

**PARENTAL SUBSTANCE ABUSE, CHILD PROTECTION AND ASFA:
IMPLICATIONS FOR POLICY MAKERS AND PRACTITIONERS**

Substance Abuse Policy Research Program

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FINAL POLICY AND RESEARCH REPORT

Submitted By

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ABSTRACT

The volume and complexity of dependency courts' caseloads has changed dramatically during the last several decades. Fueled by the explosion of parental drug use and associated child abuse and neglect, dependency cases are imposing new and expanded roles on judges and court systems. This study was designed to explore how dependency courts are making permanency decisions under the Adoption and Safe Families Act of 1997 (ASFA) for children of parental substance abusers. Research methods included a mail survey of over 300 judges presiding in dependency courts; telephone surveys with over 60 judges and community professionals; a legal analysis; and five case studies of courts who have implemented special strategies to handle dependency cases under ASFA when parents are substance abusers.

We derived four policy and practice implications and recommendations from the case studies, mail surveys, and community telephone surveys:

1. Dependency courts should recognize that most cases involve parents who are substance abusers. Instituting established "good practices" in all dependency cases can also improve the response to cases in which parents are substance abusers.
2. Dependency courts faced with a sizable caseload of parents with substance abuse issues should consider, and plan for, special approaches to these cases.
3. As dependency courts implement special approaches, they need to ensure that supports are in place, including training programs, substance abuse assessments, substance abuse treatment programs, other service programs, and initiatives to support parents throughout the dependency and treatment processes.
4. Programs should plan for, and implement, evaluations to assess the effectiveness of special approaches to dependency cases when parents are substance abusers.

CHAPTER 1

INTRODUCTION

The volume and complexity of dependency courts' caseloads has changed dramatically during the last several decades. Fueled by the explosion of parental drug use and associated child abuse and neglect, dependency cases are imposing new and expanded roles on judges and court systems. These roles must effectively address a broad range of social service, behavioral, public health, mental health, family, and legal issues. Interagency relationships involved with the disposition of these cases are changing as a result.

This study was designed to explore how dependency courts are making permanency decisions under the Adoption and Safe Families Act of 1997 (ASFA) for children of parental substance abusers. We found that some courts and child welfare agencies have implemented new initiatives to address the accelerated timeframes ASFA mandates without adding special programs to address the complexities of substance abuse disorders. Cases with parental substance abuse are benefiting from these good practices, including speedy assessments, early and frequent case reviews, monitoring of court orders, holding people accountable for following the case plan, and providing a range of services needed to help parents and children deal with the many problems frequently faced by families in dependency court. Other courts have implemented good practices *and* developed special programs for substance-abusing parents. In this report, we discuss what we learned through the mail and telephone surveys, and five case studies. In the five case studies, we discuss good practices in all dependency cases with an emphasis on

specific programs to respond to substance-abusing parents within ASFA timeframes and requirements.

Background

The number of children in foster care has almost doubled between 1985 and 2003, from 270,000 (National Conference of State Legislatures, 1998), to approximately 523,000 (Congressional Quarterly, 2005). The surge in the dependency caseload has been coupled with an equally dramatic increase in out-of-home placements. Between 300,000 and 400,000 of the 520,000 children in out-of-home care in 1997 were estimated to come from families where alcohol and other drug problems would determine whether these children could return home to safe, stable families (Young, 2000). The intersection of these phenomena on the dependency caseload has created a crisis situation for many judicial systems and communities.

In response to this crisis, Congress established the Court Improvement Program (CIP) in 1993 to address acutely needed reforms in child welfare litigation. Rapidly escalating judicial caseloads, more difficult cases such as those involving substance abuse, and the growing complexity of the litigation itself required action. Statutory changes over the past two decades require more hearings, mandate additional types of judicial decisions, and involve more parties in each case. The CIP grants are designed to help states focus on these challenges and implement a plan to address them.

The federal CIP grants are given to the highest court in each state – those with responsibility for administering state court systems – because they have oversight over the lower courts and can contribute to long-term knowledge and commitment to child welfare law. Under the CIP grants, each participating state court system conducted a

detailed assessment of how they are handling abuse, neglect, foster care, and adoption cases; developed a plan of improvement; and is now implementing that plan. Some of the types of reforms state courts are pursuing include implementing judicial case flow management; improving judicial staffing; enhancing judicial data collection; reforming state laws, policies and procedures; upgrading training; and improving legal representation. States are currently conducting follow-up assessments to determine whether their reforms are succeeding.

The CIP projects work to implement “best practices” as described in the *Resource Guidelines: Improving Court Practice in Child Abuse and Neglect Cases* (National Council of Juvenile and Family Court Judges, 1995). Endorsed by both the American Bar Association (ABA) and the Conference of Chief Justices, the *Resource Guidelines* are accepted in the field as optimal court practices. They describe and promote practices such as expedited case management, early and frequent case reviews, and mediation. Many of these practices, as well as certain social work practices such as concurrent planning, were subsequently mandated by the Adoption and Safe Families Act. The CIP projects were well established when ASFA was adopted in 1997 and therefore became leaders in its implementation in the states.

ASFA requires courts to move children into permanent placement within an accelerated timeframe (see Legal Issues, Chapter 2). ASFA also adds a significant amount of judicial system oversight and service coordination functions between courts and service agencies. Under ASFA, the judge must decide at various points in the court proceedings whether the agency made “reasonable efforts” in light of the child’s current and future health and safety needs, provide adequate services, attempt to reunify the

family, or diligently locate and secure an alternate permanent placement for the child.

The shorter time frames for permanency (12-14 months) may in fact conflict with the oft-cited substance abuse treatment time frame of 18-24 months before stabilization.

Dependency Cases and Parental Substance Abuse

Parental substance use disorders complicate permanency planning for children in the child welfare system and is a pervasive problem among families whose children enter foster care (GAO, 1998). Researchers estimate that 40-80% of the families involved with the child welfare system nationally are impacted by substance abuse, and child welfare professionals support that belief (Chiancone, 1998). The Child Welfare League of America (CWLA) documented that over one-third of referrals to public child welfare agencies in 10 states that culminated in abuse and neglect petitions were related to problems associated with parental drug or alcohol use (CWLA, 1992). The U.S. General Accounting Office, reporting on foster care cases in California and Illinois (accounting for 25% of the nation's foster care population), estimated that over 80% of the dependency cases resulting in foster care placements were referred as a result of parental abuse of drugs and/or alcohol (GAO, 1998). The National Indian Child Welfare Association has reported similar statistics of abuse and neglect cases involving Indian children. These children are placed in foster care more often as compared with nonIndian children (NICWA, 2000).

Substance-abusing parents create many challenges for caseworkers and courts due to the nature of addiction and its impact on parenting, placing children at risk by engaging in illegal activities; neglecting children during drug use; spending money on drugs rather than on food, clothing, and shelter; interacting unpredictably with children;

and leaving them unsupervised or supervised by inappropriate or dangerous caretakers (GAO, 1998; Chiancone, 1998; McGee, et. al., 1998).

