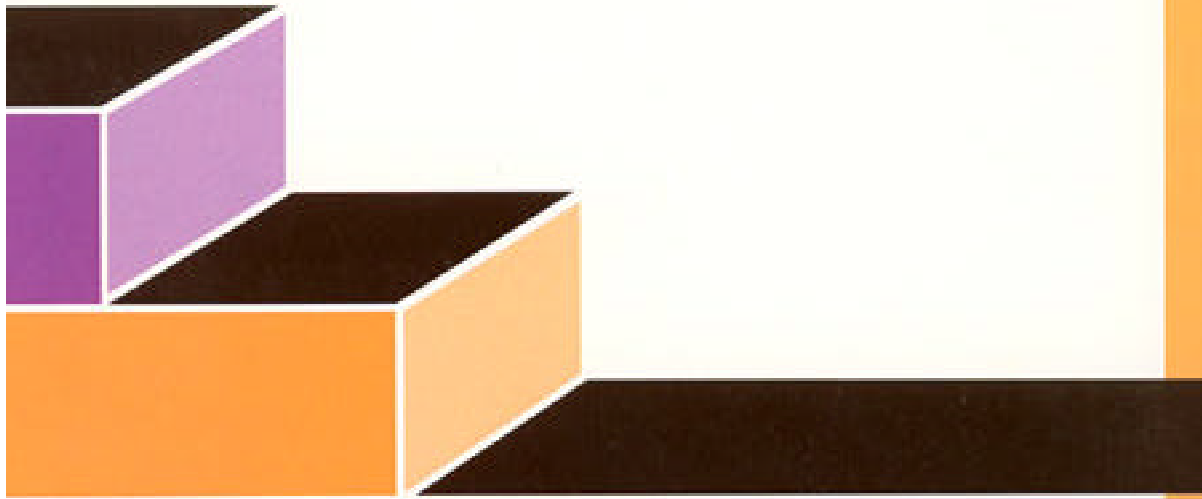

Connecting Child Protective Services and Substance Abuse Treatment in Communities

A Resource Guide

APHSA
American Public Human Services Association

Additional copies of this guide are available from APHSA, 810 First Street NE, Suite 500, Washington, D.C. 20002-4267; (202) 289-6555 (fax) or pubs@aphsa.org

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FOREWORD

Since its beginning in 1983, the National Association of Public Child Welfare Administrators (NAPCWA) has been concerned with child protective services (CPS). The children who come to our attention often reside in families where there are issues that lead to or exacerbate child maltreatment. We are also interested in how CPS impacts those issues, as well as how other social service systems might address them.

One area where there is much crossover and client sharing is the alcohol and other drug abuse treatment system. The children we protect often have parents who are addicted to alcohol or other substances. Because of the large number of clients that CPS and the substance abuse treatment agencies share, one of NAPCWA's pressing priorities is to assist child welfare agencies in learning more about the substance abuse treatment field and to work better with treatment providers to obtain better outcomes for children and families.

To better serve children and families, NAPCWA has undertaken an initiative, with support from the Edna McConnell Clark Foundation, to identify and promote community-based practices and programs where child welfare and substance abuse treatment agencies work collaboratively. NAPCWA supports community-based services because parents at risk of losing their children due to addiction who are served in or close to their communities have a much improved chance of recovering from their addiction, maintaining their children in the home, or reuniting with their children once they have addressed their addictions and created a safer and more stable environment. Child protection workers and substance abuse treatment providers who work together to enable the family to locate and use community resources best help the family to obtain natural and sustainable supports for recovery.

Although a partnership between child welfare and substance abuse providers sounds good, it has not always been easy for these two systems to work together. NAPCWA seeks to model the behavior it promotes by partnering with the National Association of State Alcohol and Drug Abuse Directors (NASADAD). Our two organizations have formed a work group to discuss and strategically plan how to address the needs of families in which parental substance abuse and child maltreatment are present.

This resource guide is a manifestation of the work the Edna McConnell Clark Foundation, NAPCWA, and NASADAD have been doing over the past year. With the help of Jill Kinney, executive director of Home Safe Inc., who is the consultant and principal author of this document, we

provide information on community-based collaborative efforts that will be useful to administrators, treatment providers, and community workers. It is our hope the enclosed materials will illustrate the need for community-based services and serve as a resource for promising practices that can be adapted to fit populations around the country.

NAPCWA would like to thank the Edna McConnell Clark Foundation, the National Association of State Alcohol and Drug Abuse Directors, the Project Advisory Committee, Jill Kinney, Nancy Young, the Legal Action Center, Rene Popovitz, the Clark Community Partnership for Protecting Children sites, and respondents to NAPCWA's Child Welfare/AOD survey for contributing to this document and to the ever-expanding body of knowledge on this subject. We are grateful for your input and expertise.

—Ramona Foley
NAPCWA President and Assistant Director
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PREFACE

The purpose of this guide is to inform administrators and staff of child welfare and substance abuse treatment agencies, community-based providers, and other interested parties of promising practices, principles for working collaboratively, examples of tools that have fostered collaborative working relationships, and possible resources for funds or technical assistance. We are not promoting one program or resource over another. Rather, we intend that this guide will serve as resource information for child welfare administrators, substance abuse treatment providers, and community members. It is our hope that you will find the enclosed information helpful and use it to guide practice.

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INTRODUCTION

The National Association of Public Child Welfare Administrators (NAPCWA) was established in 1983 as an affiliate of the American Public Welfare Association, now the American Public Human Services Association (APHSA), to provide a national forum to discuss and resolve child welfare issues. Almost since its inception, NAPCWA has been involved with child protective services (CPS) issues and resolutions to improve the lives of the children and families who come to the attention of the CPS system. As NAPCWA's involvement and knowledge of CPS issues have grown, it became necessary to look at the interaction and impact that CPS and other service providing systems and agencies have on each other. For example, many of the public agencies and services such as cash assistance, food stamps, domestic violence, child welfare, and substance abuse treatment serve the same children and families. Oftentimes these agencies and workers are not aware of the family's involvement with multiple agencies, which results in uncoordinated efforts or duplication of services.

In particular, CPS and alcohol and other drug abuse (AODA) treatment systems have had difficulty working together. Although it would simply be good practice for the child protection and AODA treatment systems to work together because they serve many of the same clients, it has also become necessary because of the timelines the Adoption and Safe Families Act of 1997 imposes on the child welfare system. These timelines call for child welfare agencies to ensure permanence for a child at a faster pace than before. These timelines are driving NAPCWA members to seek solutions and partnership with the AODA system seems to be a very viable solution. To help address this problem, APHSA and NAPCWA have taken steps to link administrators from both systems to facilitate dialogue and relationships that would result in collaborative actions and services.

In December 1990, APHSA adopted a resolution that articulated administrators' concerns regarding the co-occurrence of child maltreatment and parental substance abuse issues and provided principles for a public policy response. At that time, APHSA and NAPCWA leaders took the initiative and began devising a way to identify and address problems that had historically prevented CPS and AODA treatment systems from working together. In 1998, APHSA and NAPCWA approached the National Association of State Alcohol and Drug Abuse Directors (NASADAD) to form a work group to study the policy and practice implications of this problem in greater depth. The work group would contemplate practical issues and develop action items to facilitate a more amenable relationship between these two systems that have had major difficulties in working to-

gether. By partnering, NAPCWA and NASADAD are able to model the collaborative and reciprocal relationship they promote. This work group studies practice and public policy issues and provides advice and direction in both areas.

The primary public policy issue the NAPCWA/NASADAD work group has focused on is the Child Protection/Alcohol and Other Drug Abuse Partnership. The work group has also been gathering information on practices and programs that can provide examples of model programs that can benefit from the funding proposed in the legislation. The legislation, S. 484 in the Senate and H.R. 1909 in the House, as well as other policies such as those surrounding confidentiality all influence practice and the work public agencies do on behalf of the children and families they serve.

In addition to policy concerns, NAPCWA and NASADAD have partnered to identify barriers to collaborative work and possible solutions as well as the effect child maltreatment and substance abuse have on the community. To this end, several projects have been undertaken that would educate and inform public child welfare administrators and substance abuse treatment administrators. In October 2000 NAPCWA, with NASADAD as a cosponsor, convened a national forum, "Connecting Child Welfare and Substance Abuse Services," which brought administrators, providers, and community people together to share information and learn from one another. NAPCWA, again in association with NASADAD, also presented a grant proposal to the Edna McConnell Clark Foundation for a project that would further the work of the work group. APHSA and NAPCWA have a long-standing and productive relationship with the Clark Foundation that has lasted for more than 20 years. The projects the Clark Foundation supports with funds as well as technical support include services that protect children and ensure the health and well-being of families.

This year, Clark is funding four Community Partnerships for Protecting Children sites that provide child protective and other services directly to the communities where they are located. The sites are in Jacksonville, Florida; Louisville, Kentucky; Cedar Rapids, Iowa; and St. Louis, Missouri. Although the sites operate differently, they are all committed to the community and ensuring the health and well-being of children and their families. These sites are also providing varying degrees of substance abuse treatment at the neighborhood level. In addition to the four Community Partnership sites, the Clark Foundation funded this project, allowing NAPCWA to address CPS and AODA treatment collaboration in several ways. Through the use of a survey, NAPCWA has compiled information that has provided a wide range of examples of how CPS, substance abuse treatment, and other public systems are collaboratively serving families in the communities in which they live.

CONNECTING CHILD PROTECTIVE SERVICES AND SUBSTANCE ABUSE TREATMENT IN COMMUNITIES: A RESOURCE GUIDE

The U.S. Department of Health and Human Services reported that in 1998 state and local child protective service agencies received an estimated 2.8 million reports of abuse and neglect because family members, professionals, or other citizens were concerned about the safety and well-being of children. An estimated 903,000 of these reports were substantiated. That is, after follow-up and investigation, officials found reason to believe that abuse and neglect had occurred or that the children continued to be at risk of further harm. Although no exact number is available, it is estimated that in 40 percent to 80 percent of abuse or neglect cases, parental substance use or abuse was a contributing factor (Young and Gardner, 1998).

Children whose parents are dealing with alcohol and other drug abuse (AODA) issues are almost three times more likely to be abused and more than four times likely to be neglected than children of parents who are not substance abusers. In addition to the abuse and neglect these children face, they may also deal with mental health problems and addictions later in life.

Substance abuse can put a caregiver in a violent or unsafe environment, so that the children are more at risk. It can result in the caregiver leaving the family to get treatment. It can impact the child's safety because of being in a neighborhood where violence and drug dealing are present. It can lead to children using substances. It can cause families to be evicted and go to shelters or even be homeless. All these effects, and others, make family strengthening very difficult.

In 1997, the Child Welfare League of America (CWLA) conducted a national survey of its state public child welfare agencies on AODA issues. Results from this survey show the enormous impact of AODA issues on the child welfare system and indicate how the system is responding. Parental chemical dependency was a contributing factor in the out-of-home placement of at least 53 percent of the 482,000 children and youth in the custody of the child welfare system. Approximately 67 percent of parents with children in the child welfare system required substance abuse treatment services, but child welfare agencies were able to provide treatment for only 31 percent of them. On average, 51 percent of child welfare workers receive training on recognizing and dealing with substance abuse issues during their first year of service. And while research indicates few

positive long-term outcomes are achieved unless a client is in treatment for at least three months, 11 percent of the child welfare and AODA experts surveyed believe children and parents with AODA problems can be treated in less than one month (Child Welfare League of America, 1997).

Substance abuse is often referred to as a family disease; everyone in the family is impacted by the abuse. Children of some substance abusing caregivers are at times left alone and unsupervised. Due to the nature of addiction, for some people the substance is more important than anything, including their children. Many who are high or intoxicated cannot make appropriate choices or provide immediate care and nurturing for their children. They may, however, be able to arrange for the care of their children when they are incapacitated from drugs or alcohol—an action that could serve as a launching point for developing a future safety plan for the children.

Not uncommonly, money used to purchase alcohol or drugs may negatively impact the family's ability to pay bills, buy sufficient food and clothing, and pay the rent. Children may be left unattended and without food, causing risk of harm. Non-using family members must deal with the addict's unpredictable moods and behavior, never really knowing what to expect or when to trust what is being said. Children often take on roles for which caregivers normally are responsible, not allowing them the normal developmental process of growing up.

