County Substance Abuse Protocol
- Saginaw County Protocol
- Baraga County Substance Abuse/Child Welfare Protocol
- Baraga County Workgroup Basic Tenets

Appendix IV: **Screening Instruments**

Appendix V: **Collaborative Capacity Instrument**

Appendix VI: **A Guide to Compliance with the Indian Child Welfare Act**

Appendix VII: **Tribal Courts**

Note: The Guide to Compliance with the Indian Child Welfare Act, the Collaborative Values Inventory and the Collaborative Capacity Instrument are available for download from the National Center on Substance Abuse and Child Welfare at: http://www.ncsacw.samhsa.gov/products.asp.

Appendix I

Collaborative Values Inventory

Collaborative Values Inventory

What Do We Believe about Alcohol and Other Drugs, Services to Children and Families and Dependency Courts?

Many collaboratives begin their work without much discussion of what their members agree or disagree about in terms of underlying values. This questionnaire is a neutral way of assessing how much a group shares ideas about the values that underlie its work. It can surface issues that may not be raised if the collaborative begins its work with an emphasis on programs and operational issues, without addressing the important values issues affecting their work. Learning that a group may have strong disagreements about basic assumptions that affect its community's needs and resources may help the group clarify later disagreements about less important issues which are really about these more important underlying values.

After reviewing the results from a collaborative scoring of the Inventory, it is important to discuss the areas of common agreement and divergent views. That discussion should lead to a consensus on principles that the collaborative members agree can form the basis of state or local priorities for implementing practice and policies changes, leading to improved services and outcomes for families.

Identify your own role in your organization:

1. **Staff Level:**
   - ❑ Front-line staff
   - ❑ Supervisor
   - ❑ Manager
   - ❑ Administrator
   - ❑ Other, Specify: _____

2. **Gender:**
   - ❑ Male
   - ❑ Female

3. Area of Primary Responsibility:

- ❑ Substance Abuse Services
- ❑ Child Welfare Services
- ❑ Dependency Court Judicial Officer
- ❑ Attorney Practicing in Dependency Court
- ❑ Domestic Violence
- ❑ Mental Health
- ❑ Other, Specify: _____

4. Age: _____Years

5. Jurisdiction of Agency or Court:

- ❑ Federal Government/National
- ❑ State Office
- ❑ Within State Regional Office
- ❑ County
- ❑ Community-Based Organization
- ❑ Reservation
- ❑ Other: Specify_____

6. Race/Ethnicity:

- ❑ African-American
- ❑ Asian/Pacific Islander
- ❑ Caucasian
- ❑ Hispanic
- ❑ Native American
- ❑ Other: _____

7. Years of professional experience in my primary program area: _____

CIRCLE the response category that most closely represents your extent of agreement with each of the following statements:

1) Dealing with the problems caused by alcohol and other drugs would improve the lives of a significant number of children, families, and others in need in our community.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

2) Dealing with the problems caused by alcohol and other drugs should be one of the highest priorities for funding services in our community.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

3) Dealing with the problems of child abuse and neglect should be one of the highest priorities for funding services in our State.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

8) There is no way that a parent who abuses alcohol or other drugs can be an effective parent.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

9) There is no way that a parent who is chemically dependent on alcohol or other drugs can be an effective parent.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

10) In assessing the effects of the use of alcohol and other drugs, the standard we should use for deciding when to remove or reunify children with their parents is whether the parents are fully abstaining from use of alcohol or other drugs.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

11) Parents who have been ordered to remain clean and sober should face consequences for non-compliance with those orders.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

13) We have enough money in the systems that respond to the problems of alcohol and other drugs today; we need to redirect the money to use it better.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

14) We should fund programs that serve children and families based on their results, not based on the number of people they serve, as we often do at present.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

15) We should fund programs that treat parents for their abuse of alcohol and other drugs based on their results, not based on the number of people they serve, as we often do at present.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

16) We should provide incentive funds and penalties to courts based on their results in meeting statutory timelines.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

17) If we funded programs based on results, some programs would lose some or all of their funding.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

18) In our community, agencies should involve people from the community and court system in planning and evaluating programs that respond to the problems of substance abuse.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

19) In our community, agencies should involve people from the community in planning and evaluating programs that serve families affected by child abuse/neglect.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

20) In our community, dependency courts do a good job of involving people from the community in planning and evaluating services and programs in the dependency court.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

21) Judges have a responsibility to be involved with planning community-wide responses to the problems associated with alcohol and other drug use.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

22) Children of substance abusers who are also in children's services should be a high priority group for targeted substance abuse prevention services.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

23) Substance abuse treatment outcome measures should include indicators regarding the safety, permanency and well being of the children of parents who are in their treatment programs.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

24) Child welfare service outcome measures should include indicators regarding the substance abuse recovery status of parents of the children they seek to protect.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

26) Persons who are in recovery and have successfully transitioned out of the child welfare system should play a significant role in supporting and advocating for parents in the child welfare and family court systems.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

29) Our agencies and courts do a good job in responding to the needs of Indian children and families in the child welfare and treatment systems.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

30) Services would be improved if all clients, regardless of income, who receive services made some kind of payment for the services with donated time, services, or cash.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

31) In our community, the judges and attorneys in the dependency court and the agencies delivering services to children and families often are ineffective because they don't work together well enough when they are serving the same families.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

32) The dependency courts should provide increased monitoring of parents' recovery as they go through substance abuse treatment, and should use the power of the court to sanction parents if they don't comply with treatment requirements.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

33) The most important causes of the problems of children and families cannot be addressed by government; they need to be addressed within the family and by nongovernmental organizations such as churches, neighborhood organizations, and self-help groups.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

34) Judges should be the leaders of collaboratives seeking to solve problems associated with substance abuse and child welfare.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

35) The problems caused by use of tobacco by youth are largely unrelated to the problems caused by the use of alcohol and other drugs by youth.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

36) A neighborhood's residents should have the right to decide how many liquor stores should be allowed in their neighborhood.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

37) The messages which youth receive from the media, TV, music, etc. are a big part of the problem of abuse of alcohol and other drugs by youth.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

38) The price of alcohol and tobacco should be increased to a point where it pays for the damage caused in the community by use and abuse of these legal drugs.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

39) I believe that the significant barriers to interagency cooperation would be resolved if children's services, substance abuse and dependency court staff were involved in a comprehensive training program for child welfare staff.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

40) I believe that confidentiality of client records is a significant barrier to allowing greater cooperation among alcohol and drug treatment, children's services agencies, and the courts.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

41) I believe that publicly-funded alcohol and drug treatment providers should give higher priority in allocating treatment slots than they do at present to women referred from child protective services.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

42) Judicial ethics should be interpreted that judges not participate in collaborative efforts that involve attorneys who may appear in their courts.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

43) Attorneys who represent parents in dependency court proceedings have an ethical conflict if they advise parents to admit that they have a substance abuse problem or to seek treatment prior to the court taking jurisdiction in a case because the substance abuse admission could be negatively interpreted during the investigation of the child abuse and neglect allegations.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

45) The proportion of parents who will succeed in treatment for alcohol and other drug problems is approximately (circle one**).**

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

46) The proportion of parents in substantiated CPS cases who will succeed in family services, regain custody of their children, and not re-abuse or re-neglect is (circle one).