Challenges Parental Substance Abuse Brings to Permanency Planning

Parental substance abuse creates challenges for child protection agencies and courts working with families in the child welfare system. Parental substance use may impact children whether the mother used drugs while pregnant, or whether one or both parents use drugs while rearing children. Research shows if a mother is high, in withdrawal, or buying drugs (leaving children alone, bringing them along on the “buy,” spending money allotted for food, shelter, or clothing), she cannot adequately care for the child, leading to neglect (Zuckerman, 1994). Drug use interferes with and may impair the parent-child attachment (Young, et al., 1998). Children of drug-dependent parents are three times more likely to be abused and four times more likely to be neglected (CASA, 1999). These children are more likely to enter foster care than children of nonsubstance abusers (GAO, 1998). Children of drug abusers are at increased risk for becoming substance abusers (Chiancone, 1998). Additionally, there is evidence that being raised in a home with a drug-involved parent leads to developmental problems (SAMHSA, 1999).

Getting a parent into treatment is difficult, and getting the parent to complete treatment is much harder. A study of caseworkers in Illinois and California reported:

- nearly 40% of substance-abusing parents in each state did not enter treatment,
- 40% in each state had entered treatment but relapsed, and
- only 20% in each state had successfully completed or were in treatment at the time of the study (GAO, 1998).

Further, enrolling in a treatment program does not ensure an addicted parent will complete the program and never use drugs or alcohol again. In fact, research shows that most substance abusers cycle in and out of sobriety. There is little support from the child

welfare system for relapse prevention posttreatment. If the goal is reunification, child welfare workers must recommend if, and under what circumstances, a child may return home. Parents addressing substance abuse need long-term assistance, whether their child remains with them during treatment or is moved into foster care with the goal of reunification (Barth, 1994).

While relapse is common, treatment providers and researchers say it can be anticipated, especially for substance-addicted mothers. Women are more likely to face difficulties completing treatment and have higher rates of relapse than men (Dore & Doris, 1997). Research identifies several “triggers” for parenting women that can push them into reabuse of substances, including generally unsupportive conditions (SAMHSA, 1999); the presence of a substance-abusing partner (Terling, 1999); emerging feelings of guilt and shame, either for the neglect or abuse imposed on their children, or for their own histories of molestation (Kaplan-Sanoff, 1996; Ingram, 2001); and stress of parenting while trying to become drug-free (Ingram, 2001).

Differing professional orientations of child welfare and treatment professionals may result in a “fragmented” delivery of services to an “overlapping population” (Colby & Murrell, 1998). Without a fundamental understanding of addiction, treatment options, and recovery, child welfare professionals may fail to recognize substance abuse; refer substance-addicted parents to inappropriate treatment placements; or move to order TPR at the first sign of relapse early in recovery. Without an understanding of the interplay between addiction, parenting, and the child welfare process, treatment providers may have limited success with parents who fear losing their children. And the strict deadlines imposed by ASFA make informed decision-making even more crucial.

The fundamental difference between child welfare and treatment professionals can be summed up by the answer to the question “Who is the client?” For child welfare professionals, the answer is *the child and the family*. For treatment providers, the client is *the addicted individual*. There are practical effects to these conflicting answers.

Lawyers for children, judges, and caseworkers are mandated by law to make permanency decisions in the best interests of the child, and to do so within ASFA's strict timeframes (PL98-617 & PL105-89). Those decisions will be based on addressing the child's immediate safety needs, and ensuring the goal of a safe, nurturing, and stable situation in the future (Young, et al., 1998). The child-orientation may lead professionals working with the family to view the substance-addicted parent as a self-centered individual who cares more about getting high than caring about their child (Young, et al., 1998). Doubt about a drug-using parent's ability to overcome addiction may result in premature TPR requests (Tracy & Farkas, 1994; AIA, 1998).

Treatment providers view the adult addict as the client. Success for treatment programs is defined by a decreasing use of drugs and negative “personal consequences” of addiction (Feig, 1998; SAMHSA, 1999). The client's parenting status is irrelevant, except to motivate the parent to remain in treatment (e.g., “You don't want to lose your family because of your addiction, so get straight.”). Because drug-dependent mothers are a minority in treatment programs, child issues are “often overlooked” (Feig, 1998). Treatment counselors may be recovering addicts themselves (Young, et al., 1998), leading them to empathize with their clients, which may undermine efforts to collaborate with a child welfare system they perceive as “threatening” (Azzi-Lessing & Olsen, 1996).

A recent study highlights the difference in outlook of judges, caseworkers and addiction counselors by examining the criteria deemed as most indicative of safe reunification (Karoll, 2003). Caseworkers and judges agreed that the most important factors were motivation (e.g., breaking off with a drug-using partner), recovery (e.g., can identify own relapse triggers), competency/reliability (e.g., completes treatment goals, finds a job), social support (develops and maintains a helping network), parenting (takes care of medical and other appointments) and legal (cooperates with court and caseworkers), all of which are measurable behaviors. Addiction counselors, to the contrary, ranked experiential changes such as feeling shame and asking for advice as most indicative of progress.

A major conflict between child welfare and treatment professionals results from the very different timelines for addressing client needs (Azzi-Lessing & Olsen, 1996). ASFA mandates permanency hearings in child protection cases at 12 months, and six-month review hearings. Treatment providers regard recovery as a lifelong process, with relapse likely. And research on children's developmental growth shows the first 18 months of life to be critical for bonding, providing another justification for making decisions quickly. These three timelines converge and can cause challenges when drug-dependent parents are expected to be completely drug-free (and become nurturing parents) within the 12-18 months of ASFA's timeline.

Finally, state and federal laws and regulations protect children's and treatment clients' privacy, and treatment programs hold the confidentiality of their clients' information to be the linchpin of providing services. These safeguards can "hamper collaboration" (Azzi-Lessing & Olsen, 1996). Treatment providers may worry, for

example, that sharing information with the child welfare agency will damage the relationship of trust with the adult addict; will not positively impact reunification; or will not result in more services to the client's family (Feig, 1998). And caseworkers may similarly feel "what's the use?" if treatment does not work (Feig, 1998).

Efforts to Improve Handling of Cases Involving Parental Substance Abuse

Communities are trying to address the challenges inherent in child welfare cases with parental substance abuse by introducing new approaches and changing practices of child welfare agencies, courts, mental health agencies, and treatment programs. There is a new recognition that coordination between child welfare and treatment professionals is necessary to address the complex challenges presented by many families affected by substance use disorders, due to awareness that the child welfare agency cannot solve the problems alone (Semidei, Radel & Nolan, 2001).