Children of parents with drinking problems are at significant risk for a range of problems with their emotions, conduct, education and learning, and friendship adjustment. They are also more likely to experience disharmony in the family, often involving domestic violence. A small minority of these children abuse alcohol or other drugs as young adults. Stressful events and circumstances in the home include parental drunkenness, moodiness, unreliability and embarrassing behavior; reduced family social life, joint family activities, open family discussions; child awareness of parental arguments, violence, and pressure to take sides; a poor relationship with the using parent; being required to adopt a care-taking or coping role (Velleman and Oxford, 1999).

The child welfare system is charged with ensuring the safety of the child and must often work with the harmful effects to the children from caregiver AODA. These safety issues begin with some children prior to birth, and may last with some children in alternative care until they reach adulthood. Substance abuse is one of the three top reasons for out-of-home placements—the other two being child abuse or neglect and economic stress (Azzi-Lessing and Olsen, 1996). A very high proportion of children placed in out-of-home care (79 percent in one study) experienced caregiver substance abuse (Besinger, Garland, Litrownik, and Landsverk, 1999). These children tend to be younger, African American, from single-parent families, and neglected rather than abused.

Although parental substance abuse contributes to a large number of substantiated child abuse and neglect cases and the number of children in out-of-home care, the child welfare and AODA treatment systems generally have uneven working relationships that affect communication and cooperation. Barriers identified by both systems that prevent collaborative working relationships include conflicts in values and philosophies regarding whether the parent or child is the primary client; confidentiality issues regarding disclosure and redisclosure of information; competition of

other resources on the treatment system; inability of treatment providers to predict relapse of a client; and lack of assessment tools that can identify when to incorporate services from the other system.

Who Is the Client?

Whenever collaboration is mentioned, discussion of the issues that stand in the way of collaboration is unavoidable. One of the main issues is determining who is the client. The primary concern of the CPS system is to determine if a child or children are safe from physical and emotional harm. This can mean

- Charges of maltreatment cannot be substantiated and the child is not removed from the home; nothing further is done.

- A risk or proof of harm has been identified but not to the extent that removal is necessary and services are provided in the home to minimize any harm that has been done and to ensure that no further harm comes to the child.

- The child is removed from the home for his or her own protection.

Although workers have the option of keeping the family intact and providing services, the safety and permanence of the child is paramount. On the other hand, the primary focus of the substance abuse treatment system is to help the client get and remain sober. Substance abuse treatment is ongoing and acknowledges that relapse, sometimes more than once, is a part of recovery.

Due to these different areas of focus, there often are disparities in how the child welfare and substance abuse treatment fields deal with mutual clients. Child welfare professionals may not understand the rehabilitation process and thus do not set realistic goals for recovery and permanence with addicted parents. Likewise, the addictions treatment process does not necessarily consider permanency planning timeframes and the need for parent-child contact to support children's attachment needs (Blunt, 1999).

Confidentiality

Inextricably linked to identifying the client are the issues of confidentiality and information sharing. When families are involved with both the CPS and AODA systems, each system requires information from the other in order to give an accurate account of progress. Sharing information has presented one of the biggest obstacles to collaborative working relationships. Because of the nature of the CPS system, it is necessary to report to the court and make safety and permanency plans for a child at various times during an abuse or neglect case. These tasks can prove to be difficult if the

information on parental substance abuse treatment progress is not readily available. Although other systems may find these safeguards inconvenient and a barrier to collaborative partnerships, federal legislation established them to protect those recovering from an addiction. On the other hand, the substance abuse treatment provider may also need information to determine the proper type of treatment or placement that would best suit the client. Currently certain consent forms and service agreements enable information sharing; however, sometimes those documents are outdated or do not cover all the information a treatment provider requires or needs to supply to the child welfare agency.

Funding

In addition to philosophical and confidentiality issues impacting collaborations between the child welfare and substance abuse systems, funding and resource constraints also pose significant barriers. Lack of funding and restrictive funding streams contribute to the difficulty CPS and AODA treatment providers experience when attempting to work together. Funding for services, much like the services themselves, has been provided through categorical programs. Both the CPS and substance abuse systems have their own funding streams. Because of the rigidity of these separate pots of money, it is often difficult to get funds to jointly serve children and families who are receiving services from both systems. Funding constraints also affect agencies' abilities to provide training across different public service delivery systems as well as the amount of technical assistance that can be purchased.

The barriers the CPS and AODA treatment systems face are real. They hamper both systems and can put the clients whom each system is trying to help at greater risk of harm. There are, however, some places where collaboration is working. There are programs where children are being kept safe; children are thriving; and the parents are sober, getting and keeping jobs, and returning to the community better prepared to deal with circumstances and crises that may have contributed to their involvement with the public systems.

PROMISING PRACTICE

In recognition of the tension between the Adoption and Safe Families Act (ASFA) of 1997 and substance abuse recovery timelines, it has become necessary for child welfare agencies to work more efficiently and effectively to comply with the federal legislation. ASFA seeks to prevent children from languishing in foster care and move them to safe and permanent homes. The intent of ASFA is not to take children away from their birth parents but to ensure that children have a safe and permanent home in which to grow and thrive. The child welfare system, because of high caseloads, high worker turnover, limited services, and other reasons, has had to look to alternative methods of treatment that could achieve the safety and permanency goals within the timeframes ASFA has established. One of these alternatives involves turning to community agencies and community resources for help in serving families at different stages of their recovery and with an array of services addressing their treatment and recovery support needs.

The substance abuse treatment field is accustomed to working in the community and using natural helpers to support people in overcoming their addictions. Many of the programs that help people get and remain sober use people who have overcome an addiction of their own. The child welfare field does not typically use the community in quite the same way, but there are many ways the community can assist the child welfare agency in helping a family to heal.

APHSA's Survey on Community-Based Programs

In January 2001, NAPCWA, in association with NASADAD, conducted a survey of all 50 states and the District of Columbia to identify community-based programs where child welfare and AODA providers were working collaboratively to serve children and families with substance abuse problems. In response, NAPCWA received 35 completed surveys. The types of programs varied widely from long-term residential treatment where women bring their families, to housing programs that help parents find and maintain housing during outpatient treatment, to juvenile dependency drug court, to agencies that provide intensive in-home family preservation services, to group and individual counseling. The size and scope of these programs varied as well; some were very small programs that served 10 to 20 families a year, others served hundreds of families and children. Some programs were rural while others provided services in large metropolitan areas. Funding sources, service delivery methods, successes, and challenges all varied. There were several characteristics, however, that were evident in the programs respondents identified.

Characteristics of Community-Based Programs

Emphasis on the client in the context of the family. Many of the programs provided as examples of promising practices identified their clients as the parent with the child or children in the home. Providing services for the mother as well as the child tends to result in success for the mother because she is learning how to relate to her children in addition to achieving sobriety. The support that is provided also alleviates much of the stresses of parenting that may have led to the substance abuse as well as the abuse or neglect of the child. The children also receive day care and education through these programs. It is in many of these programs that the safe and sober environment facilitates the healing of the parent as well as provides for the safety of the children.

Moms and Babies Therapeutic Program

The Moms and Babies Therapeutic Program in Honolulu, Hawaii, allows the mother to bring her child into treatment with her when it is appropriate. The mother and child are provided with a safe, sober, and homelike environment. The mother is given parenting, vocational, and life skills training in order to model a productive and healthy lifestyle for her child. She is provided with support that helps her to maintain custody of her child while gaining sobriety and to better equip her to return to the community and function without drugs.

Gender- and culturally specific treatment. Although there are many fathers who are substance abusing parents, it is often the mother, as the custodial parent, who comes to the attention of the child welfare system. For this reason, many of the programs that were highlighted by the states provide gender-specific treatment and support services to women and their children. In addition to gender issues, culture also plays a role in how women and children respond to different types of treatment. A family's religious or spiritual beliefs, ancestry, and societal norms make up a person's culture. When this is ignored and the same type of treatment is given to all of the clients who walk in the door, a large part of the person is ignored. It is by taking into account the person as a whole that providers are able to identify the proper mode of treatment that helps a parent stay sober and achieve the proper permanency goals for the child or children.

Maternal Child Health Program/Parental Substance Abuse Project

The Maternal Child Health Program/Parental Substance Abuse Project in St. Paul, Minnesota, has positive working relationships with private agencies with strong connections to the African-American and local faith communities. The program provides early intervention and therapeutic care and family preservation services to improve the health and functioning of women and children affected by chemical dependency. By incorporating the African-American and faith communities, the agency helps foster relationships with others like the client who have some of the same experiences or who identify with some of the same beliefs. Incorporating these aspects may allow mothers to maintain the new sober lifestyle the women have achieved in treatment.

Holistic approach to the client. Practices and programs that best support child welfare clients who abuse substances help the clients achieve a variety of goals, not just custody of children or sobriety. Included in the holistic approach are gender- and culturally specific practices and treatments. This approach ensures mothers and their children have a safe place to live, have vocational training or employment as part of their treatment, are able to meet mental health treatment needs, feel connected physically as well as spiritually to the community, meet their educational or learning needs, and know how to respond to future crises.

In keeping with the holistic approach to serving substance abusing child welfare clients is the notion that services geared to the needs of the client-as-a-whole help prevent chronic relapse. Indeed, a person who has the social and resiliency skills required to build a sobriety-based lifestyle is more resistant to relapse than one who does not have these skills. Frequently child welfare clients have needs that, left unaddressed, may lead to relapse. Even positive life events—including reuniting with one's child—carry stress that can contribute to relapse. As a result, some child welfare agencies have incorporated "continuing care" supports into parenting and reunification services. For instance, support services provided after a child returns home might include respite, mentors, and homemakers; these services may be developed and implemented using the Promoting Safe and Stable Families Program. In addition to focusing on the client, research indicates that child-focused services such as child development programs, child care, and health care that are provided to children of drug abusers promote improved treatment outcomes for parents, including longer treatment stays, reduced frequency of relapse, and improved family functioning (Kumpfer, 1998; U.S. Department of Health and Human Services, 1999).

Meta House Inc.

Meta House Inc., in Milwaukee, Wisconsin, provides a comprehensive array of services to mothers who may lose custody of their children due to substance abuse. The program includes residential services, an intensive day program, and transitional and permanent housing. Children can join the mother at the treatment phase. Meta House partners with schools, neighborhood organizations, faith communities, shelters, and employment agencies to ensure the mothers and children are safe, sober, and have the support they need. Meta House also works closely with the child welfare system and integrates the child welfare and work force plans directly into the treatment plan.

Services provided in the communities where clients live. Many of the programs that were reported as promising provide services in the neighborhoods where clients live or frequent. Community-based practice means many things to different people. There are child welfare or other agencies that are in neighborhoods or communities and are therefore easily accessible to clients. These agencies can be run by professionals or paraprofessionals employed by the state or locality, or be a private not-for-profit agency, or be a group of concerned citizens who just want to help.

Community does not only mean geographic location, communities can be defined as people who share the same faith or religion, are of the same ethnicity, have similar backgrounds, or believe the same basic principals. Community-based programs can draw upon the resources and people who are already leaders in their particular community or can help develop people to be leaders.

Another practice that can identify a program as community-based is that the people who are being served often help in identifying the needs of a particular population and may have input into the design of the mode of service delivery.

Perhaps more important, what identifies a program as community based is that there is buy-in from those who are being served. Providing services in the community is the emphasis of the four Clark Community Partnership sites. These sites have experienced success in gaining community buy-in, linking clients with community services rather than the public system, and hearing from the community members what the needs of the community are so that the proper services can be identified and provided.

Community Partnership for Protecting Children Sites

The Edna McConnell Clark Community Partnership for Protecting Children sites are serving families where they live. The partnership sites in Louisville, Kentucky, Jacksonville, Florida, St. Louis, Missouri, and Cedar Rapids, Iowa, serve residents in particular catchment areas and provide a variety of services to families where they live. Each site has taken a different approach to providing substance abuse treatment to parents whose children have been removed or are in danger of being removed due to parental substance abuse. Regardless of how the treatment is dispensed, the overarching similarity the sites share is that they are connected to the community and use the community to assist in the client's recovery.