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

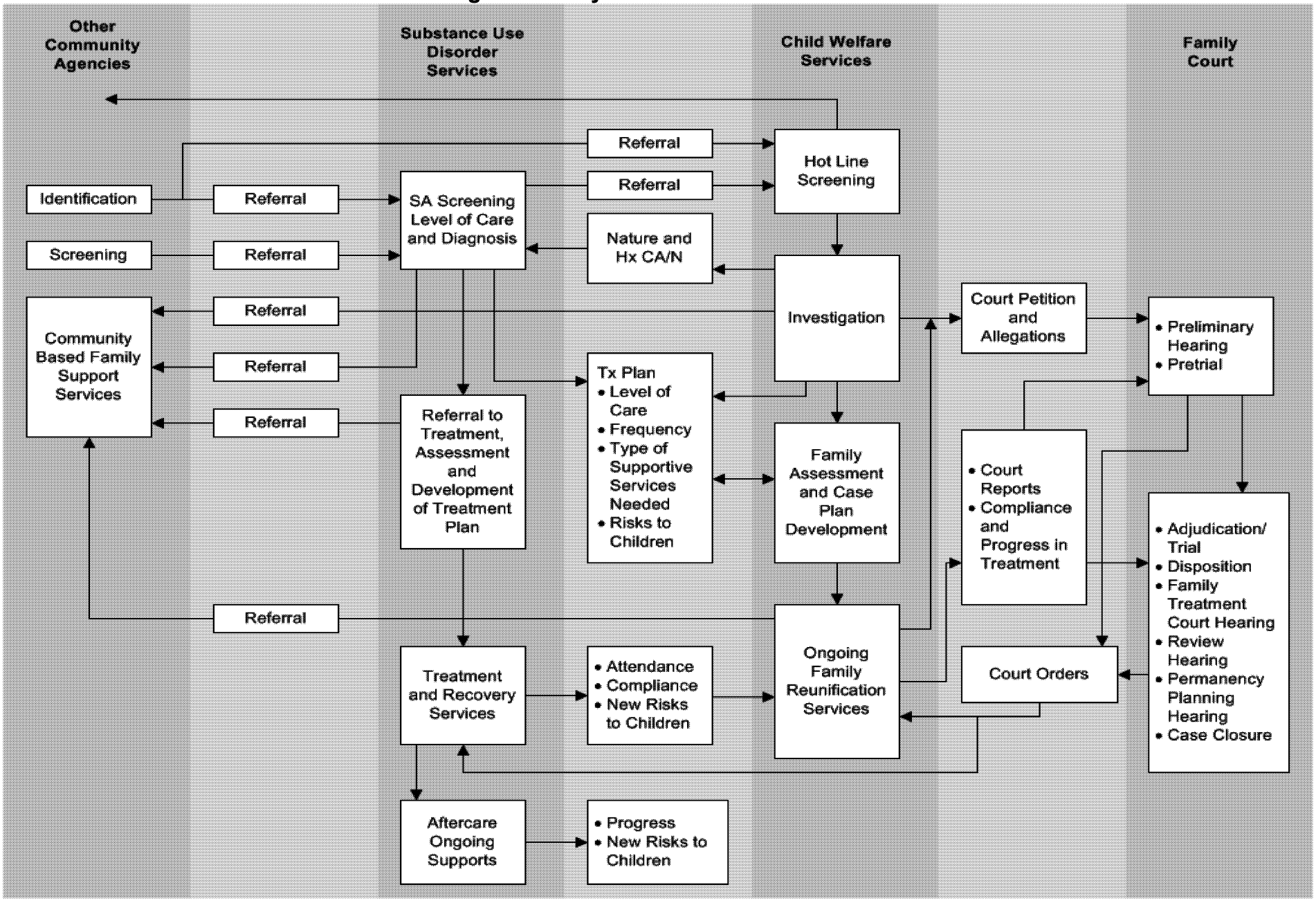
47) The most important causes of problems affecting children, families, and others in need in our community are [circle only three]:

A lack of self-discipline
The level of violence tolerated by the community
A loss of family values
Lack of skills needed to keep a good job
Racism
The harm done by government programs
Drug abuse
Too few law enforcement personnel
Mental illness
Fragmented systems of service delivery
Domestic violence
Deteriorating public schools
Alcoholism
The way the welfare program works
Poverty
Children born and raised in single-parent homes
Child abuse
A lack of business involvement in solutions
Low intelligence
Too few jails and prisons
Illiteracy
Inadequate support for low-income families who work
The drug business
Economic changes that have eliminated good jobs
Incompetent parenting
An over-emphasis upon consumer values
Illegal immigration

Appendix II

Michigan
Pathways of Communication Model

Michigan Pathways of Communication Model



Appendix III:

Sample Memoranda of Understanding

i. Eaton County Substance Abuse Protocol
ii. Saginaw County Protocol
iii. Baraga County Substance Abuse/Child Welfare Protocol
iv. Baraga County Workgroup Basic Tenets

EATON COUNTY SUBSTANCE ABUSE PROTOCOL

COLLABORATIVE AGREEMENT
BETWEEN
EATON SUBSTANCE ABUSE PROGRAM
AND
EATON COUNTY DEPARTMENT OF HUMAN SERVICES

Purpose:

The purpose of the Eaton County Substance Abuse Protocol is to ensure effective substance abuse treatment for mutual clients of the Eaton Substance Abuse Program (ESAP) and the Eaton County Department of Human Services (DHS). Effective treatment and enhanced customer service will be sustained through a streamlined referral process, coordinated service delivery, and effective, timely communication. The Eaton County Substance Abuse Protocol will assure the two agencies work together for the benefit of our mutual clients. A coordinated multi-agency response will afford families the most successful intervention with an outcome of family stability. Substance abuse is a major factor in child welfare cases whether Protective Services, Foster Care or Juvenile Justice.

Goals:

With the development of a community protocol, the protocol goals are to:

- Improve communication
- Enhance the service delivery system for individuals and families
- Provide training and continuing education for staff
- Allow for regularly scheduled meetings to address issues/concerns to best meet the needs of the family, referring agency and service provider
- Identify and address gaps in service delivery

Referral Process:

A referral will be made by the Department of Human Services worker utilizing the Eaton County Service Referral Form. This form identifies the service authorization period, number of units, payment source and identified service. The services that are available through ESAP include: a comprehensive assessment, substance abuse assessment, substance abuse intake (to be utilized when the client has previously had an intensive assessment) and ongoing substance abuse treatment. If possible, the DHS worker will attach a signed release of information to the referral. If obtaining a release prior to the sending the referral to ESAP is not possible, the Eaton Substance Abuse Program service provider will request the release of information from the client.

It is the responsibility of the DHS referring worker to inform the client that a referral for substance abuse service has been made. The referring worker will inform the client to contact ESAP to schedule an appointment. If the referring worker has provided a release of information to ESAP, DHS will be notified if the client does not attend their appointments. If

ESAP has not received a signed release of information, the referring worker will not be contacted when a no show occurs.

REPORTING REQUIREMENTS

Client Evaluation Report (CER):

Within 5 working days of the assessment or intake, a Client Evaluation Report will be completed by the substance abuse provider and sent to the referring worker.

Client Progress Report (CPR):

A Client Progress Report will be completed by the case manager each month. The CPR will be submitted to the referring worker by the 15th day of the month following treatment.

Termination Summary Report:

A discharge summary will be submitted within 5 working days of the date of case closure to the referring worker.

Client Contacts:

Initially, the number of client contacts will be identified on the DHS Services Referral Form. Through mutual agreement between DHS, ESAP and the family, the number of client sessions can be modified, after the assessment period. Client contact must be established at a minimum of one time each month.

Court Appearances:

The Eaton Substance Abuse Program provider will appear at court hearings only when subpoenaed for an appearance.

Client Transportation:

If the client is unable to find transportation to the scheduled appointment, it is the client's responsibility to contact either their Eaton Substance Abuse Program provider or the Department of Human Services worker to arrange transportation. Available options include bus tokens, taxicabs and volunteer transportation.

Continuing Education:

Within the first 3 months of the protocol being signed, a joint orientation will be held for Department of Human Services staff and the Eaton Substance Abuse providers. The joint orientation will include details of the protocol, discussion of the referring forms, reports, scheduled training and other pertinent information. Open dialog will occur on prior successes, current issues and potential resolutions.

Thereafter, DHS and ESAP managers will meet at a minimum of 2 times a year to review and discuss the protocol, services, treatment options and all topics relevant to effective services. Annually, joint training will be provided to ESAP and DHS staff. Training will be pertinent to current service topics or identified needs of either staff.

Conflict Resolution:

If a client referred from the Department of Human Services has a complaint about substance abuse services, they will contact their caseworker for assistance in resolving the issue.

It is the intent of this partnership to resolve disputes at the level closest to the onset on the concern. If concerns arise that cannot be resolved at the worker or middle management level, the directors of the respective agencies will meet to review and resolve any issues.

If there is a complaint or grievance from a customer regarding access, level of care decisions or provision of services, the customer will follow the existing grievance appeal and recipients rights procedure as applicable to the service system (in addition to contacting their DHS worker).

Customers of Eaton Substance Abuse Program will follow the Patient's Rights Procedure for assistance in resolving alleged violations of their legal rights.

Identifying and Addressing Gaps in Customer Services:
The bi-annual meeting between DHS and ESAP shall be used to discuss enhancing service and to explore funding opportunities through grant writing or other creative approaches.