Many jurisdictions are changing the way they address the multiple challenges brought by families in the dependency system by implementing what the field considers "good practices." Many of these practices are supported by the *Resource Guidelines: Improving Court Practice in Child Abuse and Neglect Cases*, which is the best practices guide for dependency courts. Published by the National Council of Juvenile and Family Court Judges in 1995, the *Resource Guidelines* have been endorsed by the American Bar Association House of Delegates and the Conference of Chief Justices. The *Guidelines* set forth the essential elements of properly conducted court hearings: timely and detailed hearings as governed by federal (ASFA) and state law; policies against continuances; reasonable efforts findings; calendaring for one-family-one judge; time-certain docketing; competent and diligent representation for parents, children and agencies; family-friendly

courtrooms; key decisions and detailed findings of fact and court orders at each hearing; and appropriate use of mediation, among others.

The literature provides numerous examples of good practice, including: coordination among child protection agencies, courts and treatment providers (whether through family drug courts, treatment providers in the courtroom, family group conferencing, multidisciplinary teams, etc.); early and intensive case management, including frequent case reviews during the first six months; contracting with outside treatment vendors for case management and referral to treatment; judicial monitoring of court orders; comprehensive alcohol, drug, and service assessments of parents, children and caregivers; mediation to identify issues and develop permanency plans; ongoing continuum of care throughout recovery; and cross-training of all professionals on substance abuse, treatment, and dependency case processing.

Family drug courts are an innovative and comprehensive approach to addressing the multiple needs of families with parental substance use disorders, as they offer a model of coordinating child welfare and service provision. Under the supervision of a judge, family drug courts offer intensive drug treatment intervention and supportive services, within a structure of sanctions and incentives. Currently there are family drug courts programs in 43 states (BJA Drug Court Clearinghouse, 2005). Family drug court dockets apply to dependency cases handled as civil abuse and neglect matters. These courts deal with such issues as custody and visitation disputes, nonsupport, TPR petitions, and guardianship proceedings. Family drug courts focus on providing and coordinating intensive drug treatment and other ancillary service delivery (e.g., housing, etc.) to parents with substance abuse problems.

Family drug courts generally share these characteristics: judicial leadership and monitoring of progress; goal of reunification; intensive treatment services; interdisciplinary team involvement; early identification and eligibility; rehabilitation of parent; agreement to program conditions; sanctions and incentives to ensure compliance; program completion and follow-up; and reunification following successful completion. Family drug courts can provide an extensive foundation for implementing ASFA. They set in motion an expedited process for identifying eligible parents for treatment, and have mechanisms for expedited screening, assessment and service delivery.

Family drug courts may also focus on different populations or approaches. Larsen (2000) notes that the drug court may focus on a “targeted population,” such as mothers whose newborns test positive for drugs, pregnant drug abusers, etc. Courts may employ a “family systems” approach, where they provide services to all the family members. Other courts may focus only on the substance abuse treatment of the parent, much like in criminal drug courts. Another strategy is to require that all adults in the dependency court be screened for substance use disorders and treatment mandated for those found needing it.

Multidisciplinary task forces and working groups can provide a forum (both formally and informally) to acknowledge differences in goals, and to learn about and understand the experiences with, and expectations for, substance-affected families through training and cross-training. Coordination of efforts may include: intensive reunification efforts immediately after the child is placed in foster care; concurrent planning, which involves providing reunification services, and simultaneously exploring alternative placement options (adoption, guardianship, custody, relative placement, or

planned permanent living arrangement) in case the child will not return home (SAMHSA, 1999); and programs where child welfare and treatment providers work together to speed up the process. The National Resource Center for Foster Care & Permanency Planning (2000) notes that key elements should include:

- individualized assessments, integration and coordination of service delivery,
- shared vision of family-centered practice,
- protocols around rapid and meaningful case coordination,
- case management with post-treatment services,
- using the Family Rehabilitation Model to work with families in the home, provide services focused on preventing abuse and neglect, and
- providing substance abuse and child welfare services by the same worker, including intensive services for parents and children, substance abuse liaison at field offices and court.

Cross-training on substance use disorders, the impact of parental substance abuse on children's safety, and on the legal responses and mandates under which child protective services and dependency courts operate can provide all professionals involved with these families the knowledge they need to work more effectively. The National Resource Center for Foster Care & Permanency Planning (2000) calls for child welfare system and treatment providers to allocate more resources to substance-affected families. In particular, they recommend that:

- child welfare workers be trained in recognizing and responding appropriately to AOD (alcohol and other drug) problems;
- child welfare workers question kinship providers and family foster parents about their own AOD involvement as part of the initial screening and assessment process;
- child welfare workers provide AOD training to all caregivers and require that all caregivers report any AOD problems in the children;
- child welfare workers develop and provide in-service trainings or refresher courses on AOD problem identification and management;
- child welfare workers support and facilitate intra- and inter-agency collaboration, including joint training and program development and resource sharing; and
- treatment providers keep child welfare agencies apprised of treatment progress, relapse, and discharges.

Conclusion

The literature that has evolved since ASFA was enacted suggests that agencies and courts face challenges in working with parental substance abuse in child welfare cases. No blanket strategies for compliance with ASFA goals have been broadly adopted. There has, however, been sufficient time for some innovations to be introduced.

This study explores how dependency court judges and child welfare professionals are making permanency decisions under ASFA for children of parental substance abusers. How are courts implementing ASFA while responding to the complex needs of children and coordinating services to their substance-abusing parents? How are courts responding to children so that permanent, safe placement is achieved? How are substance abuse providers managing treatment for the parents to promote healthy relationships with their children and reunification? The ABA Center on Children and the Law with sub-contractor Research by Smith Associates, Inc., presents the findings of an exploratory study of the challenges faced by courts and service professionals.

The four project objectives were:

- obtain a national picture of the implementation experience of courts handling dependency cases subject to ASFA, including issues and needs which have emerged and unanticipated challenges in cases in which parents have substance abuse problems;
- conduct a legal analysis of ASFA as it relates to substance abuse by parents;
- conduct a case study of five communities that have undertaken innovative approaches for meeting ASFA requirements while responding to the needs of children in foster care placement who have substance-abusing parents; and
- develop and disseminate policy recommendations to provide support to court systems handling ASFA cases and related service providers to address common implementation issues being encountered and develop recommendations for further research.

CHAPTER 2

LEGAL ISSUES

Child Welfare Proceedings

The child welfare system is designed to protect children and keep them safe from abuse and neglect. Public child welfare agencies hold primary responsibility to ensure that children are safe and secure in their homes, but they must work with courts and other social service agencies, such as substance abuse treatment providers, school systems, and health care providers.

Courts become involved when suspected abuse or neglect falls within the legal definition adopted by a particular state. The court process is complex, with specific hearings held at specific times. For example, the first hearing (often called a shelter care or emergency removal hearing) must generally be held anywhere from 24 to 72 hours after the removal of a child from his or her home, depending on state law. Times for subsequent hearings – such as adjudicatory, dispositional, permanency, review or termination of parental rights hearings – must be set according to timelines set forth in the federal Adoption and Safe Families Act of 1997 (ASFA).