Flexible funding or multiple funding sources. Funding—or more specifically, the lack of funding—was identified as an issue for many collaborative programs. Many programs experience a tension between their desire to serve parents and families and the budgetary constraints that are placed on them. There is a need for more funds to be put into community-based work as well as develop new and different funding streams to support the work that is being done. Nonetheless, practices and programs combining child welfare and substance abuse treatment obtain financial support from several sources, including Medicaid, individual insurance, government general funds, and grants.

In addition to funding, other resources may be equally as valuable when it comes to serving children and families. For example, communities need assessment tools that can help identify parents and children who are experiencing crisis or distress, especially in relation to substance abuse. Cross-disciplinary training serves not only as a "myth buster" regarding each system and its client services, but also promotes collaborative relationships, trust, and more comprehensive client services. Protocols for sharing confidential information and joint screening and assessment tools allow communities to address existing barriers to collaboration between child welfare and substance abuse services. Finally, technical assistance available from agencies that have pilot programs and special grantees can pave the way for communities intent on creating cross-disciplinary partnerships.

RESOURCES

Neighborhood-based substance abuse and child welfare approaches often do not fit established funding streams. There are three main possibilities for finding funding when the initial response you receive is, "That's not possible." Make creative use of existing federal and state funding, research and access foundations and private grants, and use personal connections.

Federal Funding

There are several federal funding streams that can support cross-disciplinary program development between public child welfare and substance abuse agencies (U.S. Department of Health and Human Services, 1999; American Public Human Services Association, 1999). These funding streams are listed by their administering agency.

- **The Centers for Medicare & Medicaid Services**

  Medicaid: Medicaid is authorized under Title XIX of the Social Security Act. It is an open-ended entitlement program providing medical services to eligible low-income children, families, pregnant women, and disabled persons. Many child welfare clients are eligible for Medicaid and, at the discretion of the individual state, Medicaid can pay for most substance abuse treatment services for adults—with the exception of services provided in large residential facilities. Inpatient hospital services, including services for the mentally ill and those with substance abuse problems, must be offered to the categorically needy population in any state program. The Child Welfare League of America (1997) reports that almost two-thirds of all states rely on Medicaid funding to support alcohol and drug prevention and treatment services. States define the details of what is provided under both the mandatory and optional services of Medicaid, and therefore may offer substance abuse treatment in a variety of forms.

  Two "optional services" that some states offer are targeted case management and rehabilitation services. Targeted case management allows the state to provide case management to "targeted" groups such as child welfare clients or individuals with substance abuse needs.

Rehabilitation services include "any medical or remedial service recommended by a physician or other licensed practitioner of the healing arts…for maximum reduction for physical or mental disability or restoration of a recipient to his best possible functional level." This broad definition allows substance abuse treatment services.

In addition, a majority of states use managed care programs for their Medicaid populations to finance and deliver both physical and behavioral health care services. Twenty-five states covered substance abuse services under Section 1115 or Section 1915(b) Medicaid managed care waivers in 1997. In addition, nine states specifically listed children eligible for adoption assistance or foster care maintenance payments as a target population for Medicaid managed behavioral health care (U.S. Department of Health and Human Services, 1999). States also may amend their Medicaid State Plan to provide optional coverage for youth up to age 21 who were in foster care at age 18.

■ U.S. Department of Labor

Welfare-to-Work Programs: Like the Temporary Assistance to Needy Families program, the federal portion of Welfare-to-Work program funds pay for nonmedical aspects of substance abuse treatment. In fact, Welfare-to-Work specifically targets individuals with significant barriers to employment, including substance abuse, and allows nonmedical substance abuse treatment to be included as a "job retention and support service" if such services are not otherwise available. States may use the matching fund portion of their MOE requirement for both medical and nonmedical services, at the state's discretion (U.S. Department of Health and Human Services, 1999). The Welfare-to-Work program is administered by the U.S. Department of Labor and implemented through local private industry councils and state and local workforce investment boards (U.S. Department of Health and Human Services, 1999).

■ Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services

Substance Abuse and Performance Partnership Block Grant (formerly Block Grants for Prevention and Treatment of Substance Abuse): This block grant provides state agencies with funds for substance abuse prevention, addiction treatment, and rehabilitation services. This block grant paid for 31 percent of national expenditures on AODA treatment in 1996. The block grant accounts for approximately 40 percent of public funds expended for treatment and prevention. It is formula-driven and includes several mandatory distributions and set-asides for allocations made to states. Of particular relevance for services to child welfare clients with substance abuse problems, the block grant requires states to spend from their allocation an amount "equal to fiscal year 1994 spending levels" on programs for preg-

nant women and women with dependent children. SAMHSA's Center for Substance Abuse Treatment (CSAT) administers the grant.

Knowledge Development and Application Program: This grant program, also managed by CSAT, provides support to states and other treatment entities to improve service quality, implement best practice, and expand service capacity. Current programs related to child welfare and substance abuse include:

- Targeted Capacity Expansion grants, which focus on providing a clinically appropriate range of services to enhance treatment capacity for populations for which local treatment capacity is insufficient. The grants are available to cities and counties.

- Long-term residential substance abuse treatment programs that enable women to bring their infants and children into treatment with them.

- The Family Drug Court Program pilots, which evaluate the use of family drug courts as a strategy for reducing the cost and trauma resulting from foster care.

■ Children's Bureau, Administration on Children and Families, U.S. Department of Health and Human Services (HHS)

Temporary Assistance for Needy Families (TANF): This capped state entitlement block grant provides assistance to needy families with children. It was authorized under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, replacing the Aid to Families with Dependent Children program. Many child welfare clients with substance abuse problems also receive welfare benefits. If substance abuse interferes with a parent's ability to care for children, it is likely that it also compromises the parent's employment. States and counties therefore may write substance abuse treatment services into employment plans for clients fitting these circumstances. TANF can pay for nonmedical aspects of substance abuse treatment, such as services provided by nonmedical personnel and outside of a hospital or clinic, if such treatment is not otherwise available to the participant (U.S. Department of Health and Human Services, 1999). The state maintenance-of-effort share of the TANF program funding—in which states are required to maintain a certain level of spending of state funds on public assistance—may be used for a variety of social service programs meeting the goals of welfare reform, including substance abuse treatment (American Public Human Services Association, 1999).

Title IV-B of the Social Security Act, Subpart 1—Child Welfare Services Program: This program assists state public child welfare agencies to improve their child welfare services in order to keep families together. Services include child maltreatment prevention and early intervention to prevent removal, services to facilitate placements if the child must be removed, and reunification services. States can use some funds from this program to support substance abuse counseling for child welfare clients (American Public Human Services Association, 1999). States must address how they will implement the child welfare services program in a five-year Child Welfare Services Plan that is jointly developed with the federal government. States also must provide a 25 percent match to the federal funds.

Title IV-B of the Social Security Act, Subpart 2—Child Welfare Formula Grants: These federal formula grants allow states to establish, extend, and strengthen child welfare services. Subpart 2 adds the Safe and Stable Families Program, formerly called the Family Preservation and Support Services Program, as a capped entitlement program. It encourages and enables "each state to develop and establish, or expand, and to operate a program of family preservation services and community-based family support services." It also allows time-limited reunification services which may include substance abuse treatment and support for family members, as long as the services support one of the following goals:

- protecting and promoting the welfare of all children; or
- preventing, remedying, or assisting in the solution of problems which may result in neglect.

Subpart 2 specifically allows for in-patient residential or outpatient treatment of substance abuse, provided either service is necessary to preserve the family (American Public Human Services Association, 1999). Treatment services funded by these grants are often provided at the local level by community-based organizations. In 1999, eight states used funding under this program to pay for substance abuse assessment and treatment services for clients. States must address how they will implement the Safe and Stable Families Program in their five-year Child Welfare Services Plan. States also must provide a 25 percent match.

Title IV-B Post-Adoptive Services: These funds, also authorized under Title IV-B, Subpart 2 of the Social Security Act, may be used to help adoptive families whose substance abuse treatment needs threaten to disrupt placement of their adoptive children.

Title IV-E Foster Care and Adoption Assistance Program: Title IV-E Foster Care, authorized under the Social Security Act, is a federal program administered by state and local pub-

lic child welfare agencies for eligible indigent children. It is an open-ended entitlement program, combining federal, state, and local matching funds. While the purpose of this program is to help states provide proper care for children who need placement outside their homes, it also assists with training for staff, foster parents, and private agency staff providing services to the eligible child population. Training may be cross-disciplinary and address substance abuse and child welfare as long as the curriculum relates these issues to the needs of the eligible foster care population.

Title IV-E Waiver Demonstration Programs: Also under Title IV-E, HHS allows states to apply for waivers to pilot programs that would reduce the demand for foster care. These programs must be cost-neutral, i.e., they do not cost any more to serve the target population than the projected regular Title IV-E expenditures for the period in which the Title IV-E waiver is operational. Under an approved Title IV-E waiver, a state can implement substance abuse treatment services to reduce the demand for foster care. As noted below, four states have already initiated Title IV-E waiver programs addressing substance abuse among the child welfare client population.

Title XX Social Services Block Grant (SSBG): This formula grant program is not an entitlement and is appropriated annually. One of the five goals of the SSBG is to prevent neglect, abuse, or exploitation of children and adults. States can use the federal grant funds to provide medical care only for initial detoxification of an alcoholic or drug-dependent individual. In addition, these federal grant funds are available to support social services provided in and by employees of any hospital, skilled nursing facility, intermediate-care facility, or prison only if the individual is alcoholic or drug-dependent and lives in such an institution. Other services may be provided only if they are an integral but subordinate part of a social service allowed under the grant. A state may transfer up to 10 percent of its allotment for any fiscal year to the certain services, including those addressing alcohol and drug abuse. SSBG funds are administered by the state human services agency.

CAPTA Community-Based Family Resource and Support (CBFRS) Program: Title II of the Child Abuse Prevention and Treatment Act (CAPTA) authorizes this program, which currently provides funds to every state for services to prevent child abuse and neglect and coordinates a statewide network of community-based family resource services. Training programs funded under CBFRS may help parents deal with stresses associated with becoming sober and caring for children; teach basic child development and parenting skills; and provide other supports for at-risk families.

CAPTA Basic State Grants: The Child Abuse Prevention and Treatment Act authorizes these grants, which provide assistance to states to develop, strengthen, and implement child abuse and neglect prevention and treatment programs. States might use funds from this program to support substance abuse programs serving child welfare clients.

- **Ryan White Comprehensive AIDS Resources Emergency (CARE), Health Research and Services Administration (HRSA)**

These funds support state and local programs that provide a network of health care and support services for persons living with HIV infection and AIDS (American Public Human Services Association, 1999). Funds are intended especially for services to uninsured persons who would otherwise be without care. Specific grants available for substance abuse and other treatment include:

HIV Emergency Relief Formula Grants: These grants target those metropolitan areas hit hardest by the HIV epidemic and fund programs that provide a continuum of health care and support services for individuals and families with HIV, including substance abuse treatment, case management, mental health treatment, and comprehensive treatment services.

HIV Care Formula Grants: These grants enable states to provide health care and support services for individuals and families with HIV. Funds may be used for substance abuse treatment, case management, mental health treatment, and comprehensive treatment services.

Access to Care and Research for Children, Adolescents, Women, and Families: This program supports the comprehensive care service system for children, youth, women, and families who are infected with or affected by HIV and AIDS.

Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease: This program supports the provision of comprehensive primary care, treatment, and early intervention services for persons with HIV.

Foundations and Private Grants

Foundation funding provides more flexibility than government funds and it is generally geared toward piloting new ideas and innovations. Some foundations have a larger scope and fund initiatives or programs at the national level. There are, however, foundations that look for smaller progressive initiatives to fund. Community-based programs should look to these local foundations first. Some foundations that focus on child welfare and substance abuse issues are described below. In addition, Appendix 1 describes tips for locating foundations to support cross-disciplinary programs addressing child welfare and substance abuse. Appendix 2 identifies other Internet resources

for grant seekers. Appendix 3 identifies listserves that focus on funding notices and information.