_____
Don Rewa, Director, Barry-Eaton Department of Human Services

_____
Thomas Spencer, Executive Director, Barry-Eaton District Health Department

SAGINAW COUNTY PROTOCOL

COORDINATION OF SERVICES AGREEMENT
BETWEEN
SAGINAW COUNTY DEPARTMENT OF HUMAN SERVICES
SAGINAW COUNTY DEPARTMENT OF PUBLIC HEALTH
AND
BAY AREA SUBSTANCE ABUSE COORDINATING AGENCY

INTRODUCTION

The purpose of this agreement is to support state and local policy of coordination and collaboration between the Saginaw County Department of Human Services (DHS), the Saginaw County Department of Public Health (SCDPH) and the Bay Area Substance Abuse Coordinating Agency (BASACA). In Saginaw County the Bay Area Substance Abuse Coordinating Agency is a division of the Saginaw County Department of Public Health.

This agreement recognizes the mutuality of many of the individuals and families served by each agency. This agreement is seen as a means to enhance the services and programs now offered by each of the agencies in ways that will increase the effectiveness of said programs for the families served. This agreement promotes and facilitates compliance with the Federal and State confidentiality laws of Bay Area Substance Abuse Coordinating Agency, the Saginaw County Department of Public Health and of the Saginaw County Department of Human Services, while permitting the communication and collaboration necessary for both the treatment of the parents and the well being of the children.

Specifically, the goals of the agreement are:

1. To enhance customer service for the individuals and families served by our agencies.
2. To facilitate eligibility determination and ensure access to services for customers.
3. To coordinate the delivery of services.
4. To facilitate communication and problem-solving.
5. To ensure continuing information exchange.
6. To identify and address unmet needs.

GENERAL PRINCIPLES

A. INFORMATION EXCHANGE AND CONFIDENTIALITY

1. Service agreements will be developed between the participating agencies to allow the transfer of initial referral information, particularly to facilitate access to the appropriate service or respond to customer emergencies. (See Appendix 1 for the "Substance Abuse Services Addendum between DHS, SCDPH and BASACA.)

2. DHS, SCDPH and BASACA will develop and use a mutually agreed upon release of information form that will comply with Federal and State confidentiality laws. (See Appendix I for a copy of the Release of Information Form.)

3. DHS, SCDPH and BASACA programs will obtain releases of information in accordance with Federal and State regulations to allow exchange of information beyond accessing services or customer emergencies. The requirements regarding confidentiality of customer records in DHS and BASACA will be summarized and communicated to providers in each agency. (See Appendices 2 and 3 for detailed statements regarding confidentiality requirements that can be distributed to staff members within the participating agencies.)

B. COLLABORATION AND INFORMATION SHARING

COORDINATION OF SERVICES AGREEMENT

1. DHS, SCDPH and BASACA will develop a service agreement to facilitate the exchange of information between agencies on an ongoing basis. This will include availability and access to the ADIA program. See Appendix 1 for the "Substance Abuse Services Addendum between DHS, SCDPH and BASACA.

2. The directors of DHS, BASACA and SCDPH will meet regularly at the Multi-Purpose Collaborative Body (MPCB) meetings for overview, information sharing and the possible need for meetings with administrations and/or staff.

3. Representatives from the participating agencies and subprograms will meet at least annually to share information, update procedures, and enhance working relationships between programs.

4. Additional collaborative initiatives will be developed as needs are identified.

C. TRAINING AND STAFF DEVELOPMENT

1. During the first six months of this agreement, there will be two training sessions between the staffs of the participating agencies to share information regarding programs, procedures and staffing.

2. A minimum of one conjoint/collaborative in-service workshop will be scheduled each year to address the coordination of programs, update policies and procedures, introduce new staff, and enhance the working relationships.

3. Information regarding conjoint/collaborative training activities sponsored by or known to participating agencies will be shared on an ongoing basis.

4. Conjoint/collaborative training activities, including local new employee orientations, sponsored by participating agencies will be open to participation by providers in the other agencies as appropriate.

5. Self-training materials developed by the participating agencies will be shared with other agencies as appropriate and available.

6. Conjoint training will be arranged as needed based on the mutual agreement of need by the DHS and BASACA.

D. PROBLEM RESOLUTION PROCESSES

1. Whenever possible, disputes should be resolved at the level closest to the onset of the concern.

2. Disagreements between staff members:

    a. Disputes regarding coordination of care are initially handled by the providers serving a customer with the various systems of care.

    b. Service differences that cannot be resolved at the line worker level are first directed to the line worker's supervisor, who will then contact the corresponding supervisor to discuss the problem.

    c. Disagreements that cannot be resolved at the supervisory level are referred to the section or program manager, who will then contact the corresponding section or program manager to discuss the problem.

    d. Final resolution of unresolved issues will be managed between the directors of the respective agencies.

3. Concerns of customers:

    a. Unresolved complaints and grievances from customers or providers regarding access, level of care decisions or provision of services will follow existing grievance, appeal and recipient rights procedures as applicable to each service system.

    b. Customers of DHS services may contact their worker for assistance in resolving the issues and/or to request an administrative hearing.

    c. Customers of Substance Abuse Services will follow the Patient's Rights procedures for assistance in resolving alleged violation of legal rights.

SPECIFIC PARAMATERS OF THIS AGREEMENT

This agreement is in effect until September 30, 2002. If any party desires a modification or change in procedure and/or basic programming structure, a written statement to this effect is to be sent to the directors of the other agencies. Any amendment, modification or revision must be approved by all three parties: DHS, SCDPH and BASACA.

_____ _____

Longino C. Gonzales, Director, Saginaw DHS Date

_____ _____

John Niederhauser, Health Officer, Saginaw DPH Date

_____ _____

Dr. Cheryl Pletenberg, Director, BASACA Date

BARAGA COUNTY SUBSTANCE ABUSE/CHILD WELFARE PROTOCOL

COLLABORATIVE AGREEMENT
BETWEEN
COURT SYSTEMS, TRIBAL ENTITIES, COORDINATING AGENCY AND SUBSTANCE ABUSE PROVIDERS, COMMUNITY MENTAL HEALTH SYSTEMS, BARAGA COUNTY SHELTER HOME, CHILD AND FAMILY SERVICES, WUP-DISTRICT HEALTH DEPARTMENT, CC-HSCB
AND
THE BARAGA COUNTY DEPARTMENT OF HUMAN SERVICES

Purpose:
To ensure Child Safety and Well-being through effective substance abuse treatment for mutual customers of Baraga County Court Systems, Tribal Entities, Community Mental Health Systems, Coordinating Agency and Local Substance Abuse, Baraga County Shelter Home, Child and Family Services and the Department of Human Services.

Goals:
- To maintain effective communication[1], while meeting all federal 42 CFR Part 2 regulations and HIPAA requirements.
- To enhance service delivery for individuals and families
- To provide training and continuing education opportunities for staff
- To allow for regularly scheduled meetings to address issues/concerns of all parties
- To identify and address gaps in service delivery

Referral Process:
A referral process will be developed in conjunction with all parties to ensure the availability of services and to determine a realistic expectation of service delivery response and to determine reporting elements.

Reporting/Confidentiality:
Specific guidelines for sharing information will be developed, in accordance with State and Federal requirements for confidentiality/HIPAA compliance (to include, but limited to, MH Code, Child Welfare policy, Tribal Codes, and 42 CFR Part 2 regulations) to assure the safety and well-being of children through effective service delivery.

Continuing Education:
Within the first six months of this protocol being signed, a joint orientation will be organized and provided for individual agency staff and substance abuse providers to discuss the referral process, reporting process and confidentiality/HIPAA guidelines, as well as, the continuing education planning process. Thereafter, protocol members will meet a minimum of two times per year to review and discuss relative issues or areas of concern, and to address any gaps in services. Annual training will be organized and offered to protocol members to address needs, changes in laws or procedures, and pertinent current practices.

[1] Reference: Interagency Communication Protocol Document

Conflict Resolution:
This group will act in concert with agencies or providers in addressing complaints regarding substance abuse/child welfare issues that cannot be resolved at the agency or provider level. It is the intent of this partnership to resolve disputes at the level closest to the onset of the concern, following federal 42 CFR Part 2 regulations and HIPAA requirements. If concerns arise that cannot be resolved at the worker or middle management level, the directors of the respective agencies will meet to review and resolve any issues.

Signature Page

BARAGA COUNTY FAMILY COURT	Date
BARAGA COUNTY SHELTER HOME	Date
CHILD AND FAMILY SERVICES	Date
COPPER COUNTY MENTAL HEALTH	Date
DEPARTMENT OF HUMAN SERVICES	Date
KBIC-DSS	Date
KBIC-SAP	Date
KBIC-TRIBAL COURT	Date
WUPSAS-CA.INC.	Date
WUP-DHD	Date
COPPER COUNTRY-HSCB	Date

May 2004

Baraga County Workgroup
Substance Abuse/Child Welfare/Courts

BASIC TENETS

- Neglect and abuse of children is frequently associated with substance abuse and addiction. Loss of custody and possible termination of rights often is critical to bringing the parent into treatment.