The Adoption and Safe Families Act of 1997

The intent behind the Adoption and Safe Families Act was to prevent “foster care drift” by moving children out of foster care and into safe and permanent placements as quickly as possible. Under ASFA, courts and social service agencies are called upon to make the health and safety of children the paramount concern in their placement and permanency decisions. ASFA places stringent requirements on the courts and the child welfare system in their attempts to protect children and assist families, especially those

with substance abuse problems. The emphasis on achieving permanency for children within the federally mandated timeframes accelerates the need to find effective responses to substance abuse and child maltreatment within families.

Under ASFA, the judge must decide at various points in the court proceedings whether the agency made reasonable efforts, in light of the child's current and future health and safety needs, to prevent removal, provide adequate services to reunify the family, or diligently locate and secure an alternate permanent placement for the child. The final ASFA regulations, published by the US Department of Health and Human Services (HHS) in 2000, also clarify application of the law's provisions. By shortening timeframes for court and child protection agency action, ASFA sets high goals for dependency proceedings. Specific provisions that affect courts include:

- Clarification of the reasonable efforts requirement that emphasizes children's health and safety as the "paramount concern" in decisions whether reasonable efforts should be made to reunify families. It permits concurrent efforts to place a child for adoption or with a legal guardian while reasonable efforts to reunify are underway.
- ASFA also includes certain situations in which services to prevent foster placement and reunify families are not required. These include if the parent has: subjected the child to aggravated circumstances as defined by state law (e.g., abandonment, torture, chronic abuse, sexual abuse); committed or aided or abetted murder or voluntary manslaughter of a sibling; or committed a felony assault resulting in serious bodily injury to a child or a sibling. States are free to include other aggravated circumstances in which reunification would not be required. When a court finds that reasonable efforts are not required, ASFA mandates a permanency hearing be held within 30 days. The Act also requires reasonable efforts to find a permanency placement once the decision that reunification is no longer the goal for the child is made.
- Permanency hearings must be held within 12 months of the child's entry into foster care (i.e., from the first judicial finding of abuse or neglect or 60 days after the child's removal from the home, whichever is earlier). The court must make a permanent placement decision at this hearing. The available permanency options, in order of preference, are reunification, adoption, legal guardianship, placement with a fit and willing relative, or another planned permanent living

arrangement. The ASFA regulations clarify that the court may order reunification as the permanent plan at this hearing if the parents have been diligently working toward reunification and reunification is expected in a time frame consistent with the child's developmental needs.

- For children who enter state care, states must initiate or join termination of parental rights proceedings if the child has been in foster care for 15 of the most recent 22 months or is found to be abandoned. The agency must begin the adoptive family search and approval process when it files the termination petition. Exceptions to the TPR provision apply when a relative is caring for the child, the agency documents compelling reasons why termination would not be in the best interests of the child, or services necessary for safe return of the child are required but have not been provided.
- While any of these exceptions may apply in cases involving parental substance abuse, the compelling reasons exception in particular may apply when a parent is making measurable progress in substance abuse treatment and reunification appears likely within a short timeframe. Compelling reasons not to file a termination petition must be made on a case-by-case basis considering the individual circumstances of the child and family and must be documented in the case plan. In addition, the exception relating to unavailability of services may be particularly relevant given the reported shortage of effective and appropriate substance abuse treatment options.
- Foster parents, preadoptive parents and relatives caring for children are entitled to notice and opportunity to be heard in all reviews and hearings. However, they need not be made parties to the action.
- Other changes in case plan and review requirements mandate that case plans and six-month reviews ensure that child safety is specifically addressed. Also, when the permanency plan is adoption or placement in another permanent home, case plans must document the steps the agency is taking to find an adoptive or permanent home, place the child with the adoptive family, legal guardian or other permanent home, and finalize the adoption or guardianship.

ASFA in Practice

Before ASFA, uncertainty about the meaning of reasonable efforts and a common belief that reasonable efforts had to be made in every case for the sole purpose of reunification resulted in children remaining in the foster care system for years. ASFA seeks to overcome this perception by clearly stating that there are exceptions to the reasonable efforts requirement. This provision acknowledges that there are certain

circumstances in which no efforts to preserve or reunify a family will ever be reasonable in light of the severity of the abuse. Thus, the court should inquire at each hearing whether any of these conditions, as listed under state law, apply. If they do and the judge determines no reasonable efforts are required, the court must hold a permanency hearing within 30 days and the agency must make reasonable efforts to place the child in accordance with the new permanency plan, including placing the child for adoption or with a legal guardian.

In keeping with this provision of ASFA, state responses to parental substance abuse have focused on outlining situations in which reasonable efforts for reunification would not be mandated. Although some state statutory language, such as Alabama's, provides that reasonable efforts are not necessary simply based on parental substance abuse (Ala. Code Sec. 12-15-65(m)(1), the majority of provisions concerning parental substance abuse only negate the reasonable efforts requirement when the parent has been a chronic abuser of drugs who has already failed to make appropriate progress in a treatment program.

For example, California requires that the parent's use of drugs or alcohol be "extensive, abusive, and chronic" and that the parent resisted treatment in the previous three years or previously failed or refused to comply with a drug or alcohol treatment program at least twice even when a program was available and accessible (Cal. Welf. & Inst. Code Sec. 361.5(b)(13). Similarly, Ohio requires that the parent have "rejected treatment two or more times or refused to participate in further treatment two or more times" after a case plan requiring substance abuse treatment was made part of a court order. Ohio's statutory language also mandates that reasonable efforts to reunify can

only be suspended if parental substance abuse has resulted in “substantial risk of harm [to the child] two or more times due to alcohol or drug abuse” (Ohio Rev. Code Sec. 2151.414(D)(9)).

Case law related to the reasonable efforts requirement and substance abuse has often dealt with the provision in many state statutes that no reasonable efforts are necessary when the parent’s rights to another child were involuntarily terminated. Several states have upheld such aggravated circumstances provisions as constitutional. For example, in *State ex. rel. Children, Youth & Families Department v. Amy B.*, 61 P.3d 845 (N.M. App. 2002), the court upheld statutory provisions that did not require the agency to provide reunification services when a mother’s parental rights to the child’s two older siblings had been involuntarily terminated based on the mother’s substance abuse and continued failure to respond to services.

In New Jersey, the Superior Court ruled that the Division of Youth and Family Services was not required to provide reasonable efforts in a case involving a history of parental physical abuse, substance abuse and domestic violence. *In re Guardianship of B.L.A. and T.A.*, 753 A.2d 770 (N.J. Super. 2000). Furthermore, the parents’ rights to five other children had been previously terminated. Notable about this case is that the Court ruled that it was not an attempt to improperly give retroactive effect to ASFA despite the fact that the precipitating events occurred prior to its effective date, but rather that the public interest in protecting the welfare of the children outweighed the parents’ rights.

Implications for Substance-Using Parents

ASFA provisions have obvious implications for substance-abusing parents. For instance, ASFA requires that a permanency hearing to determine a child's permanent placement be held 12 months after a child has entered foster care (which runs from the date of adjudication or 60 days from the child's removal from the home, whichever is earlier). This leaves 14 months, at most, for a parent to succeed under a case plan before a permanency plan must be determined. For parents battling substance abuse, the 12-month time frame for the permanency hearing is significant. The treatment reality is "a day at a time for the rest of your life," with critical long-term supports needed (Young, 2004; DiNovo, 2003). One or more relapses are common. As a result, the time frame imposed by ASFA poses numerous challenges for the courts, substance abuse treatment providers, and addicted parents.