■ The Robert Wood Johnson Foundation

Contact:	Robert Wood Johnson Foundation
P. O. Box 2316
College Road East and Route 1
Princeton, NJ 08543-2316
Telephone: 1-888-631-9989
Web Site: www.rwjf.org

The Robert Wood Johnson Foundation (RWJF) is the largest U.S. foundation devoted to improving the health and health care of all people in the United States. RWJF concentrates funding in three areas: to assure that all people in the United States have access to basic health care at reasonable cost; to improve care and support for people with chronic health conditions; and to promote health and prevent disease by reducing the harm caused by substance abuse — tobacco, alcohol, and illegal drugs.

RWJF has a history of funding research initiatives and community substance abuse programs that try to reduce the harm caused by tobacco, alcohol, and illegal drugs to one's health and to address the social consequences of alcohol and illegal drug abuse. RWJF is committed to understanding how these issues contribute to social isolation and poor health and has invested significant funding to strengthen these communities.

Grant Process: The majority of RWJF grants are issued through a call for proposals. However, they do consider new and unknown projects—good ideas that come from the field. Grants for these projects are reviewed throughout the year and there is no specific application or deadline. For more information, visit the RWJF web site and select "Applying for a Grant."

Web Site: RWJF's web site has much current information on substance abuse. From the RWJF home page, click on "Publications & Links" and "Resource Centers" to download publications; read newsletters, data, news, and information on RWJF programs; and to find other resources related to the abuse of alcohol, illegal drugs, and tobacco.

■ W. K. Kellogg Foundation

Contact: W. K. Kellogg Foundation
One Michigan Avenue East
Battle Creek, MI 49017-4058
Telephone: (616) 968-1611
Web Site: www.wkkf.org

The W. K. Kellogg Foundation (WKKF) is a nonprofit organization committed to helping people help themselves through the practical application of knowledge and resources to improve their quality of life and that of future generations.

Since its beginning, the foundation has focused on building the capacity of individuals, communities, and institutions to solve their own problems. One of WKKF's program goals is to improve the health of people in communities by increasing access to integrated, comprehensive health care systems that are organized around public health, prevention, and primary health care, and which are guided, managed, and staffed by a broad range of appropriately prepared personnel. WKKF has funded many programs to strengthen families and neighborhoods, and has invested funds to develop grassroots leaders.

Grant Process: WKKF accepts unsolicited grant proposals year-round and encourages applicants to submit their preproposal request electronically using the foundation's online application. If you are unable to submit the application online, WKKF accepts preproposals in the mail. For more information, go to the WKKF web site and select "Grants" to learn about the funding request process.

Web Site: This web site is still under development, but offers access to many of its publications. From the WKKF home page, select "Knowledgebase" to see these publications and to get final reports from WKKF grantees. Also useful to the novice grant researcher is the link, "Other Grantseeking Resources," that can be accessed from the "Grants" link on the WKKF home page.

■ The Lindesmith Center

Contact: The Lindesmith Center
925 9th Ave
New York, NY 10019
Telephone; (212) 548-0695
Fax: (212) 548-4677
Web Site: www.lindesmith.org

The Lindesmith Center (TLC), created in 1994, is the leading independent drug policy institute in the United States. The Drug Policy Foundation (DPF), founded in 1987, represents more than 25,000 supporters who favor alternatives to the current war on drugs and is the principal membership-based organization advocating drug policy reform. The two organizations merged July 1, 2000, to build a national drug policy reform movement.

The guiding principle of the center is harm reduction, an alternative approach to drug policy and treatment that focuses on minimizing the adverse effects of both drug use and drug prohibition. TLC-DPF and its affiliated organizations are deeply involved in educating Americans and others about alternatives to current drug policies. It covers issues ranging from marijuana and adolescent drug use to illicit drug addiction, the spread of infectious diseases, policing drug markets, and alternatives to incarceration. It promotes drug policies based on common sense, science, public health, and human rights. Particular attention is paid to analyzing the experiences of foreign countries in reducing drug-related harms.

It believes there are steps that can and should be taken soon to reduce the harms associated with both drug use and our failed policies. These include:

- Redirecting most government drug control resources from criminal justice and interdiction to public health and education;

- Supporting public health measures, notably syringe exchange and other harm reduction programs, to reduce HIV/AIDS, hepatitis, and other infectious diseases;

- Supporting effective, science-based drug education and ending support for ineffective programs; and

- Ending racially discriminatory drug policies and enforcement measures.

Grant Process: The Lindesmith Center funds a variety of programs. The grant processes differ according to the specific grant. Visit its web site for up-to-date information.

Web-Site: www.Lindesmith.org The website is user friendly and has up-to-date information on current funding opportunities, programs, and legislation.

■ The Edna McConnell Clark Foundation

Contact: The Edna McConnell Clark Foundation
250 Park Avenue, Suite 900
New York, NY 10177
Telephone: (212) 551-9100
Fax: (212) 986-4558
Web Site: info@emcf.org

For the past 30 years, the foundation has been committed to improving the lives of people from low-income communities. It is known to have a down-to-earth approach to philanthropy. It funds programs in four areas: the poor, children, the elderly, and the developing world. Its focus is on:

- Keeping children safe and strengthening families;

- Enhancing the ability of communities to protect children from abuse and neglect by engaging a broad range of stakeholders;

- Helping young people from low-income families make a successful transition to independent adulthood;

- Supporting urban school districts in their efforts to improve learning opportunities for students in grades six through eight; and

- Supporting long-term, sustainable efforts to improve the living conditions in Central Harlem and South Bronx neighborhoods.

Grant Process: The Edna McConnell Clark Foundation is in the midst of a significant change in both its grant-making focus and its approach to grant-making. Visit its web site for up-to-date information and opportunities.

Web Site: www.emcf.org The web site is easy to navigate and has a wealth of up-to-date information.

■ Annie E. Casey Foundation

Contact: Annie E. Casey Foundation
701 St. Paul Street
Baltimore, MD 21202
Telephone: (410) 547-6600
Fax: (410) 547-6624
Web site: www.aecf.org

The Annie E. Casey Foundation (AECF) is a leader in the child welfare field committed to developing innovative strategies to overcome dysfunctional service systems that hurt families, rather than help families. In the next decade, AECF will focus its efforts on rebuilding the most vulnerable communities by providing significant grants and other forms of assistance to a limited number of sites in a long-term effort to strengthen the support services, social networks, physical infrastructure, employment, self-determination, and economic vitality of distressed communities.

The foundation's work is divided into three areas: improving major systems serving disadvantaged children and families; transforming neighborhoods; and promoting accountability and innovation by promoting findings, ideas, and strategies that help others create and sustain family-supporting communities.

Grant Process: Mainly funds programs by invitation, however, it does consider unsolicited proposals. Organizations wishing to make proposals to the foundation should submit a proposal outlining the goals of the project, the population served, the amount of funds requested, and a brief history of the organization.

Web Site: AECF offers extensive publications that can be downloaded or ordered free of charge from its web site. Check out the Family-to-Family series and other publications on neighborhood transformation, family development, and rebuilding communities. Sign-up for

Casey Connects, a newsletter that reports on current activities of the Casey Foundation and its grantees, and join the AECF listserv to receive announcements of new additions to their web site.

Personal Connections

Talk to everyone you know. Contact the United Way. Tell them what you want to do and why. Ask them if they know anyone who might know someone who might support your program. Talk to your local, state, and federal politicians. If they are not available, talk to their staff members. You are looking for someone to share the spark you feel about the potential for your work. Do not believe people who tell you it is impossible. All you need is one powerful champion, and you may have to talk to 100 people before you find him or her.

TOOLS

When agencies begin working together to deliver services to substance abusing families, systemic changes must take place that will equip workers with the knowledge they need to identify child maltreatment as well as AODA in homes. To make this possible, agencies have to cross-train staff and provide information and tools necessary to do a job thoroughly.

Cross-Disciplinary Training

When either a child protection worker or a substance abuse treatment provider is working with a client, it is sometimes difficult to know when to bring in the other agency. A key factor in assuring that both substance abuse and child protection issues are addressed is making sure that workers (from both agencies) are trained to look for and identify both problems in families served (U.S. Department of Health and Human Services, 1999). Successful cross-disciplinary training efforts include involving professionals from all involved disciplines early in the process; implementing needs assessments to assure curricula address the needs of the target populations; employing intensive outreach and recruitment of potential trainees; and involving both management and line staff. With the passage of ASFA, cross-disciplinary training curriculum must include information about ASFA timelines, how decision-making timeframes have changed, and the implications for practice and treatment. It also might include effective parenting and family interventions, engagement and retention of clients in treatment, relapse management, and post-treatment support. Some sources of cross-disciplinary training curricula include:

- **Multidisciplinary training curricula from Children's Bureau grantees:** In 1997, the Children's Bureau of the U.S. Department of Health and Human Services issued 10 three-year grants to universities affiliated with public child welfare agencies to develop and implement interdisciplinary training curricula. The curricula were designed to enhance the capacity of public child welfare workers and their supervisors to respond effectively to child abuse and neglect, with particular emphasis on families experiencing problems related to substance abuse, mental illness, and domestic violence. The grantees are listed in Appendix 4 and provide their curricula as a tool to other states or localities interested in implementing cross-systems training.

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

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

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

Contact: Nancy Roncancio
AODA Coordinator
Illinois Department of Children and Family Services
Telephone: (271) 524-3207

Screening and Assessment

Through the APHSA survey, child welfare agency respondents repeatedly requested examples of assessment tools to help identify parental substance abuse and to highlight when it is advantageous to use a drug and alcohol specialist to address those issues. Currently, most states and localities that are pursuing child welfare and substance abuse collaborations are using a joint model for screening and assessment whereby they consolidate assessment strategies and data from both systems. In addition and in support of this joint screening and assessment model, some agencies out-station or deploy staff from a local substance abuse service agency to a child welfare office to obtain timely and accurate substance abuse assessments. State and federal substance abuse treatment funds support such activities. In addition, child welfare agencies can contract with local substance abuse service providers to set aside several assessment appointments per week that are designated specifically for parents whose children have been placed in foster care or on whom child abuse or neglect complaints have been substantiated. Some resources that employ mutual assessment models include:

- Connecticut uses an assessment model that combines child welfare and substance abuse-specific information. Under Connecticut's Project SAFE—a collaboration between the state's Department of Children and Families and the Department of Mental Health and Addiction Services—all contracted substance abuse treatment providers implement a standardized "Bio-Psycho-Social/Substance Abuse Evaluation" tool which scores clients according to the Addiction Severity Index, assesses their mental health needs, identifies earlier traumas and their implications for parenting, and identifies parental strengths and needs.

- Some states and localities are experimenting with co-location of staff. As an integral part of their Title IV-E waiver demonstration programs, for instance, both Delaware and New Hampshire co-locate substance abuse specialists with their CPS workers to provide thorough assessments to families whose initial screening indicates substance abuse; immediate consultation on high-risk cases; and liaison work with community substance abuse treatment providers.

Content of Shared Information

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

Confidentiality

Agencies are searching for ways to overcome the issue of confidentiality so they can share relevant client information on a consistent basis. For instance, substance abuse and child welfare agencies may establish Memoranda of Understanding (MOUs) to facilitate information sharing. Likewise, service providers may establish Qualified Service Organization Agreements (QSOAs) to assure that either agency can share information on behalf of their mutual clients—sometimes even without the consent of individual clients—pursuant to federal drug treatment confidentiality guidelines.

As an example, the University of North Carolina at Chapel Hill developed a compact disc and online training on the Federal Confidentiality Regulations Dealing with Substance Abuse Patient Records (42CFR, Part 2). This electronic course offers interactive video, audio, text and testing technologies. It can be accessed at http://unc.blueshoe.com/course.asp.

Joint Formal Policies, Procedures, and Protocols

The child welfare agency and substance abuse service providers can establish policies, procedures, and protocols to improve working relationships. For instance, one critical protocol to support a child welfare/substance abuse collaborative would address the ongoing exchange of information—especially confidential information—about mutual clients, such as by establishing QSOAs. Confidentiality policies might establish the process to obtain consent from the client at the time of referral to share treatment information between the agencies. They also might address the circumstances under which the substance abuse treatment agency will notify the child welfare caseworker of a relapse. Another key protocol might provide guidance about when to return children to their families when substance abuse is involved. For instance, since early recovery is often a risky time for reunification, a protocol might establish which supports might be employed to address those risks. Other policies and procedures might state that each system will receive a complete record of the family's history and current situation before making any permanent decisions; how each system will be involved in parent/child visitation; and who has responsibility for providing post-treatment supports for families and children at the community level (Blunt, 1999).