- Safety of children must always be assured.

- The first focus of services to the parent must be assessment and treatment of the addiction, as we know that other behaviors and needs are rooted in it.

- A drug/substance free, supportive living environment is critical to successful recovery.

- Addiction is a disease. We acknowledge that relapse may occur and that this will require modified and/or intensified services.

- No single agency contains all the resources and expertise to fully respond to the needs of the parent who is addicted and who has abused and/or neglected his/her children.

- We will consult on decisions with each other and with the parents to develop and implement plans that meet family member needs to the best of our agencies' resource capabilities.

- We will modify policies and procedures that impede the family's cooperation with all service providers.

- We will adopt creative approaches to building family support systems, improving parenting skills, meeting child-care needs and filling gaps in service.

- Our objective is reunification of the family as quickly as the children's protection can be assured. A child deserves a safe and permanent home. If the parent does not achieve recovery, consideration will be given to filing for permanent custody.

December 2003

Appendix IV

Screening Instruments

Screening instruments for alcohol or other drug involvement (For child welfare workers):

1. CAGE (amended for drug use):

C Have you ever felt the need to **CUT** down on your drinking or drug use?
A Have you ever felt **ANNOYED** by people criticizing your drinking or drug use?
G Have you ever felt bad or **GUILTY** about your drinking or drug use?
E Have you ever had a drink or used a drug first thing in the morning to steady your nerves or get rid of a hangover? (**EYE-OPENER.)**

Scoring:

If the answer is "yes" to one or more questions, the parent should receive a formal alcohol and drug assessment.

- "Yes" to one or two questions may indicate alcohol and drug related problems.
- "Yes" to three or four questions may indicate alcohol or drug dependence (addiction).

2. TWEAK (designed for detecting drinking in pregnant women):

	TWEAK QUESTIONS	***score***
T	**Tolerance:** How many drinks can you hold without falling asleep or passing out?	**2 points** -- if can hold 5 drinks
W	Have close friends or relatives **Worried** or complained about your drinking in the past year?	**2 points** – if yes
E	**Eye-Opener:** Do you sometimes take a drink in the morning when you first wake?	**1 point** – if yes
A	**Amnesia:** Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?	**1 point** – if yes
K (C)	Do you sometimes feel the need to **Cut down** on your drinking?	**1 point** – if yes
Scoring: Alcohol is likely to be a problem with a score of 2 or more.		

Source: Russell, 1994. [16]

Screening Instrument for Risk of Abuse or Neglect of Children
(For use with substance using parent)

Designed for Substance Use Disorder service providers:

Screening Questions	*Indicators for Concern and Referral*
1. Number of children _____	1. Parent may appear overwhelmed or unable to provide for basic needs or demonstrate consistent parenting
2. Ages of children _____	2. **Red Flag**: Any children under the age of six.
3. Where are children living?	3. **Red Flag**: Children living part-time or full time with substance abusing parent.
4. Who cares for your children when you are using or looking for drugs?	4. **Red Flags**: Children younger than 12 years old left alone. Children present when parent uses. Children left with partner when parent seeks drugs. Children taken with parent who is seeking drugs or partying.
5. Have you had children's protective services (CPS) involved in your life? In the past? Currently?	5. **Red Flag**: If CPS was ever involved. Note: If CPS is currently involved and the children may be at risk as a result of behaviors connected with alcohol or drug use by the parent (or parent's partner) a report should be made.

Screening Tool for Domestic Violence

As with all tools, it is important to be aware of the limitations of the instrument and the complexities and nuances indicated by the respondent. Although all responses on the tool might appear to be weighted evenly, some may actually be much more important or indicative of danger than others. The professional must use discretion and common sense when interpreting these measurement tools and making decisions about the level of risk victims of violence may be facing, also considering the level of fear the respondent expresses.

Sample questions include:

- Does your partner behave in ways that frighten the children and you?
- Has anyone else in the family been hurt or assaulted?
- Has anyone made threats to hurt or kill another family member or himself?
- Have weapons been used to threaten or harm anyone?
- Have the police ever been called to the home? Have arrests been made?
- Has the batterer threatened to leave with the children?
- Has any family member stalked another family member?
- Has anyone taken a family member hostage?

DANGER ASSESSMENT

Jacquelyn C. Campbell, Ph.D., R.N.

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Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were abused by your partner or ex partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones
4. Threat to use weapon; head injury, internal injury, permanent injury
5. Use of weapon; wounds from weapon

(If **any** of the descriptions for the higher number apply, use the higher number.)

Mark **Yes** or **No** for each of the following. ("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

____ 1. Has the physical violence increased in severity or frequency over the past year?
____ 2. Does he own a gun?
____ 3. Have you left him after living together during the past year?
3a. (If have *never* lived with him, check here___)
____ 4. Is he unemployed?
____ 5. Has he ever used a weapon against you or threatened you with a lethal weapon?
(If yes, was the weapon a gun?____)
____ 6. Does he threaten to kill you?
____ 7. Has he avoided being arrested for domestic violence?
____ 8. Do you have a child that is not his?
____ 9. Has he ever forced you to have sex when you did not wish to do so?
____ 10. Does he ever try to choke you?
____ 11. Does he use illegal drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", street drugs or mixtures.
____ 12. Is he an alcoholic or problem drinker?
____ 13. Does he control most or all of your daily activities? For instance: does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car? (If he tries, but you do not let him, check here: ____)
____ 14. Is he violently and constantly jealous of you? (For instance, does he say "If I can't have you, no one can.")
____ 15. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: ____)
____ 16. Have you ever threatened or tried to commit suicide?
____ 17. Has he ever threatened or tried to commit suicide?
____ 18. Does he threaten to harm your children?
____ 19. Do you believe he is capable of killing you?
____ 20. Does he follow or spy on you, leave threatening notes or messages on answering machine, destroy your property, or call you when you don't want him to?

_____ Total "Yes" Answers

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.

Appendix V

Collaborative Capacity Instrument

Collaborative Capacity Instrument: Reviewing and Assessing the Status of Linkages Across Alcohol and Drug Treatment, Child Welfare Services and Dependency Courts

This tool is intended to be used as a self-assessment by State (and/or local jurisdiction) alcohol and other drug (AOD) service and child welfare service (CWS) agencies and dependency courts* who are preparing to work with each other or who may be seeking to move to a new level of cooperation after some initial efforts. The questions have been designed to elicit discussion among and within both sets of agencies and the court about their readiness for closer work with each other.

Responses from this assessment should be tabulated and distributed, along with the total from all participants, to each State team. The results can be used to compare the jurisdiction with the matrix of progress in linkages and prioritizing any needed action. The NCSACW has the ability to tabulate these responses via the internet for interested sites.

Identify your own role in your organization:

1. Staff Level:

- ❑ Front-line staff
- ❑ Supervisor
- ❑ Manager
- ❑ Administrator
- ❑ Other, Specify: _____

2. Gender:

- ❑ Male
- ❑ Female

3. Area of Primary Responsibility:

- ❑ Substance Abuse Services
- ❑ Child Welfare Services
- ❑ Dependency Court Judicial Officer
- ❑ Attorney Practicing in Dependency Court
- ❑ Domestic Violence
- ❑ Mental Health
- ❑ Other, Specify: _____

4. Age: _____Years

5. Jurisdiction of Agency or Court:

- ❑ Federal Government/National
- ❑ State Office
- ❑ Within State Regional Office
- ❑ County
- ❑ Community-Based Organization
- ❑ Reservation
- ❑ Other:
  Specify_____

6. Race/Ethnicity:

- ❑ African-American
- ❑ Asian/Pacific Islander
- ❑ Caucasian
- ❑ Hispanic
- ❑ Native American
- ❑ Other:
  _____

7. Years of professional experience in my primary program area: _____

*Dependency court is used in this document to include the courts that have jurisdiction in cases of child abuse and/or neglect and include judicial officers as well as the attorneys that represent parents, children, social services and the state.