It is essential that agencies work to ensure prompt provision of substance abuse treatment services, as there has historically been insufficient capacity for parents who are ready to get help. The short time frame also increases the need for court systems to ensure close judicial supervision, coordination, and accountability by the providers of services to families in crisis.

Substance Abuse and Specific ASFA Provisions

HHS responded to concerns from the field about the time needed for parents to successfully address substance abuse issues in its commentary to the federal regulations on ASFA. The commentary stated that reunification can continue as the permanency plan if the parent is complying with the established case plan, making significant measurable progress toward achieving the goals established in the case plan, and

diligently working toward reunification. This approach acknowledges that relapse may be a common occurrence in treatment; however, the child's safety must still remain paramount.

ASFA also contains a requirement that the child protection agency file or join a termination of parental rights petition in certain circumstances, including if a child has been in foster care 15 of the last 22 months. One exception is that the agency has documented compelling reasons that TPR would not be in the best interests of the child. A substance-abusing parent who is complying with and making substantial progress towards the goals in the case plan and diligently working towards reunification may fall under the compelling reasons exception. Another exception may be that the agency did not provide appropriate services. Identifying the extent to which this exception is used when substance-abusing parents are not given the treatment they need would identify barriers to permanency for children and enlighten child welfare policy and practice under ASFA.

However, aside from California's stipulation that reasonable efforts are not necessary if the parent resisted treatment even when a program was available and accessible (Cal. Welf. & Inst. Code Sec. 361.5(b)(13), little statutory language seems to address the ramifications of parental compliance with substance abuse treatment or procedures for dealing with termination of parental rights when treatment services have not been available. Instead, in the statutes that address the issue, chronic substance abuse and resistance to treatment are considered grounds for termination of parental rights.

For example, Illinois considers "habitual drunkenness or addiction to drugs, other than those prescribed by a physician, for at least one year immediately prior to the

commencement of the unfitness proceeding” to indicate parental unfitness (Ill. Stat. Ch. 750 Sec. 50/18.5(D)(k). Illinois also stipulates that a rebuttable presumption of parental unfitness exists when a child is born with “any amount of a controlled substance” in his “blood, urine, or meconium...the presence of which in the newborn infant was not the result of medical treatment administered to the mother or the newborn infant” and when “the biological mother of this child is the biological mother of at least one other child who was adjudicated a neglected minor.”

Rhode Island also uses parental substance abuse as an indication of unfitness, stating that termination of parental rights can be granted when “the parent has a chronic substance abuse problem and the parent’s prognosis indicates that the child will not be able to return to the custody of the parent within a reasonable period of time, considering the child’s age and the need for a permanent home” (Rhode Island Stat. Sec. 15-7-7(a)(2)(iii). However, this finding must be made even following “the reasonable efforts which shall be made by the agency prior to the filing of the petition to encourage and strengthen the parental relationship” (Rhode Island Stat. Sec. 15-7-7-(b)(1).

The complexity of child welfare proceedings is evident through much of the case law addressing substance abuse and ASFA. Many of the reported appellate decisions relate to termination of parental rights. For instance, an Ohio court upheld the grant of permanent custody of a child who tested positive for cocaine at birth to the county department of children and family services when, among other things, the mother failed to seek treatment of substance abuse and the father failed to attend periodic drug screenings or complete a drug and alcohol assessment. *In re I.M.*, WL 23010024 (Ohio App. 8 Dist.).

Another case that keenly illustrates the complexity of these issues involved the termination of parental rights supported by clear and convincing evidence that termination was in the children's best interest. This finding was due to the parents' historical inability to provide for the children as a result of their significant and longstanding substance abuse histories and failure to comply with agency recommendations and court orders for services. Neither parent completed a drug rehabilitation program or secured stable housing. However, on appeal, the court ruled that although the termination was supported by clear and convincing evidence, a remand was required for further evaluation of the parents, who had progressed in their substance abuse rehabilitation efforts, and for consideration of any changes regarding a grandparent's previous commitment to adopt. *NJ Division of Youth and Family Services v. P.P. and S.P.*, 852 A.2d 1093 (N.J. 2004).

Although it presents many challenges, the intent behind ASFA is to find permanent homes for children in foster care. Anecdotal evidence from existing family drug courts suggests that even parents who might otherwise be considered "lost causes" are able to successfully complete a program of early and intensive treatment and reunify with their children (McGee, 2001). Nevertheless, ASFA demands that the child's health and safety always be considered paramount. Courts and related system-wide services must implement innovative approaches to help substance-abusing parents stabilize their lives and maintain their families.

ICWA and ASFA

The Indian Child Welfare Act (ICWA) imposes additional requirements on courts when the child is of Native American origin. These requirements may pose special

challenges as courts seek to comply with timeframes set by ASFA. In 1978, Congress enacted the Indian Child Welfare Act (25 U.S.C. Sec. 1901 et. seq.) to reverse the trend of removing Indian children from their tribes when they became involved with the child welfare system. ICWA provides a number of procedural safeguards to protect Indian children, and ASFA cannot be read to interfere with them (Laver, 2002). States must still provide notice to tribes of custody proceedings involving a member of that tribe, transfer jurisdiction to tribal courts when requested, make *active* efforts to prevent removal and reunify the family, and follow ICWA placement preferences. The child welfare agency must be careful to follow ICWA's requirements while also meeting ASFA's mandates. In *Stanislaus County Community Services Agency v. Shantina D.*, 2002 WL 454307 (Cal. App. 5 Dist.), the appellate court reversed a trial court's denial of reunification because the court had failed to comply with ICWA's notice requirements, although evidence supported the finding that reunification was not in the child's best interests.

Although ASFA relieves a state or tribe from making reasonable efforts under certain circumstances, it does not prohibit such efforts from being made. Thus, making active efforts under ICWA (which are generally seen as more rigorous) on behalf of an Indian child to prevent placement or reunify the family would not conflict with ASFA. In fact, the Supreme Court of South Dakota held that ASFA did not relieve the social services agency of any duty under ICWA to provide active efforts to reunite a child with his father. *People in the Interest of J.S.B., Jr.*, 691 N.W.2d 611 (SD 2005). The court stated that while the presence of aggravated circumstances could eliminate the need to provide reasonable efforts, it did not remove the requirement to provide active efforts for reunification under ICWA. The court affirmed the termination of the father's rights as

warranted, however, because the child had been removed from his parents custody for substance abuse related neglect three times and had spent the majority of his life in foster care, and the parents continued to abuse substances. Thus termination was the least restrictive alternative available and in the best interests of the child.