- The Illinois Department of Children and Family Services (DCFS) and the Office of Alcoholism and Substance Abuse (OASA) of the Illinois Department of Human Services have an interagency agreement that establishes how each agency will work with the other pertaining to child welfare clients with substance abuse issues. Through its Title IV-E waiver demonstration program, DCFS provides funds to OASA to pay community substance abuse treatment providers for services to DCFS clients. The interagency agreement establishes that DCFS clients receive priority admission and enhanced services in these community treatment agencies. In addition, the interagency agreement allows DCFS and OASA to use a jointly devel-

oped, standard release of information for sharing information on mutual clients throughout the life of a case. The interagency agreement also outlines the monthly reporting format for substance abuse treatment providers to submit information on mutual clients. A major future interagency effort in Illinois includes the creation of a joint database between DCFS and OASA to share histories on mutual clients.

Safety Planning

With the parents, the child welfare and substance abuse agencies create a safety plan (potentially at a family conference or other early-in-the-case meeting involving all stakeholders) which addresses what steps the parent(s) will undertake to care for the children in the event of a relapse. Since relapse is probable—especially if a client never has attempted to become clean and sober before—child welfare and substance abuse agencies might create a relapse assessment tool to be incorporated into a safety assessment and plan (Blunt, 1999). In addition, since the period immediately following treatment is associated with increased risks to children returning home, professionals from both systems should focus on safety planning during this period.

Concurrent planning may not explicitly mandate that addicted parents obtain treatment as a condition of reunification. Nonetheless, it requires that parents receive up-front, clear disclosure regarding the consequences of their lack of participation or progress in resolving the issues that led to the initial maltreatment.

Child Welfare Services and Adult Addiction Services

In Montgomery County, Maryland, the state Child Welfare Services and Adult Addiction Services developed a blended intervention model to address the requirements of the Adoption and Safe Families Act of 1997 while also meeting the needs of substance-affected families. The intervention model combined levels of service intensity with graduated sanctions for noncompliance. The program succeeded in engaging client participation and motivating clients to complete their treatment programs.

Mandating Treatment

To address the tension between ASFA's goal of speeding permanency planning for children and the nature of the addicted to initially resist engagement and treatment, many communities are leveraging child protective services involvement to require treatment participation. Some of these treatment "incentives" occur through state adaptations of criminal drug court models to the family court, where the court links treatment mandates with intensive follow-up procedures and strict sanctions for noncompliance.

TECHNICAL ASSISTANCE PROVIDERS

Technical assistance is a useful tool to those who are looking for a new way to do their current job, enhance their current program, or to teach workers and community members a new way of working together that is mutually beneficial. Technical assistance resources are grouped below according to the type of organization or agency they are.

Federal Agencies
While some of the federal agencies listed below provide small grants, they also offer other services to support or inform cross-disciplinary work between public child welfare and substance abuse agencies. These federal agencies can be located on the Internet through www.samhsa.gov. Specific agencies and their main areas of focus are described below. States and localities interested in enhancing their resource options might first consider which innovations in child welfare and substance abuse programming, tools, technical assistance, or research their clients require. These jurisdictions then might research the Internet to determine if these agencies have issued any requests for proposals for programs fitting their parameters. Tips for searching the Internet are included in Appendix 7.

- **Center for Substance Abuse Prevention (CSAP)**

  5600 Fishers Lane
  Rockwall II
  Rockville, MD 20857
  Telephone: (301) 443-0365
  Web Site: www.samhsa.gov/csap

  The Center for Substance Abuse Prevention (CSAP) provides national leadership in the development of policies, programs, and services to prevent the onset of illegal drug use, to prevent underage alcohol and tobacco use, and to reduce the negative consequences of using substances. CSAP promotes programs that reach all audiences—researchers, prevention professionals, employees and employers, concerned community members and parents, people who are starting to experiment with drugs, and those who are most at risk for developing

substance abuse problems. CSAP has the following areas of focus:

- Develop knowledge centers and dissemination strategies to increase awareness and education within the child welfare system regarding prevention information and methods;

- Provide technical assistance to, and create linkages among, the various CSAP-sponsored community coalitions;

- Build bridges between the child welfare and CSAP stakeholders to increase evidence-based service design and delivery;

- Develop a community-driven research agenda; and

- Develop cross-system training and an interdisciplinary orientation to increase direct staff knowledge base and attitudes regarding other system requirements, skills, methods, and limitations.

■ **The Center for Substance Abuse Treatment (CSAT)**

5600 Fishers Lane
Rockville, MD 20857
Web Site: www.samhsa.gov/csat

The Center for Substance Abuse Treatment, also known as CSAT, is part of the of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. It was created in October 1992 with a congressional mandate to expand the availability of effective treatment and recovery services for alcohol and drug problems.

CSAT's mission is to improve the lives of individuals and families affected by alcohol and drug abuse by ensuring access to clinically sound, cost-effective addiction treatment that reduces the health and social costs to our communities and the nation. CSAT's areas of focus include:

- Developing knowledge centers and dissemination strategies to increase awareness and education within the child welfare system regarding alcohol and other drug treatment modalities and matching with client characteristics;

- Presenting at alcohol and other drug and child welfare conferences on current linkages, program innovations, and system reform efforts;

- Providing technical assistance to community groups regarding working with child welfare system stakeholders and developing linkages among and between them;

- Developing in-home, family-based treatment modalities for women and children known to the child welfare system using wraparound, family support, and natural helper approaches; and

- Reducing gaps between the systems through leadership, advocacy, and policy development.

■ Center for Mental Health Services (CMHS)

5600 Fishers Lane
Room 17-99
Rockville, MD 20857

The Center for Mental Health Services, known as CMHS, focuses on mental health issues, but those issues often overlap with child welfare and substance abuse issues. The center's focus includes:

- Developing knowledge centers and dissemination strategies to increase awareness and education within the child welfare system regarding mental health services, opportunities, and barriers;

- Providing technical assistance to System of Care Grantees regarding linkages, collaborations, and models to improve outcomes for children and families known to the child welfare system;

- Developing family-driven integrated models for families known concurrently to both systems; and

- Developing opportunities to improve leadership, direct practice, and advocate for more effective, evidence-based service design and delivery.

■ National Institute for Drug Abuse (NIDA)

National Institutes of Health
6001 Executive Boulevard, Room 5213
Bethesda, MD 20892
Telephone: (301) 443-1124
Web Site: www.nida.nih.gov

The National Institute for Drug Abuse, or NIDA, is primarily a research organization. NIDA's mission is to lead the nation in bringing the power of science to bear on drug abuse and addiction. Its goals are to:

- Develop knowledge centers and dissemination strategies to increase awareness and education within the child welfare system regarding AODA research findings and opportunities;
- Create a Return On Investment Services research agenda that identifies criteria, protocols, and sites for the next generation of research issues regarding intersection of alcohol and other drugs, child welfare, and community-based services; and
- Develop clinical trials nodes for child welfare/alcohol and other drug populations.

■ Office of National Drug Control Policy (ONDCP)

Drug Policy Information Clearinghouse
P.O. Box 6000
Rockville, MD 20849–6000
Telephone: (800) 666-3332
Fax: (30) 519-5212
Web Site: www.whitehousedrugpolicy.gov

The Office of National Drug Control Policy is also known as ONDCP. This office is part of the Executive Branch (i.e., its staff reports to the president) arm of drug control policy. The principal purpose of ONDCP is to establish policies, priorities, and objectives for the nation's drug control program, the goals of which are to reduce illicit drug use, manufacturing, and trafficking; drug-related crime and violence; and drug-related health consequences. Its areas of focus include:

- Developing a child welfare work group to increase education and involvement of child welfare stakeholders regarding public awareness campaign; and

- Developing a targeted initiative for children of substance abusers and children of alcoholics to improve life chances for such children and families known to the child welfare system.

Title IV-E Waiver Demonstration Program States

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

Delaware: One of the first child welfare agencies to receive a Title IV-E demonstration waiver, Delaware uses a multidisciplinary team model to address parental substance abuse as it relates to cases where children are placed in foster care or are likely to enter foster care. Specifically, contracted substance abuse counselors work with child protective services workers in each of the state's three county child welfare offices. Substance abuse counselors accompany child protective workers on initial visits, and together they assess the substance abuse problem and its effect on parenting. The counselor may conduct a substance abuse evaluation or arrange for one, and the counselor stays connected with the family throughout treatment. The substance abuse counselors participate in the Division of Family Services' (DFS) two-month new worker training, and then receives follow-up training throughout their tenure. In addition, child welfare caseworkers receive a three-day overview on the impact of alcohol and other drugs on individuals, as well as the indicators that a person may be abusing substances. Savings in foster care caseloads, pursuant to the waiver demonstration, pay for the counselors. In addition, DFS and the Division of Substance Abuse and Mental Health implemented a joint Memorandum of Agreement (MOA) which requires substance abuse treatment providers who serve DFS clients to honor confidentiality issues; share information within the parameters of those rules; and follow a standard format for the content and submission of progress reports to both state agencies. The MOA also explicates that a provider must see a referral within 72 hours and provide written reports within two weeks. Finally, the MOA states that neither state agency can close a case without first meeting on the issues and clients' progress. Delaware's "one judge, one child" model also ensures judicial oversight and support of parents' treatment and progress in addressing the issues that brought them to the attention of the child welfare agency.

Contact: Joanne Bruch
Delaware Division of Family Services
Telephone: (302) 633-2690

Illinois: The Illinois Department of Children and Family Services (DCFS) contracts with a local treatment provider for addictions specialists called recovery coaches to assist families early in their treatment process, and to continue to provide support to families during and after treatment to prevent relapse and facilitate reunification. The process to link recovery coaches with child welfare clients begins long before a formal relationship develops. During the period when a DCFS caseworker first contacts a family, the DCFS workers implement a substance abuse screening of their clients; both DCFS and the Illinois Office of Alcoholism and Substance Abuse jointly developed this screen and trained caseworkers on its use to ensure it captures substance abuse issues pertaining to child welfare clients. If a screen indicates a parent has a problem with substance abuse, the caseworker documents this fact and refers the parent to treatment. In addition to treatment, at the 90-day judicial hearing the court and the DCFS caseworker strongly encourage parents to obtain a more complete assessment of substance abuse issues; assessment providers are located in the same building as the Family Court to facilitate the transition from court to services. A recovery coach—certified by the Illinois Alcohol and Other Drug Addiction Professional Counselors' Association—is present at the assessment site and makes initial contact with the parents there. The recovery coach offers support services in addition to traditional child welfare and substance abuse treatment services. If the family accepts, then the recovery coach follows up in cooperation with the DCFS caseworkers and the family's treatment provider, with specific staffings among these stakeholders at every critical case juncture, e.g., six-month administrative case review or the period immediately before children are returned home. Once the children are returned home, the court may require that recovery coaches continue services to address associated stresses and the potential for relapse. To ensure that the recovery coaches and DCFS workers understand the services each provides, recovery coaches receive the same risk assessment training as DCFS caseworkers, and caseworkers receive AODA training.

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

Contact: Rosie Gianforte
Coordinator, Title IV-E Waiver AODA Project
Division of Health Policy
Illinois Department of Children and Family Services
Telephone: (312) 814-2440

Maryland: The state is providing services to substance-abusing caretakers to prevent unnecessary out-of-home placement and expedite family reunification. Family support services teams, comprised of addictions specialists, local Department of Human Resources staff, treatment providers, parent aides, and mentors provide comprehensive, coordinated services to families of children at risk of foster care placement or who already are in foster care due to parental substance abuse. Upon referral and if the parents exhibit an interest in obtaining help with their substance abuse, an addictions specialist implements a modified Cage Questionnaire assessment tool to assess the level of parental substance abuse and its impact on child welfare. Parents with substance abuse and child welfare concerns are then assigned to one of three community-provided treatment options: inpatient treatment for parents and their children; intermediate 28-day residential care; or intensive outpatient treatment. Treatment providers additionally provide wraparound services including case management; individual, group, and family therapy; obstetrical or gynecological care and family planning clinics; HIV education and testing; relationship groups; parenting skills training; domestic violence and sexual assault survivor groups; housing; employment; child care; and transportation.