I. Underlying Values and Principles of Collaborative Relationships

Circle the response category that most closely represents your extent of agreement with each of the following statements:

Disagree Somewhat Agree Agree Not Sure/Don't Know

1. **Our state has included the judicial officers and attorneys from the dependency court as partners in the development of new approaches to serving substance-abusing parents in the child welfare system.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

2. **Our state AOD and CWS agencies and dependency courts have used a formal values assessment process to determine how much consensus or disagreement we have about issues related to AOD use, parenting, and child safety.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

3. **Our state AOD and CWS agencies and dependency courts have negotiated shared principles or goal statements that reflect a consensus on issues related to families with AOD-related problems in child welfare and the dependency court.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

5. **In our state, CWS staff and the courts view alcohol abuse as being as important as other drug as a contributing factor in child abuse and/or neglect.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

6. **Our state has discussed and developed responses to the conflicting time frames associated with CWS, TANF, AOD treatment and child development.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

II. Daily Practice – Screening and Assessment

1. **Our state has developed a joint AOD-CWS-Dependency Court policy on its approach to standardized screening and assessment of substance abuse issues among families in child welfare.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

2. **Our state has successfully out-stationed AOD workers at CPS offices and/or the dependency court to help with screening and assessment of clients.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

5. **Our state supplements child abuse/neglect risk assessment with an in-depth assessment of AOD issues and their impact on each of the family members.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

6. **Our state's child welfare intake process is able to identify prior AOD treatment episodes based on previously negotiated information sharing protocols.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

7. **Our state's AOD intake process identifies parents who are involved in the CWS system based on previously negotiated information sharing protocols.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

8. **Our state's AOD providers have sufficient information about the child welfare case to conduct quality assessments among families referred by child welfare to treatment.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

9. **Our state routinely documents AOD factors from its screening and assessment process in the information system.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

10. **When our AOD treatment providers assess clients, they routinely include questions about children in the family, their living arrangements, and child safety issues.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

11. **Our state routinely monitors the implementation and the quality of its screening and assessment protocols.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

III. Client Engagement and Retention in Care

1. **Our state's CWS staff have the skills and knowledge to talk with their clients about their AOD use and related problems.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

2. **Our state's AOD staff have the skills and knowledge to talk with their clients about child safety and CWS involvement.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

3. **Our state's dependency court judges have the skills and knowledge they need to talk with their clients about child welfare and substance abuse issues.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

4. **Our state's dependency court attorneys have the skills and knowledge they need to talk with their clients about child welfare and substance abuse issues.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

5. **Our systems have assessed common drop-out points where clients in care leave the system prior to completing treatment.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

6. **Our systems have implemented integrated case plans that include the substance abuse recovery plan integrated or linked with the child welfare case plan.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

7. **Our dependency court system has adequate access to treatment monitoring information to determine how parents are progressing through treatment in a timely way.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

8. **Our state's dependency court system has realistic expectations for CWS parents with AOD problems (e.g., approach to relapse and drug testing issues).**

Disagree Somewhat Agree Agree Not Sure/Don't Know

9. **Our state's CWS staff provides outreach to clients who do not keep their initial AOD appointment or drop out of treatment.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

10. **Our dependency court staff follows up with the substance abuse treatment agency that the parent is ordered to attend if a parent fails to keep a court date.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

12. **Our state has developed and trained our staff in approaches with clients that improve rates of retention in treatment once they enter it.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

13. **In our state, CWS and AOD agencies have agreed on the level of information about clients' progress in treatment that will be communicated from treatment agencies to CWS workers and the courts.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

14. **In our state, there is an adequate system for monitoring jointly-agreed upon outcomes of child welfare, substance abuse and dependency court programs and interventions.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

15. **In our state, client relapse typically leads to a collaborative intervention to re-engage the client in treatment and to re-assess child safety.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

16. **In our state, drug testing is used effectively and in conjunction with a treatment program to monitor clients' compliance with treatment plans.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

17. **Rate your state's AOD treatment on the following areas**:

	Poor		**Fair**		**Excellent**
Gender specific	1	2	3	4	5
Culturally relevant	1	2	3	4	5
Geographically accessible	1	2	3	4	5
Family focused	1	2	3	4	5
Age-specific responses to children's needs	1	2	3	4	5
Adequacy of adolescent treatment	1	2	3	4	5

18. **Rate your state's child welfare services in the following areas:**

	Poor		Fair		Excellent
Gender specific	1	2	3	4	5
Culturally relevant	1	2	3	4	5
Geographically accessible	1	2	3	4	5
Family focused	1	2	3	4	5
Age-specific responses to children's needs	1	2	3	4	5
Adequacy of adolescent treatment	1	2	3	4	5

IV. Daily Practice – Services to Children

1) **Our state has implemented substance abuse prevention and early intervention services for most children in the CWS system.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

2) **Our state targets children of substance abusers in the child welfare system for specialized substance abuse prevention programming.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

3) **Our state ensures that all children in the child welfare system have a comprehensive mental health assessment that includes screening for developmental delays, neurological, effects of prenatal AOD exposure, and the emotional and mental effects of their parents substance use.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

4) **Our state ensures that all children in CWS are screened for: Neurological effects of prenatal substance exposure**

Disagree Somewhat Agree Agree Not Sure/Don't Know

a. **Developmental delays associated with parental substance abuse**

Disagree Somewhat Agree Agree Not Sure/Don't Know

b. **Emotional/mental health problems associated with parental substance abuse**

Disagree Somewhat Agree Agree Not Sure/Don't Know

c. **Substance use disorders**

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

6) **Our state has developed a range of programs for children of substance-abusing parents that are targeted on the special developmental needs of these children.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

7) **Our state is familiar with national models of prevention and intervention for AOD-affected children.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

V. Joint Accountability and Shared Outcomes

1) **Our state's AOD agency has identified system outcomes and has communicated them to CWS and the dependency court.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

2) **Our state's CWS agency has identified system outcomes and has communicated them to the AOD agency and the dependency court.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

3) **Our state's dependency court has identified system outcomes and has communicated them to the AOD and CWS agencies.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

4) **Our state AOD and CWS agencies and the courts have developed shared outcomes for CWS-AOD involved families and have agreed on how to use this information to inform policy leaders.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

5) **Our state has developed outcome criteria in their contracts with community-based providers (who serve CWS-AOD clients) to measure their effectiveness in achieving shared outcomes.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

6) **Our state has shifted funding from providers who are less effective in serving clients in the CWS-AOD systems to those that are more effective.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

7) **In our state, CWS-AOD involved parents are referred to parenting programs that have demonstrated positive results with this population.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

8) **Our state CWS agency shares accountability with their AOD counterpart for successful treatment outcomes for their mutual clients.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

9) **Our state AOD agency shares accountability for positive child safety outcomes for clients who have enrolled in treatment programs.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

10) **In our state, drug testing is used in the court system as the most important indicator of clients' status in resolving their AOD problem.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

VI. Information Sharing and Data Systems

1) **Our state has assessed its data system to identify gaps in monitoring clients involved in both CWS and AOD systems.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

2) **Our state's data system can retrieve the percentages of families that receive services in both the AOD and CWS agencies.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

3) **Our state has identified the confidentiality provisions that affect CWS-AOD and dependency court connections and has devised means of sharing information while observing these regulations.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

4) **Our state has developed formal working agreements with the courts that include how child welfare and treatment agencies will share information about clients in treatment with the court system.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

6) **Our state's AOD services have supplemented the alcohol/drug data system to generate data on their clients' children and their CPS involvement.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

7) **Our state has developed the capacity to automate data about the characteristics and service outcomes of the clients who are in both the CWS and AOD caseloads.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

8) **Our state is using data that can track CWS/AOD clients across information systems to monitor system outcomes.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

VIII. Training and Staff Development

1) **Our state CWS ensures that all managers, supervisors and workers receive training on working with AOD-affected families.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

2) **Our state AOD agency ensures that their staff/providers receive training on working with families in the CWS system.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

3) **Our state has trained court staff in the principles of effective drug treatment and gender-specific services for mothers.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

4) **Our state has trained attorneys who practice in the dependency court regarding effective advocacy and basic education regarding substance abuse and addiction.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

5) **Our state has developed joint training programs for AOD, CWS and court staff and providers to learn effective methods of working together.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

6) **Our state has a multi-year staff development plan that includes periodic updates to the training and orientation received by the staff of both CWS and AOD agencies on working together.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

7) **Our state has training programs that include cultural issues to improve staff's cultural relevance and competency in working with diverse AOD-CWS client groups.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

8) **Our state has revised the state university and social work pre-service educational programs so that future staff are prepared to work across systems on substance abuse and child welfare issues.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

9) **Foster parents, guardians, kinship placement providers and group home providers are sufficiently trained to work on issues related to substance abusing families.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

10) **Training programs regarding substance abuse, child welfare and dependency court issues that are offered in our state are multidisciplinary in their approach and in their delivery.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

VIII. Budgeting and Program Sustainability

1) **Our state CWS agency currently uses a portion of its funding for AOD treatment services (excluding drug testing).**