In addition, one of the exceptions to filing a TPR under ASFA is when a child is placed with a relative. This would be consistent with ICWA placement preferences and may apply in the case of an Indian child placed with extended family. Because Indian culture broadens the definition of family, preserving families under ICWA is not always the same as preserving parental rights (Laver, 2002). Finally, ICWA does not have any permanency hearing requirements, and so ASFA timeframes govern. However, the permanency planning decision would need to meet the substantive requirements of ICWA (Shaening, et al., undated), i.e., active efforts, notice to tribes and placement preferences.

CHAPTER 3

PROJECT METHODOLOGY

Mail Survey of Judges

We developed a mail survey for judges who handle dependency cases (child abuse, child neglect, and foster care). To encourage completion, we kept the survey short (could be completed within 15-20 minutes) and largely closed-ended with check-off answers and few open-ended questions. Issues addressed include: (a) what has been the impact of ASFA on handling children in dependency courts whose parents are substance abusers; (b) how are dependency court judges handling such cases under ASFA; (c) what training have judges had on handling such cases under ASFA; (d) how quickly do they get feedback from substance abuse providers on how parents are progressing in treatment in ASFA cases, and how often do privacy barriers prevent such feedback; (e) to what extent do they coordinate with substance abuse providers in cases in which client children are involved in dependency court cases; (f) what obstacles do they face in meeting the requirements of ASFA while giving substance-abusing parents the time to recover, and how are they attempting to overcome those obstacles; and (g) are they doing anything special to handle dependency cases under ASFA when parents have serious substance abuse problems (a copy of the Mail Survey is attached in Appendix A).

Selecting the mail survey sample. Using the National Association of Counties (NACO) database, we randomly selected a proportional population-based county sample. We selected more large-size than small-size counties (since more cases are heard in large courts than small courts, and we wanted the survey to reflect how most cases are being handled throughout the sample). We randomly sampled counties as follows:

- Population 1,000,000+: 30 counties, sampled 100%
- Population 500,000-999,999: 72 counties, sampled 50%
- Population 250,000-499,999: 115 counties, sampled 50%
- Population 100,000-249,999: 278 counties, sampled 50%
- Population 50,000-99,999: 384 counties, sampled 50%
- Population 25,000-49,999: 641 counties, sampled 14%
- Population 10,000-24,999: 869 counties, sampled 14%
- Population 5,000-9,999: 390 counties, sampled 14%
- Population 5,000 or less: 287 counties, sampled 14%

Once the county was sampled, we contacted the Court Improvement Project (CIP) director in each of the states to find out which courts hear dependency matters, as we reasoned they would be in the best position to identify both judges and innovative courts. After the court was identified, we either used the court's web site to randomly select one judge per court to survey; if a court web site was not available, we asked the CIP director to identify which judges hear these cases and then randomly selected one judge. We mailed out just over 800 surveys and tracked responses. Ten percent of judges indicated they did not hear dependency cases, and an additional 4% of the surveys were returned as "addressee unknown" at that address. Therefore, we sent an additional 98 surveys to replace those judges. We mailed a second survey to those judges who did not respond to the original survey. We received surveys from 317 judges, a 40% response rate.

Follow-Up Telephone Surveys with Judges Who Responded to the Mail Survey

The mail survey was intended to be short and provide a snapshot of how courts are meeting the requirements of ASFA in relevant cases in which parents are substance-dependent. To obtain a more detailed view of the strategies being implemented, we followed up with an open-ended telephone survey of 60 judges who indicated they had a special approach to handling dependency cases under ASFA when parents have a serious substance abuse problem, using an interview protocol.

Conducting Telephone Surveys with Professionals Involved in Dependency Cases in Which Parents Are Substance Abusers

We needed to hear from more than judges to understand how various agencies within communities are responding to substance-abusing parents whose cases are being heard in dependency courts under ASFA requirements. In more than one dozen communities, we followed up with other professionals who are involved with these families; these contacts were recommended by the judge.

Within these communities, we interviewed key individuals who had been initially identified during the telephone calls with the judges. The list was expanded in a “snowball” fashion as we spoke with professionals in the communities. We interviewed the key players who varied by community and included, for example, substance treatment providers, child welfare agency staff, parent’s attorneys, agency attorneys, drug court personnel, and so on.

The community-wide telephone surveys were open-ended and intended to gain a broader perspective of what is happening in cases in which children are in dependency court and their parents are substance abusers. The interview protocol asked (a) why they developed the innovative approach to these cases; (b) what did it take to implement the innovative approach; (c) what successes/setbacks they encountered in implementing the approach; and (d) what advice would they give to others who want to replicate their approach. We also asked if they had (a) data available on the outcome of substance-abuse related dependency cases, including compliance with ASFA; (b) relevant materials relating to implementation procedures, training, and case law developed for use in substance abuse-related cases as a result of ASFA; (c) data available on the outcome of these cases, including success rates for completion of treatment, relapse data, and length

of treatment; (d) any pamphlets, descriptive materials, or other publications that explain the processing of substance-abusing parents whose children are in dependency court; and (e) other materials that described their approach to these cases.

These phone surveys served two purposes. First, we used the information to illustrate approaches communities are taking (see Chapter 5). Second, the community-wide surveys helped us identify five sites for case study.

Case Studies

Five sites were recruited for on-site case studies. The site studies are exploratory, consisting of process evaluations, and are based on interviews with multiple professionals representing court and agency personnel in each jurisdiction. To the extent possible we also directly observed the processing of dependency cases. The three-to-five day site visits allowed us to obtain the perceptions of child protective services, state's attorneys, parent's attorneys, treatment providers, and judges who handle dependency cases. The site reports were reviewed by representatives in each of the five sites for accuracy, and approved for inclusion in this Report.

Site selection criteria included:

- jurisdictions that have different approaches to handling children whose parents are substance abusers in dependency courts;
- different court structures for handling substance abuse-related dependency cases;
- communities in diverse regions of the country;
- variously sized communities and courts;
- communities with different economic, racial, and ethnic compositions; and
- a willingness to participate in the case study.

Within each of the communities selected for study, we interviewed a wide range of professionals handling dependency cases involving parental substance abuse.

Depending on how these cases are handled, the number, and composition, of the

informants varied, but we tended to interview 3-4 head administrators and/or supervisors and held several small focus group interviews with line workers. Key interviews were determined when setting up the site visit and included judges, substance treatment providers, child welfare agency staff, parent's attorneys, agency attorneys, drug court personnel, etc.

We interviewed supervisors and line staff from pertinent agencies. It was important to gather the perspective of head administrators (such as the director of a substance abuse program, CPS foster care supervisors, the administrative judge, etc.) as well as those doing the day-to-day work (e.g., CPS caseworkers, treatment staff workers, drug court case managers, etc.). Those "in the trenches" may have very different perspectives than those administering programs and different questions are appropriate for administrators versus line staff. The nature of the interviews varied depending on how dependency cases under ASFA were handled. Illustrative questions for administrators overseeing innovative approaches to these cases included:

- What is your approach to these cases?
- Why did you start your approach? What had been your experience in handling cases prior to ASFA and after ASFA in cases of children in dependency court whose parents are substance abusers?
- When did your approach begin? Who spearheaded it? Who needed to be "on board" to make it work?
- What resources were needed to start, and maintain, your approach? Where did they come from?
- What are you trying to accomplish with your approach? What are the goals? How have they changed over time? How do you measure whether they are being achieved?
- What challenges did you face in implementing your approach? What challenges do you still face? How have you responded to challenges? What successes have you experienced?
- What unexpected results emerged from your approach?
- What advice would you give to others who want to replicate your approach?