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New Hampshire: The Title IV-E demonstration project in New Hampshire involves contracting with a licensed alcohol and drug abuse (A&D) specialist who also is certified in family therapy. The A&D specialists are stationed in each DHS field office and work with the child protection service workers on a consultant basis, providing training, information, and recommendations regarding treatment. Once a CPS worker identifies potential substance abuse issues in a family referred for abuse or neglect during the initial risk and safety assessment, she or he refers the family to an A&D specialist. The A&D specialist approaches the family, obtains their approval to proceed—along with the appropriate releases of information—and implements a modified version of the Substance Abuse Self-Evaluation Inventory (SASEI) to

caretakers to determine the extent to which substance abuse impacts parental capacity to provide adequate care and supervision of the children. Furthermore, this assessment informs the Department of Children, Youth, and Families (DCYF) of the A&D specialist's recommendations regarding safety and case plans and current or future treatment needs once the court substantiates a case for abuse or neglect. Since so many cases in New Hampshire are unsubstantiated, the A&D specialists also may provide up to 60 days of intensive substance abuse services for child abuse or neglect cases that are referred but not substantiated to mitigate the potential for future risk. If a case is substantiated, the SASEI is part of the case record and thus the court also may use it to tie a client's substance abuse needs to treatment plans. In addition and implemented prior to the Title IV-E demonstration project, New Hampshire's court system and DYCF jointly created a protocol in which the court specifically states to the client the consequences of not meeting the terms of the case plan, including accessing substance abuse treatment.

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

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

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

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

Contact: Sandra Durham, Director
Joan Martin, Administrative Assistant
Jacksonville "0809" Community Partnership for the Protection of Children
Telephone: (904) 924-1680

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

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

The substance abuse case manager at UJIMA participates in outreach undertakings and events within the community such as health fairs and other type of forums. Staff are also available to consult with faith-based or other social service entities to include substance abuse related curriculum in their endeavors to reach others affected by substance abuse. Staff also collaborate with other CPPC components such as a domestic violence prevention and community resources team to help in their efforts.

The case manager attends regular Neighborhood Place UJIMA, CPPC, and other related meetings and is cochair of the family focus work groups. The manager also takes part in all forums and services sanctioned by the CPPC. The case manager provides education and consultation in the areas of substance abuse treatment and recovery to all UJIMA staff and community members who desire it.

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

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Neighborhood Place UJIMA
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Keith Vandeveer, CADC
CPPC at Neighborhood Place UJIMA
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Cedar Rapids, Iowa: In response to the prevalence of prenatal exposure to illegal substances, staff at area hospitals, the Iowa Department of Human Services (DHS), and community agencies created the independent Children at Risk Task Force. The task force is funded by the Partnership for Safe Families, Iowa's self-titled program funded by the Clark Foundation's Community Partnership for the Protection of Children grant. The task force consists of administrators from the Iowa Department of Human Services and two hospitals, and local treatment providers, including the Heart of Iowa, a residential treatment program for mothers at risk of losing their children due to substance abuse. The task force meets monthly to coordinate

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

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St. Louis, Missouri: The primary goal of this community partnership program is to provide CPS workers with the tools they need to recognize and help their clients address alcohol and drug abuse issues. The site employs a high-level CPS worker who also is an A&D specialist. This specialized staff person is housed in the hotline to provide front-end technical assistance workers who suspect that a referred client has substance abuse issues who present risks to his or her children. Ongoing workers also may access the services of the A&D specialist. In addition, the A&D specialist attends all 72-hour family team meetings where caretaker substance abuse is suspected. There, the specialist is a resource to the family, referring them to treatment or counseling as their case plan allows. The A&D specialist also provides training for child welfare staff and community partners on addressing substance abuse with child welfare clients. In addition to co-locating the cross-trained A&D specialist in the child welfare agency, Missouri's departments of Mental Health and Social Services bring together their staff working with clients with substance abuse, child welfare concerns, developmental dis-

abilities, and mental illness for a one-day interdisciplinary training. This training focuses on sharing information on each division's role and responsibilities in serving mutual clients, and offers job-shadowing opportunities so that peers can directly experience another's job. To provide immediate information to child welfare workers on community-based substance abuse treatment services, St. Louis' Neighborhood Network is creating an Internet-accessible database of available treatment slots for child welfare clients. Finally, in November 2001, St. Louis implemented its first Family Drug Court to leverage compliance with treatment and to provide intensive supervision and incentives for continued progress.

Contact: Francis Johnson
Supervisor, Child Welfare Hotline
Missouri Department of Social Services
Telephone: (314) 301-7822

■ National Child Welfare Resource Centers

The Administration for Children and Families of the U.S. Department of Health and Human Services funds several national resource centers on child welfare issues. The national resource centers provide information, technical assistance, and support to public child welfare agencies. A selection of those with information most relevant to serving child welfare clients with substance abuse is listed below. (A complete list can be found on the National Clearinghouse on Child Abuse and Neglect Information web site, www.calib.com/nccanch.)

National Child Welfare Resource Center for Family-Centered Practice: The National Child Welfare Resource Center for Family-Centered Practice builds the capacity and resources of state and tribal child welfare agencies to provide family-centered, culturally competent, and coordinated child welfare services that will achieve the outcomes of safety, permanence, and well-being for families who enter the child welfare system. The resource center provides technical assistance and consultation to identify policy, practice, and program changes necessary to improve front-line practice and improve child and family outcomes. It also offers training for child welfare professionals on the principles, methods, and strategies of family-centered practice. Finally, it distributes information on innovative family-centered practices around the country, including family-oriented substance abuse services.

Contact: Learning Systems Group
Telephone: (800) 628-8442
E-mail: info@cwresource.org
Web Site: www.cwresource.org

National Child Welfare Resource Center on Legal and Judicial Issues: The National Child Welfare Resource Center on Legal and Judicial Issues offers assistance to improve the quality of legal representation to child welfare agencies, juvenile court rules and procedures, relationships between the courts and child welfare agencies, reasonable efforts determinations, skills of social workers in dealing with the legal system, risk management by child welfare agencies, and state child welfare laws. The resource center provides materials on confidentiality related to substance abuse and child welfare, safety and permanency planning, and the court improvement projects, including family drug courts.

Contact: Center on Children and the Law
American Bar Association Young Lawyers Division
Telephone: (202) 662-1746
Web Site: www.abanet.org/child/rclji/home.html

National Resource Center on Child Maltreatment: This national resource center supports human services agencies through three divisions: practice development, organizational development, and community information services. It provides training, technical assistance, consultation, and information in response to needs related to the prevention, identification, intervention, and treatment of child abuse and neglect.

Contact: Child Welfare Institute
Telephone: (404) 876-1934
Web Site: www.gocwi.org/nrccm

National Resource Center for Community-Based Family Resource and Support Program (FRIENDS): Specifically dedicated to serving lead agencies implementing the Community-Based Family Resource and Support grant program, FRIENDS offers a range of technical assistance on topics, including evaluation and peer review, parent involvement, development of state networks (including substance abuse and child welfare), family support principles, collaboration, and respite care.

Contact: Chapel-Hill Training Outreach Project
Telephone: (800) 888-7970
E-mail: jldenniston@intrex.net
Web Site: www.friendsnrc.org/friends.htm

National Resource Center for Foster Care and Permanency Planning: This resource center seeks to improve the capacity of child welfare agencies to provide children with safe, permanent families in supportive communities. Services focus on implementing federal legislation; working with vulnerable families affected by substance abuse and other social concerns; and providing tools for permanence such as concurrent planning, family group conferencing, mediation, and kinship options.

Contact: Hunter College School of Social Work
Telephone: (212) 452-7053
E-mail: nrcfcpp@shiva.hunter.cuny.edu
Web Site: guthrie.hunter.cuny.edu/socwork/nrcfcpp

National Child Welfare Resource Center for Organizational Improvement: This national resource center helps child welfare agencies improve management and operations, bolsters organizational capacity, and promotes service integration, such as between child welfare and substance abuse agencies.

Contact: Edmund S. Muskie School of Public Service
University of Southern Maine
Telephone: (800) HELP KID
E-mail: patn@usm.maine.edu
Web Site: www.muskie.usm.maine.edu/research/natlchildwel

■ Family Drug Courts

The U.S Department of Justice funds a Family Drug Court Curriculum Development Project. The National Drug Court Institute and the National Council of Juvenile and Family Court Judges are working together to develop a family drug court curriculum and to conduct trainings for court staff from around the country who are interested in developing a family drug court.

In addition, many of the state Court Improvement Programs are developing family drug court programs. These programs and other jurisdictions that are implementing family drug courts can provide crucial technical assistance information on starting a family drug court. These jurisdictions are listed in Appendix 9.

Contact: Stephen Antkowiak
Policy Specialist
Drug Courts Program Office (DCPO)
U.S. Department of Justice
Telephone: (202) 305-1735.

■ Connecticut's Project SAFE

In 1998, the state's child welfare and substance abuse agencies created a joint strategic plan to address substance abuse among the child welfare population. The strategic plan became Project SAFE (Substance Abuse Family Evaluation), and is implemented statewide. Each agency employs specialists from the other discipline to guide practice. For instance, the Department of Children and Families has regional substance abuse specialists who consult on CPS cases, and the Department of Mental Health and Addiction Services employs regional women and children consultants who address substance abuse issues specific to mothers. Both agencies use a joint "Bio-Psycho-Social/ Substance Abuse Evaluation" that community substance abuse treatment providers complete. Based on client focus group responses, Project SAFE developed an array of comprehensive, community-based services which, in addition to traditional treatment, also offers nonclinical recovery support services such as child care and transportation to promote a wraparound approach for families. Project SAFE initiated the creation of a separate, standardized release of information specific to substance abuse clients to aid in addressing confidentiality concerns between the two agencies. In addition, each system blends state and federal funds to support assessment and treatment of their mutual clients through a joint contract with Advanced Behavioral Health, Connecticut's network of treatment providers (U.S. Department of Health and Human Services, 1999).

Contact: Peter Panzarella
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Web Site: Peter.panzarella@po.state.ct.us

PEARLS OF WISDOM

Because the number of overlapping cases between the child welfare and substance abuse treatment fields is so high, it is no longer an option to not work together. As this resource guide suggests, there are myriad ways to overcome the barriers to collaboration among child welfare and substance abuse agencies. Successful collaboratives—however, incipient—are based on the shared commitment to providing services to the country's most vulnerable populations. Both systems are in the business of helping families heal or helping them cope with difficult situations. And while both child welfare and substance abuse agencies realize that not all parents will become sober and retain custody of their children, we nonetheless agree that only joint ventures will make it possible to give addicted parents and their children a chance at a better life.

This guide outlines several strategies for initiating community-based child welfare and substance abuse collaborations. It underscores that, while the "macro" issues such as federal funding and statewide commitment are crucial to supporting and sustaining successful joint service ventures, the rubber hits the road where the family lives: in the community. By enabling and enhancing the community's ability to take part in a family's recovery from child maltreatment and substance abuse, we help to create a far more lasting safety net.

Just as at the state level, local child welfare and substance abuse service systems must begin talking to each other, in consultation with the juvenile and family courts and their other community partners. Public child welfare representatives and their colleagues in the substance abuse field who have implemented successful collaborations almost universally agree there are core activities that need to occur to begin the collaboration.

Incite Leadership

Commissioners or administrators from both the child welfare and substance abuse treatment systems and judges from the courts must commit to addressing the needs of the child welfare population with substance abuse needs. For those who need convincing, data on the target population, including costs to provide treatment versus the costs of not assisting substance affected families, can support the need for a combined service approach.