Disagree Somewhat Agree Agree Not Sure/Don't Know

2) **Our AOD treatment agencies currently use a portion of their funding for services to improve clients' parenting skills.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

3) **Our AOD treatment agencies currently use a portion of their funding for children development screenings for AOD effects on children of their clients.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

4) **Our State uses a portion of its TANF allocations to fund programs for AOD-CWS clients.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

5) **Our state's CWS and AOD agencies and dependency courts have jointly sought funding for pilot projects to work more closely together.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

6) **Our state has identified the full range of potential funding from all sources that could support the changes needed to work more closely across CWS-AOD agencies.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

7) **Our state has identified whether federal waivers would be appropriate to fully utilize available funds for families in the CWS-AOD systems.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

9) **Our courts have sought additional funding to take dependency drug court programs to a county-wide scale of operations.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

IX. Working with Related Agencies

1) **Clinical services to address mental health and trauma issues are included in comprehensive assessments and case plans for all families.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

2) **Domestic violence advocacy and services are included in comprehensive assessment and case plans for all families in the CWS and AOD services systems.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

3) **Our state ensures that primary health care and dental care are available for families in the child welfare and AOD services systems.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

4) **Specialized health services for substance abusing parents regarding HIV/AIDS, Hepatitis C and other diseases frequently transmitted among intravenous drug users are accessible in our state.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

5) **Our state CWS staff know how to identify and link families with the support services that are frequently needed by CWS-AOD involved clients (e.g., transportation, child care, employment, and housing) and makes effective referrals to those agencies.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

6) **Our state routinely assesses for rates of referral and service completions for all clinical and supportive services needed by families and monitors barriers to access for these services.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

7) **Our state AOD staff/providers know how to identify and link CWS-involved families with the other services that are frequently needed services (e.g., transportation, child care, family violence services, and mental health services) and make referrals to those agencies.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

8) **Our state has AOD support/recovery groups that include a special focus on CWS and child safety issues.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

9) **Our state coordinates with law enforcement, AOD, and CWS to meet the needs of parents and their children affected by the criminal justice system (e.g., visitation for children with incarcerated parents, treatment while parents are incarcerated).**

Disagree Somewhat Agree Agree Not Sure/Don't Know

X. Working with the Community and Supporting Families

1) **Our state has developed strategies to recruit broad community participation in addressing the needs of AOD-CWS and dependency court involved families.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

2) **Our state includes community members in its planning and program development for substance abuse issues in child welfare and dependency court services.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

3) **In our state, prevention of child abuse/neglect and substance abuse operates at the community level as well as statewide.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

4) **Our state has developed a formal mechanism to solicit support and input from community members and consumers and this is widely used.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

5) **CWS and AOD staff members have access to up-to-date resource directories to locate family support centers and resources.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

6) **Community-wide accountability systems or "report cards" are used to monitor AOD and CWS issues with specific indicators for both systems.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

8) **Consumers, parents in recovery and program graduates have an active role in planning, developing, implementing and monitoring services for families with substance abuse problems in the child welfare system.**

Disagree Somewhat Agree Agree Not Sure/Don't Know

9) **Our state provides aftercare services to parents in the AOD & CWS systems that include the full array of family income support programs (EITC, Child Support, SCHIP, Food Stamps, Housing Subsidies, etc.).**

Disagree Somewhat Agree Agree Not Sure/Don't Know

Appendix VI

A Guide to Compliance with the Indian Child Welfare Act

A Guide to Compliance With the Indian Child Welfare Act

Following is a guide to Indian Child Welfare Act (ICWA) compliance. This information, including the flow chart on page 12, is from the National Indian Child Welfare Association's curriculum, "Cross Cultural Skills in Indian Child Welfare: Guide for the Non-Indian" (1987), with information derived from Oregon Children's Services Division's "A Guide and Checklist to ICWA Compliance," developed by Maria Tenorio, ICWA Specialist, Salem, Oregon, 1986.
State rules and regulations may vary from this guide; therefore, workers should make sure they know what their agency requires. Also, many States supply sample letters and/or checklists for compliance. Following this guide will ensure compliance with the Act, but not necessarily State rules.

WHEN THE ACT APPLIES

Tribal–State Agreements

The first precaution in applying ICWA is to make sure there is no tribal State agreement that has specific procedures to follow. Several tribes now have agreements with State agencies on child welfare matters.

Not Covered

Juvenile delinquency proceedings (violations of criminal law) are not covered with two exceptions:

- Juvenile delinquency proceedings where parental rights may be terminated; and
- Status offenses (juvenile delinquency proceedings which involve an offense that would not be a crime if committed by an adult, e.g., drinking, being a runaway, and being a truant)

Divorce proceedings when one parent is granted custody

Voluntary placement if the parent may regain custody "upon demand" (placement preferences still apply)

Covered

- Foster care placements
- Termination of parental rights
- Preadoptive placements

Adoptive placements (include conversion from foster care to adoptive placement)

- Both voluntary and involuntary placements if parents can't regain custody of child "upon demand"
- Divorce proceedings in which neither parent will get custody
- Juvenile delinquency proceedings where parental rights may be terminated
- Status offenses (juvenile delinquency proceedings which involve an offense that would not be a crime if committed by an adult, e.g., drinking, being a runaway, and being a truant)

Initial Determination

Oral Inquiry

At intake, and in every change or potential change in custody, the worker orally requests racial/ethnic data by reading aloud the racial/ethnic categories for the client's self-identification and asks: "Which of the following do you consider yourself a member: Asian, Black, Hispanic, Indian, White?"

If the family member responds that he or she is Indian or believes there is Indian ancestry, the worker fills out a family tree chart with the help of client family or other form provided by the agency.

Indian Tribe Verified

If the Indian tribal name and/or address is given, proceed to next section.

Indian Heritage Uncertain

If the parents are unavailable or unable to provide a reliable answer regarding the Indian heritage of their children—

- Make a thorough review of all documentation in the case record;
- Contact the previous caseworker, if any; and
- Make a close observation of the physical characteristics of the child, parents, siblings, and relatives.

Indian Tribe Unknown

If, in following the above steps, you have reason to believe the child is Indian, you will need to identify the Indian tribe by—

- Consulting with other relatives or extended family members; and
- Contacting, as appropriate, the suspected tribe, an Indian social services organization, or the Bureau of Indian Affairs.

Inquiry to Indian Tribe

- The worker checks with the child's tribe to determine whether the child is a member or is eligible for membership. If several tribes are suspected, the worker should send the inquiry letter to all of them.
- The worker can also telephone tribe(s), since this inquiry does not constitute the required official notice to a tribe. Any phone conversation should be documented in the case record with a letter to the effect, "As we discussed by phone today, you believe (stated)... etc."

Tribe Does Not Respond

If the tribe does not respond, call the tribal enrollment officer and follow up with a letter documenting the conversation.

Child Eligible for Membership

- If the tribe responds that the child is eligible for membership, request (or assist the family in filling out) application forms. Proceed to next section.
- If necessary, counsel parents hesitant to enroll a child by emphasizing the positive benefits of tribal membership.

Child Eligible for Membership

Once a tribe has determined that a child is not a member and not eligible for membership, the response must be documented in the case record, including date and source of documentation:

- Document all steps taken to determine the child's Indian or tribal ancestry; and
- File in the case record the tribe's written statement declaring the child ineligible for membership.

Incorporate in any court hearing the tribe's written statement declaring the child ineligible for membership.

Cultural Heritage Protection

For cases in which ICWA does not apply, but the child is biologically an Indian, and considered Indian by the Indian community, follow the Act in your case planning. Respect the child's right to participate in the culture of origin, particularly if such child is identifiably Indian by physical features and/or social relationships declaring the child to be Indian.

THE STATE MAY HAVE NO JURISDICTION

Exclusive Jurisdiction

Some tribes have exclusive jurisdiction over child welfare matters. If the child is a member of such a tribe, the child must be released to his or her parents unless this is an emergency (protective services) removal. You may wish to make a referral to the tribe's social services department to notify them of the family's difficulties.

Nationwide tribes with exclusive jurisdiction as of 1987 are Yakima, Spokane, Colville, and Muckleshoot (Washington); Omaha (Nebraska); Penobscot (Maine); Lac Courte Oreilles and Ho-Chunk Nation (formerly known as the Wisconsin Winnebago) (Wisconsin); Passamaquoddy (Maine); White Earth (Minnesota); and Warm Springs and Burns Paiute (Oregon).

Tribal Court Ward

A tribe has exclusive jurisdiction over tribal court wards, regardless of the child's residence or domicile.

If there is reason to believe that the child has resided or is domiciled on the reservation, phone the tribal court clerk to ask whether the child is a ward of the tribal court.