Sample questions for line staff included:

- What responsibilities do you have in working with cases in which children of substance-abusing parents are in dependency court?
- What challenges do you face in these cases? What have you done to overcome these challenges? How successful have you been?
- What do you see as the primary obstacles to doing your job in these cases? What is needed to handle them better?
- What are the unmet needs of children and their parents in these cases?
- What suggestions do you have to improve the response to these cases?

During site visits, and where appropriate, we also: (a) directly observed case processing involving parental substance abuse (e.g., dependency court hearings, pretrial conferences), following strict confidentiality procedures by signing confidentiality agreements; (b) reviewed a sample of case files (respecting confidentiality); (c) collected relevant materials relating to implementation procedures, training, and case law developed as a result of ASFA; and (d) collected any statistical reports on case outcomes involving substance-abusing parents, including success rates for completion of treatment, relapse data, and length of treatment; and any pamphlets, or other publications that explain the processing of substance-abusing parents whose children are in dependency court. Following each site visit, a site study report was prepared containing the results of the interviews, observations, and any data, protocols, rules, procedures, pamphlets, and other information available from the site related to substance-abusing parents whose children are in dependency court under ASFA regulations. These site reports were reviewed and approved by representatives from the jurisdiction studied.

CHAPTER 4

RESULTS FROM THE MAIL SURVEY WITH JUDGES

Respondents

The vast majority of the judges who responded to the mail survey (95%) handle dependency cases in addition to other cases. Only 5% exclusively handle dependency matters (Table 1). (Note: Table 1 and all subsequent Tables may be found at the end of this chapter.) Over what other types of case do they preside? In descending order of frequency, they hear cases involving juvenile delinquency (94%), domestic relations (67%), other civil matters (62%), criminal matters (62%), related family cases (43%), and “other” matters, for example, traffic, probate, child support, protective orders for domestic violence cases, and general jurisdiction (34%) (Table 1). Clearly, the judges distribute their time over a wide variety of cases.

Most of the judges (46%) have been hearing dependency cases for 4-11 years; 31% have 12-15 years or more of experience; and 23% have 3 years or fewer hearing dependency cases (Table 1). For 77% of the judges, their assignment to dependency cases is “indefinite”; 29% have “other” assignment lengths (such as indefinite and rotational, rotational and other, two-year commitment, four-year commitment); and 4% hear these cases on a “rotational” basis (Table 1).

Training on ASFA Issues

ASFA contains many provisions that judges need to understand and which training can help foster. Over three-quarters of the judges have received training on ASFA issues. Most (85%) said the training changed how they handle cases. Still, 82% responded that they would benefit from additional ASFA training (Table 2).

Training on Substance-Abusing Parents

Judges reported receiving less training on substance-abusing parents than on ASFA issues. Almost three-quarters of the judges have received training on substance-abusing parents. Of those who were trained, 76% said that training changed how they handle cases. Due to the brief nature of the survey, we were not able to probe in what ways training changed practice. For example, did it encourage them to change practices which were not in compliance with the law? As with the ASFA training, many judges indicated they would like further training on substance-abusing parents. Over four-fifths said they would benefit from additional training (Table 3).

Obstacles Encountered in Meeting ASFA Timeframes When the Child's Parents are in Substance Abuse Treatment

ASFA requires judges to move children out of foster care and into safe and permanent placements as quickly as possible. The emphasis on achieving permanency for children within the federally mandated timeframes accelerates the need to find effective responses to substance abuse and child maltreatment within families. While ASFA accelerates timeframes, parents may need more time to treat their substance abuse habits; treatment programs may be unavailable, especially for parents without financial resources; waiting lists may be long; and/or meaningful feedback from treatment providers may be nonexistent. Do ASFA timeframes create obstacles in treating parents with substance abuse problems? We gave judges a list of potential obstacles to meeting the timelines required by ASFA when parents are in substance abuse treatment. Most judges checked many of the listed obstacles. Only 12% said they encounter no obstacles. What are the most common difficulties?

- Insufficient treatment resources available for parents, 80%

- Substance abuse recovery takes more time than ASFA timeframes allow, 65%
- Lack of effective programs for dually diagnosed patients, 65%
- Costs of treatment programs, 65%
- Waiting lists for services, 64%
- Not enough treatment programs to meet local needs, 63%
- Not enough treatment programs, 56%
- Court needs to provide more intensive or continuous supervision of these cases, 37%
- Court intervention needs to be sooner in the process, 29%
- Difficulty in obtaining meaningful information from providers, 25%
- Poor quality of treatment programs, 24%
- Statutory constraints resulting from ASFA, 23%
- Not enough treatment programs for non-English speaking parents, 20%
- Not enough treatment programs that are culturally sensitive, 19%
- Other reasons, including, transportation, high recidivism, budget limitations, delay in getting early assessment, programs where children can be placed with the other, and parents don't want to change (Table 4)

Knowledge of Professionals Involved in the Dependency Case Process About How Substance Abuse Affects Ability to Parent

There are a number of key professionals involved in processing dependency cases. We asked judges how knowledgeable seven different professionals are about the effect of substance abuse on parenting. They were given the option of responding “very knowledgeable,” “knowledgeable,” “somewhat knowledgeable,” or “not knowledgeable.” Not every court has all of the seven professionals inquired about (e.g., some do not have CASAs or nonattorney GALs); therefore judges did not answer regarding professionals with whom they have no experience. If they left it blank for whatever reasons (i.e., they do not have that type of professional or they left it blank as they had no opinion), it was treated as missing data and the “n” adjusted to only those who expressed an opinion. Thus, caution is advised in making sweeping generalizations.

Who did they rate as the most knowledgeable? Judges responded that the following professionals are “very knowledgeable” or “knowledgeable”: child protective

workers (73%), agency attorneys (70%), attorney GALs (66%), children's attorneys (63%), CASAs (61%), parent's attorneys (56%), and nonattorney GALs (48%) (Table 5).

Knowledge of Professionals Involved in the Dependency Case Process About How Substance Abuse Affects Recovery Process

In general, judges thought the seven categories of professionals were somewhat less knowledgeable about how substance abuse affects recovery than the topic discussed above. Some judges did not answer all sections of this question and thus there are missing data that should trigger caution in interpreting these data. Again, child protective workers and agency attorneys were given the highest scores and parent's attorneys and nonattorney GALs were given the lowest. "Very knowledgeable" or "knowledgeable" ratings were given to child protective workers (64%), agency attorneys (61%), children's attorneys (55%), CASAs (55%), attorney GALs (53%), parent's attorneys (48%), and nonattorney GALs (42%), according to the judges (Table 6).