Identify Strengths and Needs

Initial discussions among stakeholders from the child welfare, substance abuse treatment, and court systems should focus on:

- The way the child welfare system, substance abuse treatment system, and the courts operate and interact.
- The impact of current operations on child safety and family functioning.
- Gaps in each system's services.
- Strategies for involving families and community partners.
- Strengths that each service system and the courts bring to serving child welfare clients with substance abuse problems.
- The impact on each stakeholder of not jointly addressing child welfare clients' substance abuse needs.
- Shared goals (or outcomes) for jointly addressing mutual clients' needs. Outcomes need not be the same, but crossover in certain key areas is advisable to provide some common purpose.
- Innovations that would improve children and family outcomes in one's particular community.

Address Bureaucratic Hurdles

Related to both leadership and identification of strengths and needs is an exhortation to attend to process. Almost all states interviewed for the guide related a bureaucratic snafu and suggested ways for states beginning the process to avoid them. The suggestions include:

- Understand each system's dynamics and issues. Substance abuse takes the long view when considering a client's progress toward sobriety, while child welfare must "work a case" within the time limits established by ASFA. Both systems must come to an agreement—preferably codified in a Memorandum of Understanding—which establishes a compromise to address these dynamic issues.

- Understand where the “red tape” is. One child welfare-substance abuse collaborative did not realize that its state had an Internal Review Board—an oversight body that reviews all new state-funded projects involving human subjects. The collaborative was well on its way to implementation when it had to stop, submit its plan and justification to the Internal Review Board, and wait for approval before it could proceed. This process added months to the implementation plan.

- Establish parallel timelines for implementing collaborative service agreements. For instance, if one system has full agreement from its leader about the need to proceed in developing a joint system for dealing with child welfare clients with substance abuse issues, but the other has not even developed the data to present to its administrator, then one or both is bound to become frustrated.

Cross-Train Staff at All Levels

Successful collaborations require an understanding of the other side’s perspective. Mixing levels of staff and community members from every stakeholder system ensures that there is internal—and vertical—dialogue, as well as cross-agency discussion of the issues. Training also must address basic issues such as identifying the client, the variability in timelines for successful completion of child welfare treatment versus substance abuse recovery, and confidentiality. It then must establish what each side gains from collaborating in contrast to what they stand to lose if they do not. For instance, one state engaged substance abuse treatment providers in cross-training with child welfare caseworkers by initially inviting them to share their expertise in working with the toughest addicts. Finally, cross-training must address what each system needs to be able to work—or at least converse—in the other’s arena.

Undertake Everything as a Joint Venture

Just as two heads are better than one, jointly developed policies, procedures, and forms ensure that all stakeholders are on the same page in implementing the collaborative.

Plan for Sustainability

Many of the successful states and localities interviewed for this guide are planning how to sustain their programs once their grant funds or waiver programs are completed. For collaborative programs with more traditional beginnings, stakeholders will either make or break their momentum if dedicated resources—or at least a plan for securing them—are not part of the planning and implementation process.

States and localities just embarking on the development of a system that addresses the needs of families involved in the child welfare system that have substance abuse problems could not start at a more auspicious time. The national commitment to providing improved services to this population is established—in ASFA, by the U.S. Department of Health and Human Services, and by national associations representing child welfare and drug and alcohol treatment professionals. This guide is intended to add to the public cache of resources to guide the way to improved services to children and families impacted by substance abuse.

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APPENDIX 1

Tips for Locating Foundations to Support Cross-Disciplinary Programs

Use the Internet
The best way to find out about foundations is to research the Internet. If you do not have a computer or do not know how to use the Internet, go to a library and ask for help. Some general tips for searching on the Internet include:

Be Specific: Make sure your searches are as specific as possible. For example, if you are looking for information on funding for community-based programs in a certain state, do a search using such terms as "community-based," "funding," and "Ohio." Don't just type in "funding."

Be Prepared: Make a list of possible word combinations before you start your search. You may need to try several variations to narrow the search to exactly what you are looking for. See Appendix 9 for a list of common keywords and phrases that will be helpful.

Use On-line Help Sources: Most search engines and web sites have links to "help" pages, which offer tips and frequently asked questions (FAQs) to speed up your searches and clarify any questions you may have.

Check Your Spelling: Spelling counts when searching the Internet. Make sure your search terms are spelled correctly before you start your search.

Try Off-Peak Hours: As with anything on the Internet, the speed of your searches depends in part on how many other people are using the search engine at the same time.

Applying for a Grant

Learn about national and local foundations and how they might support working with child welfare clients with substance abuse disorders.

Once you have identified potential foundations to support your specific program, enlist your personal contacts to identify any foundation staff or board members they might know. Then call the foundation staff to offer a preliminary description of your program idea and to formally request an application.

Once you receive an application, make sure you follow procedures. Refer to the fact sheet you have from the foundation center. Pay attention to the requirements. Grant application process can be different for every organization. For example, if it asks for a letter of inquiry, do not send them an entire proposal.

Take advantage of the on-line application option if it exists. It is faster and easier.

APPENDIX 2

Other Internet Resources for Grant Seekers

Council of Foundations: http://www.cof.org

Charity and Philanthropy at Yahoo: Go to Issues and Causes

The Foundation Center: http://www.foundationcenter.org/

GuideStar: http://www.guidestar.org/

Women in Philanthropy: http://www.womenphil.org/

Philanthropy in Australia: http://www.philanthropy.org.au/

Philanthropy in Canada: http://www.ccp.ca/

Thompson Publishing (www.thompson.com)

Grantseeking Index

National Science Foundation: http://www.nsf.gov/home/grants.htm
http://grants.nih.gov/grants/index.cfm

Center for Substance Abuse Prevention–Provides national leadership in the federal effort to prevent alcohol, tobacco, and illicit drug problems.

Join Together–A project of the Boston University School of Public Health providing resources for communities working to reduce substance abuse and gun violence.

My Health Advisor–This web site is supported by your local health system and brings you health information and local health links.

National Institute on Drug Abuse–Major player in the war against drugs.

National Substance Abuse Web Index: Source of relevant, authoritative information on substance abuse prevention and treatment communities and excellent links

Office of National Drug Control Policy–Executive Branch Outreach Program

Prevline–National Clearinghouse for alcohol and drug information, a service of the substance abuse and mental health services administration.

The National Clearinghouse for Alcohol and Drug Information (NCADI)–NCADI's site has links to almost everything on the topic that is available from the federal government, and claims to be the world's largest resource for current information concerning substance abuse. The site is a source of grant announcements for AODA prevention, treatment, and research funding opportunities.

APPENDIX 3

Listservs to Keep Informed of Funding Notices and Information

A listserv is an electronic mailing list used to share ideas and publish information to people who have a common interest in the contents of the message. Individuals can "subscribe" or "unsubscribe" to mailing lists as they choose, but you must have an e-mail address to receive notices. Joining listservs is an effective way to stay updated on information in the field of your interest.

Each web site contains a home page, which is the first document users see when they enter the site. The site might also contain additional documents or files that can be downloaded. Most sites offer a feature called "Links." When you click on this section, you will be connected to other web sites that offer more information. Look at these sites on the Internet also. You can often sign up for updates on new funding sources.

The Foundation Center offers the Request for Proposal (RFP) Bulletin delivered to your e-mail address. To view the full RFP-Bulletin listing on the Internet, visit: http://fdncenter.org/pnd/rfp/index.html

APPENDIX 4

Children's Bureau Interdisciplinary Training Grantees

Each of these universities received three-year grants from the Children's Bureau of the U.S. Department of Health and Human Services to implement cross-disciplinary training curricula for public child welfare agency workers and their supervisors. The cross-disciplinary training curricula addressed the intersection of child welfare, substance abuse, mental illness, and domestic violence.

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

APPENDIX 5

Legal Action Center Memorandum of Understanding and Qualified Service Organization Agreement

The Legal Action Ceter (LAC), through the Center for Substance Abuse Treatment (CSAT), is developing a document to provide guidance on how alcohol and other drug treatment and programs can communicate and collaborate with child welfare agencies without violating the federal confidentiality law and regulations that govern alcohol and drug treatment records.

Those interested in learning more about the ways in which providers from both the child welfare and substance abuse treatment fields can work together can contact the Legal Action Center.

Legal Action Center – New York
153 Waverly Place
New York NY 10014
1-800-223-4044
(in New York State call (212) 243-1313)
email: lacinfo@lac.org

Legal Action Center – Washington
236 Massachusetts Avenue NE,
Suite 505
Washington DC 20002
(202) 544-5478
email: lacdc@lac-dc.org

APPENDIX 6

Maryland's Cross-Disciplinary Training Curriculum for Child Welfare and Substance Abuse Professionals

Module 1: IV-E Waiver Project Orientation and Grow Work Dynamics

Orientation: This training will review the background, scope, and the philosophy of the IV-E waiver project, as well as its implications for human professional services staff and alcohol and drug service providers.

Group Work Dynamics: This training will review the dynamics of the working task group. Participants will become more familiar with modes of work groups, leadership functions, properties of groups, and how to operate more effectively in groups. This training uses both presentation and experiential group activities. Group participation is an essential part of the learning experience in this training.

Competencies

- The participant is aware of the scope and philosophy of the IV-E waiver project.
- The participant understands when to use a team, group, or when to work alone or delegate.
- The participant understands work boundaries.
- The participant understands the properties of groups.
- The participant knows and can describe the modes of group behavior.
- The participant is aware of leadership functions in group.
- The participant can assess the modes of group as they evolve.
- The participant can describe how to apply learning from this training to one's work in the IV-E waiver project.

Module 2: Overview of Child Welfare Services
This training reviews the historical, legal, and philosophical basis of human services. Participants will become familiar with how culture and ethnicity impact practice. Case management, planning, assessment, and their use in the continuum of services are addressed.

Competencies
- The participant understands the historical, legal, and philosophical basis of human service, and how they impact practice.
- The participant is aware of the impact of culture and ethnicity on his/her approach to human service.
- The participant is aware of several theories of human development and this use in assessing individuals and families.
- The participant knows how assessment information is used in case planning.
- The participant is aware of the Continuum of Family and Children's Services.
- The participant knows the principles of concurrent permanency planning.
- The participant can recognize the basic indicators of child maltreatment.
- The participant understands how identified risk and safety factors are used in case planning.
- The participant is aware of how basic casework methodology is used to support safety and permanency for children receiving family and children's services.

Module 3: Drugs of Abuse: their Effects on the Individual and Family
This training reviews the electrochecmical basis for drug dependence, which contributes to our understanding of addiction as a chronic illness. The drug families and their effects on the central nervous system are described. Participants will become familiar with common responses of the family to addiction, including codependence, enabling, and provoking.

Competencies
- The participant is aware of addiction as an illness of the central nervous system.
- The participant knows how drugs work and their impact on behavior.

the participant can list drug families.
- The participant can describe use, abuse, and dependence.
- The participant understands the progressive stages of the family with addiction.
- The participant is aware of roles that family members play in families with addiction.
- The participant understands codependency, enabling, and provoking behaviors on the part of family members.
- The participant understands recovery symptoms and the recovery process.
- The participant is aware of common precipitants of relapse.

Module 4: Double Abuse: Addiction and Child Maltreatment

This training reviews the connections between alcoholism/addictions and child maltreatment by focusing on the impact of drug involvement on parenting. Identification, assessment, intervention, and treatment are presented.

Competencies

- The participant is aware of correlation between addictions and child maltreatment.
- The participant understands the impact of substance use on parenting.
- The participant knows the likely impact of early recovery on parenting.
- The participant is aware of Prochaska and DiClementes stages of change.
- The participant is aware of the history, models, and modalities of AODA treatment.
- The participant understands the impact of acute intoxication, acute withdrawal, protracted withdrawal, neonatal complications, and child outcomes on parenting.
- The participant is aware of common health problems associated with drug-addicted families.
- The participant understands the common defense mechanisms used by "double abusers" to justify child maltreatment and drug use.
- The participant understands the double abuse treatment model and its goals of treatment.
- The participant can apply information gained in this training to a case scenario and work collaboratively across disciplines to develop a service/treatment plan.