If yes, the child must be released to parents or custodians unless this is an emergency (protective services) removal. You may wish to make a referral to the tribe's social services department at the same time.

If not, be sure to document this fact in the case record.

NOTICE

Timelines

No requests for a court proceeding (with the exception of emergency removals) can be made until—

- At least 10 days after receipt of notice by parents or custodian, OR after 30 days if 20 days is requested by the parents or custodian to prepare for the proceeding; OR
- At least 10 days after receipt of notice by the tribe, OR after 30 days if the tribe requests an additional 20 days to prepare for the proceeding; OR
- No fewer than 15 days after receipt of notice by the BIA. (See below.)

Who Receives Notice

- Parents, always
- Custodian, if one is involved
- Tribe, always
- If child is affiliated with or eligible for membership in more than one tribe, all tribes should receive notice
- The BIA only if the identity/location of parents or custodians cannot be determined

Service of Notice

Notice should be served in person whenever possible; otherwise, notice should be served by registered mail, return receipt requested. File a copy of this notice with the court, along with any returned receipts or other proof of service.

Tribe Does Not Respond

Even if a tribe does not respond to an official notice sent, or if the tribe replies that it does not wish to intervene in the proceeding, continue to send the tribe notices of every proceeding. It is important to keep the tribe informed because the tribe can intervene at any point in the proceeding to assert its interest and the tribe has the right to notice of all hearings, motions, and other actions related to the case.

Translation of Notice

If there is reason to believe that the parent or Indian custodian will not understand the notice because of possible limited English proficiency, a copy of the notice shall be sent to the BIA Area Office nearest to the residence of that person. BIA staff should be requested to arrange to have the notice explained in the language that the person best understands. The BIA, by Federal regulation, is required to assist in identifying interpreters.

Transfer to Tribal Court

Section 191 L(b) of ICWA allows the parent or custodian or Indian tribe to transfer the proceeding to tribal court. The State court must transfer the proceeding unless the tribal court declines jurisdiction,

either parent objects to such transfer, or if the court determines that good cause exists to deny the transfer.

If the tribe requests orally, or in writing, a transfer of the proceeding to its tribal court—

- Inform the parents or custodians of their right to object to the transfer.

If any party believes that good cause exists not to transfer the proceeding:

- They should state in writing their reasons for such belief; and
- Their written statement must be distributed to all parties so that everybody has the opportunity to provide the court with their views.

Services To Prevent Out of Home Placement

Active efforts must be undertaken to provide remedial services subsequent to an investigation and before a decision is made to place the child out of the home. Proceed by—

- Contacting the tribal social services program for involvement at the earliest possible point; and
- Using other community services specifically designed for Indian families:
  - Extended family;
  - Urban Indian program, when appropriate; and
  - Individual Indian caregivers, such as medicine men.

Definition of Active Efforts

Active effort means not just an identification of the problems or solutions, but efforts showing an active attempt to assist in both arranging for the best-fitting services and helping families to engage in those services. *These can be demonstrated by—*

- Making an evaluation of the family's circumstances that takes into account the prevailing social and cultural conditions and the way of life of the child's tribe and/or Indian community.
- Intervening only when supported by relevant, prevailing Indian social and cultural standards regarding intervention in familial relationships by people who are not members of the family:
  - Develop a case plan with assistance of the parent/custodian that involves use of tribal Indian community resources;
  - Encourage maintenance of the child in his or her own family except where physical or emotional harm may result; and
  - Involve the child, if old enough, in the design and implementation of the case plan.
- Providing time and resources to prevent family breakup in at least equal measure to time and resources provided to other families.
- Assisting parents or custodian and child in maintaining an ongoing familial relationship.

Documentation

All remedial services offered to the family need to be recorded to demonstrate that, prior to petitioning for removal, active efforts were made to alleviate the need to remove the child. The case record cannot simply state that such efforts were unsuccessful, but efforts must *be shown* to be unsuccessful.

Before court proceedings to remove a child are initiated, case records should document that:

- Conduct or condition of the parent will result in serious physical or emotional harm to the child; and
- Efforts were made to counsel and change the parent's behavior, but did not work.

Documentation in the case record should relate indications of the likelihood of serious emotional or physical damage to particular conditions in the home, showing a causal relationship between the conditions and the serious damage that is likely to result to the child. (For example, it is not adequate to show that the parent abuses alcohol. It is necessary to show how, because of alcohol abuse, the parent may cause emotional or physical damage to the child.)

BURDEN OF PROOF

Through ICWA, Congress has declared that an Indian child may not be removed simply because there is someone else willing to raise the child who is likely to do a better job or that it would be "in the best interests of the child" for him or her to live with someone else. Nor can a placement or termination of parental rights be ordered simply based on a determination that the parents or custodians are "unfit parents." It must be shown that it is dangerous for the child to remain in his or her present conditions.

Foster Care Placement: Clear and Convincing Evidence

ICWA states that a court may not issue an order effecting a foster care placement of an Indian child in the absence of a determination, supported by clear and convincing evidence, including the testimony of one or more qualified expert witnesses, that the child's continued custody with the child's parents or Indian custodian is likely to result in serious emotional or physical damage to the child.

Termination of Parental Rights: Evidence Beyond a Reasonable Doubt

In order to ask the court to terminate parental rights, the agency as petitioner must show the court by evidence beyond a reasonable doubt, including the testimony of one or more qualified expert witnesses, that continued custody of the child by the parent or Indian custodian is likely to result in serious emotional or physical damage to the child.

Clear and Convincing

This is a high level of proof, though not as high as proof beyond a reasonable doubt. It means that in order to be successful, the side favoring foster placement must present evidence that is not just slightly more persuasive than the evidence against it, but clearly more persuasive.

Beyond a Reasonable Doubt

This means that the side favoring termination must not only put on a more convincing case than the opposition, but must be so convincing that it eliminates all reasonable doubts in the mind of the person deciding the case. If the court fails to do so, the court is obligated by the Act to deny termination.

Qualified Expert Witnesses

Persons with the following characteristics are considered most likely to qualify as experts:

- A member of the Indian child's tribe who is recognized by the tribal community as knowledgeable in tribal customs as they pertain to family organization and child rearing practices;
- A layperson having substantial education and experience in the area of his or her specialty along with substantial knowledge of prevailing social and cultural standards and child rearing practices within the Indian child's tribe; or
- A professional person having substantial education and experience in the area of his or her specialty along with substantial knowledge of prevailing social and cultural standards and child rearing practices within the Indian community.

This list is not meant to be exhaustive or limited in any manner. Enlist the assistance of the Indian child's tribe in locating persons qualified to serve as expert witnesses. The BIA is also required to provide this assistance.

PLACEMENT OF INDIAN CHILDREN

A diligent search to follow the Act's placement preferences shall include, at a minimum—

- Contact with the tribe's social services program;
- Search of State and county lists of Indian homes; and
- Contact with other tribes and Indian organizations with available placement resources.

Foster Care/Preadoptive

Contact the tribe to ask whether it has a different placement preference from the following:

1. Member of child's extended family;
2. Foster home licensed, approved, or specified by the Indian child's tribe;
3. Indian foster home licensed or approved by an authorized non Indian; or
4. Institution for children approved by an authorized non-Indian licensing authority.

Change of Placement: Notify Parents

If the child is to be moved from one placement to another, or if the foster family plans to move, the child's parents or custodians must be notified in writing. Follow placement preferences outlined above, unless the child is returned to parents or custodians.

Adoptive Placements

Contact the tribe to ask whether it has a different placement preference from the following:

1. Child's extended family;
2. Other members of the child's tribe; or
3. Other Indian families.

Disrupted Adoptive Placements

If an adoption is vacated or set aside, or adoptive parents voluntarily consent to termination of parental rights, the Indian parents or custodians must be notified:

- Notice of their right for a return of their child must include a statement that such petition will be granted unless the court rules it is not in the child's best interest.
- Where parental rights have been terminated, it is up to the agency to decide whether or not to notify parents or custodians of their right to petition for a return of their child.

Documentation

Written records are to be maintained on each child, separate from the court record, of all placements and efforts to comply with required placement records. This record shall contain the following:

- The petition or complaint;
- All substantive orders entered; and
- Complete record of placement determination.

Where required placement preferences have not been followed, efforts to find suitable placements within those priorities shall be documented in detail.

Voluntary Placements

Consent cannot be accepted unless—

- The child is older than 10 days old;
- The consent is in writing and recorded before a judge; and
- The consent is accompanied by the judge's certificate ensuring that terms and consequences of the consent were—
  - ✶ Fully explained in detail and fully understood by the Indian parents or custodians; and
  - ✶ Fully explained in English or interpreted into a language understood by the parents or custodians.

Consent signed by Indian parents or custodians should contain the following:

- Name and birth date of child;
- Name of child's tribe;
- Child's enrollment number or other indication of membership in the tribe;
- Name and address of consenting parents or custodians;
- Name and address of prospective parents, if known, for substitute care placements; and
- Name and address of person or agency through which placement is being arranged, if any, for adoptive placements.

EMERGENCY REMOVALS

Unless circumstances do not permit such inquiry, the racial/ethnic status of the child shall be immediately determined by asking:

Of which of the following do you consider yourself a member?

Asian Black Hispanic Indian White

Indian: Name of tribe and/or band:

Emergency protective custody of any Indian child can be taken only if—

- the child is not located on the reservations of tribes that have jurisdiction over child custody proceedings; and
- the child is in danger of imminent physical damage or harm.

Placement

If the child is believed to be Indian, efforts shall be made to place the child during emergency care in a setting that follows the placement priorities established by either the tribe or ICWA:

1. A member of the child's extended family;
2. A foster home licensed, approved, or specified by the Indian child's tribe;
3. An Indian foster home licensed or approved by an authorized non Indian licensing authority; or
4. An institution for children approved by an Indian tribe or operated by an Indian organization that has a program suitable to meet the child's needs.

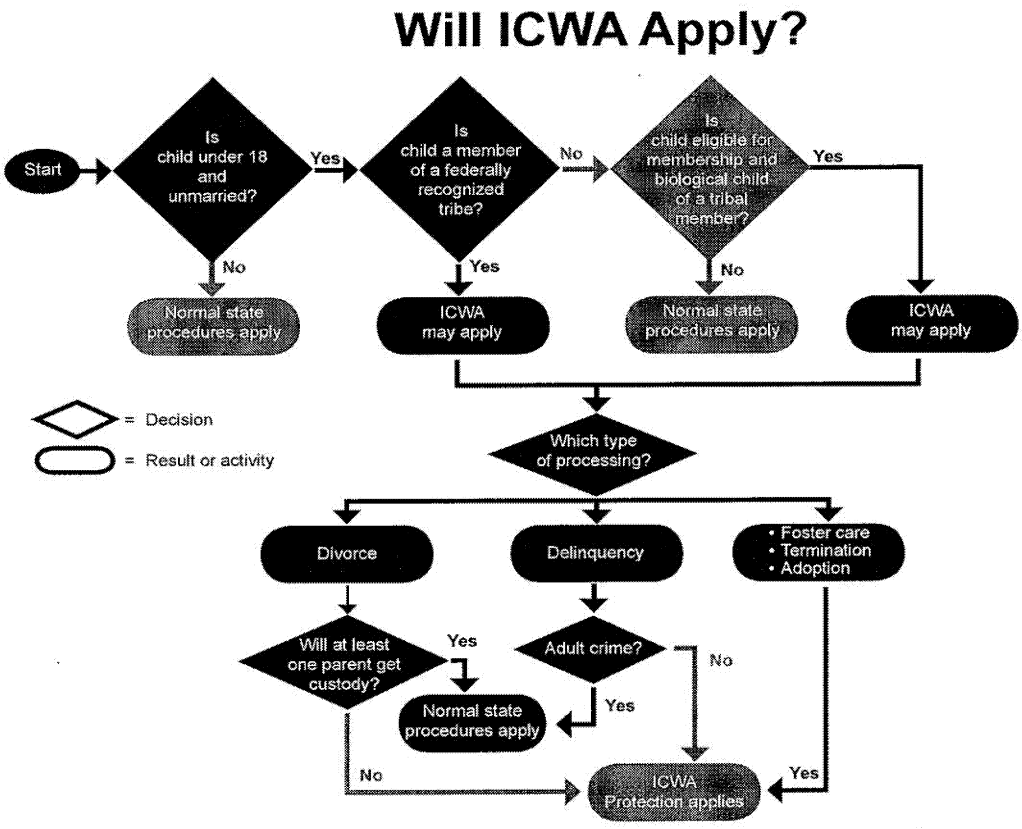
Termination of Placement

Emergency custody must be terminated when removal is no longer necessary to prevent imminent physical damage or harm to the child, or the appropriate tribe exercises jurisdiction over the case.

Continuation of Custody

If termination of an emergency removal is not possible, a court order should be obtained authorizing continued protective custody. The petition filed in such a proceeding should include the following in addition to that information required by State law:

- The name, age, tribal affiliation, and last known address of the Indian child;
- The name and address of the child's tribe and parents and/or Indian custodian, if any. If unknown, the agency shall provide a detailed description of efforts made to locate them;
- If known, whether the residence or domicile of the parent, Indian custodian, or child is on or near a reservation, and which reservation;
- A specific and detailed account of the circumstances that led to the conclusion that the child would suffer imminent physical damage or harm; and
- A specific plan of action to restore the child to his or her parents or Indian custodian, or to transfer the child to the jurisdiction of the appropriate Indian tribe.



Source: National Indian Child Welfare Association. (2002). *Online ICWA course*. Accessed September 18, 2006, at http://www.nicwa.org/services/icwa/index.asp

Appendix VII

Michigan Tribal Courts

Bay Mills Indian Community
12140 West Lakeshore Drive
Brimley, MI 49715
906-248-3241
Website: http://www.baymills.org/tribalcourt
Tribal Code: http://www.baymills.org/tribalcourt (click "Tribal Code")

Grand Traverse Band of Ottawa and Chippewa Indians
2605 N.W. Bayshore Drive
Suttons Bay, MI 49682
231-534-3538
Website: http://www.gtb.nsn.us/
Tribal Code: http://www.narf.org/nill/Codes/gtcode/index.htm

Hannahville Indian Community
N14911 Hannahville Road
Wilson, MI 49896
906-466-2932
Website: http://www.hannahville.net/index.html
Tribal Code

Keweenaw Bay Indian Community
107 Beartown Road
Baraga, MI 49908
906-353-6623
Website: http://www.kbic-nsn.gov
Tribal Code

Lac Vieux Desert Band of Chippewa Indians
P.O. Box 446
Choate Road
Watersmeet, MI 49969
906-358-4577
Website: http://www.lvdtribal.com
Tribal Code

Little River Band of Ottawa Indians
3031 Domres Road
Manistee, MI 49660
231-398-3406
Website: http://www.lrboi.com/council
Tribal Code: http://www.lrboi.com/council/ordinances.html

Little Traverse Bay Band of Odawa Indians
7500 Odawa Circle
Harbor Springs, MI 49740
231-242-1400
Website: http://www.ltbdodawa-nsn.gov
Tribal Code: http://www.ltbbodawa-nsn.gov/ltbb_V_2/TribalCode/Tribal%20Code.pdf

Match-E-Be-Nash-She-Wish Band of Potawatomi Indians (Gun Lake Tribe)
P.O. Box 218
1743 142nd Avenue
Dorr, MI 48323
Website: http://www.mbpi.org
No judicial department at this time.

Nottawaseppi Huron Band of Potawatomi Indians
Pine Creek Reservation
2221 1 1/2 Mile Road
Fulton, MI 49052
269-729-5151
Website: http://www.nhbpi.com
Tribal Code

Pokagon Band of Potawatomi Indians
P.O. Box 355
58620 Sink Road
Dowagiac, MI 49047
269-783-0505
Website: http://www.pokagon.com/tribalcourt.htm
Tribal Code: http://www.pokagon.com/codes/tribalcourtcode.pdf

Saginaw Chippewa Indian Tribe
Public Safety Building
6954 E. Broadway Road
Mt. Pleasant, MI 48858
989-775-4800
Website: http://www.sagchip.org
Tribal Code: http://www.sagchip.org/tribalcourt/code.htm

Sault Ste. Marie Tribe of Chippewa Indians
523 Ashmun Street
Sault Ste. Marie, MI 49783
906-635-6050
Website: http://www.saulttribe.com
Tribal Code: http:/www.narf.org/nill/Codes/saultcode/ssmcode86judg.htm

Endnotes:

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[4] "S.T. A.R. T.: Sobriety Treatment and Recovery Teams," Cuyahoga County Department of Children and Family Services, Cleveland, Oh., July 1998,

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[13] Ibid.

[14] Office for the Prevention of Domestic Violence (January, 1998). Child welfare system. From *Model Domestic Violence Policy for Counties.* State of New York. Retrieved October 10, 2004, from http://www.opdv.state.ny.us/coordination/model_policy/childwel.html.

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