APPENDIX 7

Tips for Searching the Internet

Keywords and phrases to use when searching for funding information for neighborhood-based alcohol and drug-related programs:

Addiction
Alcohol
Alcohol and other drugs (AOD)
Blended funding
Call for Proposals (CFPs)
Chemical dependency
Child welfare
Child welfare system
Collaboration
Community
Community-driven
Consumer-driven
Coordination
Drug abuse
Drugs (could list specific drugs)
Family support
Family-driven
Funding
Funding streams
Guide for Applications (GFAs)
Integrated services
Integrating silos
Integrated systems
Neighborhood-based
RecoveryRequest for Applications (RFAs)
Request for Proposals (RFPs)
Strength-based
Strengthening families
Substance abuse

APPENDIX 8

Illinois' Interagency Agreement Between the Department of Children and Family Services and the Office of Alcohol and Substance Abuse

Purpose

The Illinois Department of children and Family Services (DCFS) and the Illinois Department of Human Services (DHS) acknowledge that the need for this collaborative effort arises from the prevalence of substance abuse, the destructive impact it can have on parenting ability and child well-being and safety, and the state's responsibility to address parenting deficiencies while moving expeditiously to safe and permanent homes for all of Illinois' neglected and abused children.

This interagency agreement formally states the commitments of the Illinois Department of Children and Family Services and the Illinois Department of Human Services, through its office of Alcoholism and Substance Abuse (OASA), to develop and implement a statewide, community-based system to ensure that parents and children being served by DCFS or its purchase-of-service (POS) providers have timely access to alcohol and other drug (AOD) assessment and treatment services. These services are to be provided by selected OASA licensed and funded agencies. Through ongoing collaboration, child welfare workers and substance abuse providers will work to address DCFS-involved clients' dependence on alcohol and/or drugs and its impact on family life, parental functioning, child safety, permanency, and well being.

Joint Roles and Responsibilities

1. DCFS and DHS agree to continue use of the statewide, community-based system of AOD referral, assessment, and treatment services provided by OASA-licensed and -funded agencies, originally implemented under the former DASA/DCFS Initiative. Henceforth, this initiative will be referred to as the OASA/DCFS Initiative.

2. DCFS and DHS agree that clients participating in and funded by this initiative must meet the following criteria:

- all initiative clients must be affiliated with an open DCFS case;

- all initiative clients must have completed Initiative Referral Forms (CFS 440-6) in their AODA treatment provider's client file;
- all initiative clients must consent to and maintain consent for the exchange of necessary information between the OASA provider, DCFS, and the court; and
- the client may be the mother, father, relative, or on-going member of the household who is effecting the decision regarding a child's placement; or may be the child or children for whom the DCFS case was opened.

Any client not meeting all of these criteria will not be considered an initiative client.

3. DCFS and DHS agree that the service continuum for DCFS clients will include service levels one through three as defined by the American Society of Addiction medicine (ASAM) Placement, Continuing Stay, and Discharge Criteria. Level four of these criteria, which refers to medically managed intensive inpatient treatment is an acute level of care and not available via the community-based system of care supported by OASA.

4. DCFS and DHS accept and acknowledge that the statewide, community-based system of substance abuse assessment and treatment services will occur based on the geography of the Child and Adolescent Local Area Networks (LAN), the geographical service boundaries of DCFS offices or service teams, and DHS geographic service regions.

5. DCFS and DHS will continue to convene the OASA/DCFS Advisory Committee (formerly the DASA/DCFS Initiative Steering Committee), a multidisciplinary group designated by OASA and DCFS which shall provide advice on the implementation of the ASAS/DCFS Initiative, help identify policy deficiencies, program gaps/barriers and possible solutions for serving DCFS-involved clients, and develop and submit recommendations to the director of the Department of Children and Family Services and the secretary of the Department of Human Services. The advisory committee will serve as a resource for the departments concerning innovative policies and practices deemed essential for ensuring effective services to parents and children served by DCFS.

6. DCFS and DHS will each appoint a program administrator to oversee substance abuse services for clients of the initiative.

7. The departments acknowledge that exchange of information is critical to ensuring child safety and well-being and for providing that DCFS (or the private child welfare agency) and the court receive accurate, timely, and complete information regarding client progress. Data exchange also allows both DHS and DCFS to assess the strengths and weaknesses of the Initiative Program. Therefore, the departments shall work together toward the elimination of all barriers which restrict the

exchange of necessary information between initiative AOD providers and child welfare workers and toward the development of specific outcome measures and a data tracking system which allows the collection, exchange, and statistical analysis of data for all clients receiving services through the OASA/DCFS Initiative. This tracking system shall be consistent with federal and state confidentiality requirements.

8. DHS and DCFS agree to develop internal and interagency procedures to facilitate the implementation of this initiative.

DCFS Role and Responsibilities

1. Each DCFS office shall designate a primary liaison and a regional office back-up contact to assist with local coordination of the OASA/DCFS Initiative and to serve as a contact point for communication between OASA providers and child welfare staff.

2. DCFS shall ensure that DCFS staff and purchase-of-service (POS) agencies which will make substance abuse treatment referrals receive appropriate instruction regarding the referral and treatment process and staff responsibilities under the OASA/DCFS Initiative.

3. DCFS agrees to establish and maintain a statewide system for client referrals to providers funded through this initiative for assessment and treatment services and to ensure that sufficient referrals are made to support the initiative. This system will be outlined in the DCFS rules and procedures and will be promptly communicated to OASA.

4. DCFS and POS agencies which provide child welfare services to DCFS-involved clients shall follow DCFS rules and procedures which are consistent with the "Guidelines for OASA/DCFS Initiative Programs," which are jointly developed by OASA and DCFS, when accessing services for clients through the OASA/DCFS Initiative, including participation in joint staffings at required intervals.

5. DCFS shall pay for child care services for DCFS-involved clients who have been referred by DCFS or a private child welfare agency in accordance with DCFS and DHS rules and procedures and who require child care services in order to participate in substance abuse treatment, aftercare, and treatment-related interventions through this initiative.

6. DCFS shall have primary responsibility for developing and funding initiative training curriculum and events and will require that DCFS and POS agency staff participate in initiative training.

DHS Role and Responsibilities

1. DHS will require each substance abuse provider funded through the OASA/DCFS Initiative will designate one primary liaison and one back-up staff member to receive and coordinate OASA/DCFS Initiative referrals, assessments, treatment, and aftercare for DCFS-involved clients.

2. DHS will supply to substance abuse treatment providers appropriate instruction regarding the referral and treatment process and staff responsibilities under the OASA/DCFS Initiative.

3. DHS will require OASA/DCFS Initiative providers to give priority placement for substance abuse treatment to clients referred from DCFS and from POS child welfare agencies, where the parent is a resident of the Child and Adolescent LAN served by the provider, unless inconsistent with federal or state law or constitutions, and to conduct assessments on such referrals no later than the following business day.

4. DHS will require OASA/DCFS Initiative providers to follow the protocols outlined in the "Guidelines for OASA/DCFS Initiative Programs" when accepting referrals and providing services through the OASA/DCFS Initiative, including participation in joint staffings at required intervals.

5. DHS will require OASA/DCFS Initiative providers to develop and maintain outreach services as defined in the OASA publication, *The Delivery and Supervision of Outreach Services.*

6. DHS will require OASA/DCFS Initiative providers to establish interim services, as defined in the principal contract agreement, for DCFS-involved clients for whom the recommended treatment modality is not available as determined by the provider through OASA's Capacity Management System automated bulletin board.

7. DHS will require OASA/DCFS Initiative providers to participate in training and technical assistance sessions on child welfare and substance abuse issues. DHS will coordinate training for DHS staff and OASA/DCFS Initiative providers.

8. DHS will require OASA/DCFS Initiative providers to conduct Child Abuse and Neglect Tracking System (CANTS) checks on all new and existing personnel employed to deliver services funded by the OASA/DCFS Initiative.

9. DHS will require OASA/DCFS Initiative providers to cooperate with investigations conducted by DCFS child death review teams or the DCFS Office of Inspector General as requested and appropriate.

10. DHS shall have primary responsibility for collecting and reporting initiative service and funding information. The information needed will be mutually agreed upon and used in the joint DHS/ DCFS quarterly and annual reviews as well as in the annual evaluation of the initiative.

Review/Monitoring of the Agreement

1. The departments shall meet at least quarterly to review progress of the initiative, identify problems, and design strategies to successfully address such problems. Elements to be reviewed will include service utilization by initiative providers, the availability of appropriate treatment capacity, numbers of clients referred, admitted, treated, and completing or withdrawing from treatment.

2. The departments shall conduct an annual review of each initiative provider, focusing on such elements as the number of DCFS referrals, the sufficiency of treatment capacity, service utilization, and treatment outcomes. The departments will conduct a joint review and mutually agree on contract language related to this initiative in the state's contracts with initiative provider contracts and the proposed allocation of initiative funds for the upcoming year.

3. The departments shall establish a quality improvement effort designed to proactively monitor and improve initiative services and respond to indications of needed quality improvements.

4. The departments shall cause their staffs and contracted providers to cooperate with the outcome evaluation required by Public Act 89-268. Responsibility for the administration of the outcome study will alternate yearly between OASA and DCFS, starting with DCFS.

5. Upon written request from either of the parties, a formal review will be scheduled to modify or terminate the agreement. The agreement may be modified or amended with the written consent of both parties at any time during its term. Any amendment shall be in writing and signed by the parties or their authorized representatives.

6. The parties shall attempt to resolve any disagreements and misunderstandings between them pertinent to the implementation of this agreement. The secretary of the Department of Human Services and the director of the Department of Children and Family Services shall oversee the resolution of such disagreements or misunderstandings.

Severability

changes to any part of this agreement do not change the remaining body of the agreement nor void the agreement. A change in rule or procedure of a party which alters any part of this agreement only affects the relevant parts and not the remainder of this agreement and does not alter nor void the remainder of the agreement.

APPENDIX 9

Family Drug Court Information

Pilot Family Drug Courts (by State)

California
San Diego County
Juvenile Court
Contacts: Judge James Milliken, (619) 694-4222
Andrea Murphy, Superior Court Project Manager, (619) 515-8678

Florida
Miami
Family Drug Court Initiative, Miami Juvenile Court
Contacts: Judge Jeri B. Cohen, (305) 638-6879
Bruce Fry, Center for Substance Abuse Treatment (CSAT) Project Officer, SAMHSA, (301) 443-0128; e-mail: bfry@samhsa.gov

Pensacola
Escambia County Court

Kentucky
Bowling Green
Warren District Court

Massachusetts
Greenfield
Franklin County

Missouri
Kansas City
Jackson County Family Court
Contacts: Commissioner Molly Merrigan, (816) 435-8033
Penny Howell, Program Manager, (816) 435-4757
Bruce Fry, Center for Substance Abuse Treatment (CSAT) Project Officer, SAMHSA, (301) 443-0128; e-mail: bfry@samhsa.gov

Montana
State Court Improvement Program
Contact: Sherry Meador, Court Improvement Program Project Manager, (406) 449-0622

Nevada
Las Vegas
Clark County Family Court
Juvenile Division

Reno (Washoe County)
Second Judicial District Court
Contacts: Judge Charles McGee, District Judge
Tori King, Family Court Clerk, (775) 328-3144
Nancy Tribble, Family Court Clerk, (775) 328-3132

New York
Central Islip
Family Drug Treatment Court

New York
Manhattan Family Treatment Court
Contact: Judge Gloria Sosa-Lintner, (212) 374-2623
Bruce Fry, Center for Substance Abuse Treatment (CSAT) Project Officer, SAMHSA, (301) 443-0128; e-mail: bfry@samhsa.gov

Suffolk County
Suffolk County Family Court
Contact: Judge Nicolette Pach
Christine Olsen, Project Director, (631) 853-4482; e-mail: colsen@courts.state.ny.us

Rhode Island
Court Improvement Program
Contact: George DiMuro, Court Improvement Program Project Manager, (401) 458-5320

Texas
El Paso
Family Drug Court Program
Contact: Anna Belle Casas, (915) 351-8853

Utah
Court Improvement Program
Contact: Adam Trupp, Court Improvement Program Project Manager, (801) 578-3929

Provo
4th District Juvenile Court Dependency Drug Court Program
Contact: Brent Platt, Dependency Drug Court Coordinator, (801) 374-7023; e-mail: bplatt@pro.state.ut.us

Virginia
Alexandria
Juvenile & Domestic Relations District Court
Contact: Judge Nolan Dawkins, (703) 838-4088.