Indian Child Welfare Act (ICWA)

During the mail survey, just over half of the judges (52%) said they never had an ICWA case (Table 7). Of those who have had such a case, 40% (n=60) said ICWA posed special challenges. Because so many judges said ICWA posed challenges, we attempted to survey each of these judges by telephone to learn more about their perspectives. Of the 60 attempted contacts, five were eliminated (3 judges were retired and 2 were part of the five case studies and thus were already interviewed). Of the 55 judges eligible for telephone survey, we interviewed 44, an 80% completion rate. Judges reported a variety of challenges posed by ICWA. For some, the challenges were seen as obstacles that bore no productive outcome. Therefore, some judges concluded that ICWA is a "waste of time." Others said ICWA posed few, or no challenges, or said that despite any

challenges, ICWA has a positive impact as it results in case resolutions in the best of the child.

The follow-up telephone survey was open-ended to allow judges to relate their unique experiences with ICWA cases. Some judges had presided over only one of these cases over the past year, or several years, while others see these cases on a daily or weekly basis. Therefore, we tailored our interview to accommodate their history in handling ICWA cases.

Frequency of ICWA Cases. Among the 44 judges, some had very little experience with cases in which ICWA is raised while others saw these cases fairly routinely. We categorized them as “rarely” having cases in which ICWA is raised if they saw such cases only once, twice, or a few times a year, or if they said these cases represented less than 5% of their cases. Nearly half (48%) of judges said they “rarely” see these cases; over one-fourth, 27%, “sometimes” see such cases (i.e., 5-10% of their cases involve ICWA), and one quarter (25%) “often” preside over cases in which ICWA is raised (i.e., ICWA applies in over 10% of their cases).

Because the frequency with which judges hear dependency cases in which ICWA is raised varied so widely, the questions asked were different. Therefore, we were not able to tally the responses. Rather, we reviewed the interviews to identify common themes. During the interviews, we tried to focus on the impact of ICWA in dependency cases in which parents are substance abusers, but most judges could not answer the questions with that qualification. Thus, their answers reflect all cases in which ICWA is raised.

Notification. If the child has Indian blood, ICWA requires the court to notify the appropriate Tribe. This can be difficult, because the appropriate Tribe may be hard to identify or difficult to reach, especially when the Tribe is loosely organized. Negative comments raised by judges regarding notification were: it is time-consuming or difficult to locate Tribes; Tribes are slow to respond; Tribes do not want to get involved; notification is a waste of time, and parents raise the issue of Tribal heritage only as a ploy to delay cases. On the positive side, judges responded that notification of the Tribe is no problem; notification is no problem if the process begins early in the case, and Tribes are well organized, so notification is easy. Comments included:

- ICWA “is a good idea, but in practice it requires too much paperwork and lost time;” ICWA takes an “insanely high amount of time.”
- “Notification is a hassle. It is hard to track down the Tribe;” “I see no positive effects of ICWA. It just slows the process down and the Tribe does not do anything.”
- ICWA is “a waste of taxpayer’s money;” “we spend a lot of money notifying Tribes, but I am not sure to what effect as we don’t get much back.”

Appearance. We frequently heard that the physical distance to the Tribe is problematic; often it is located many miles away, making it difficult for the Tribe to send a representative. Other challenges raised were: the Tribe changes its designee from hearing to hearing leading to a lack of consistency; and the Tribal representative does not have to be a lawyer and the representative does not understand the law. However, some judges said the Tribal representative’s appearance is helpful in deciding how to resolve the case. Positive and negative comments were:

- Appearance by Tribal representatives is “no problem; the Tribal attorney appears in court. That causes some scheduling issues as we have to fit the Tribal attorney’s schedule into ours, but it is not a big problem.”

- The Tribe provides “insight into family and cultural issues and makes appropriate recommendations.”
- ICWA “slows down the process but that is not a bad thing; the Tribes have programs we do not have in the county.”
- “Untrained Indian representatives don’t understand the law and there are no resources to train them. There needs to be joint training on ICWA for child protective services, the state’s attorneys, and the Tribal representatives.”

Resources. A number of judges said that the Tribes do not have any resources to help children or parents in dependency cases; the Tribes are too far away to help; and/or the Tribes limit their services to Tribal members. One judge summarized it as “the Tribe has nothing to offer.” Other judges noted a number of resources Tribes bring to bear in dependency cases, such as:

- The Tribes have “culturally sensitive programs.”
- The Tribal representative was “very helpful” in finding kinship care.
- The Tribe provides foster care, which is not available in enough homes within the community.
- The “special programs among the Tribe are helpful. We don’t have enough foster care parents. Indian children are placed with Indian foster care parents. That is good for the child.”
- “The Indian mental health and health services are good.”
- “Some Tribes have resources and have families to place the child with. The Tribe may be able to work with resistant parents to see they have a substance abuse problem and provide treatment.”
- “ICWA brings in more resources and more information. It has resulted in greater family involvement, because Tribal issues bring a focus on the extended family. Also, the Tribe has more substance abuse and other resources to help than is available in our county.”

Tribal Politics. Some judges raised the issue of Tribal politics as a challenge. Issues that emerged included in-fighting among Tribes as to who has rights to the child, turn-over among Tribal judges is frequent, and the skill of the Tribal judges is mixed.

Legal Standards. A few judges complained that the legal standards of ICWA are much higher than those required by state laws. ASFA itself does not address the burden of proof, so each state's own law governs. ICWA requires a "preponderance of evidence" to remove the child whereas state law generally requires "probable cause." Termination of parental rights under ICWA requires evidence "beyond a reasonable doubt," while state laws require "clear and convincing" evidence. A few judges thought this leaves Indian children at greater risk of harm from their parents, because they are not removed from their care.

Feedback to Court from Treatment Provider

In order for courts to respond knowledgeably to parents who are in substance abuse treatment and make informed decisions about termination of parental rights, it is important for them to get feedback from providers in a helpful and timely way. We asked five questions concerning feedback from treatment providers. First, do judges receive feedback from service providers on a parent's treatment progress? Over three-quarters (77%) said yes. Among those who do not receive feedback, 69% said such feedback would be helpful.

Feedback is given via a written report (87%), in person (40%), by having the provider attend court hearings (26%), or by phone (7%). "Other" mechanisms were named by 13%, including, for example, team meetings (Table 8).

Receiving feedback is not enough. The feedback has to be helpful to do any good: 69% of the judges said the feedback is “usually” helpful, 29% said “sometimes” helpful, and just 2% thought the helpfulness of the feedback given by treatment providers is “not very” useful (Table 8).

What obstacles exist to providers giving feedback to the court on the parent’s progress in treatment? Some judges (16%) said there were no obstacles, but most checked a number of obstacles we inquired about. As reflected in Table 9, they named the following in descending order of frequency:

- confidentiality concerns of treatment providers, 47%
- resource problems, 43%
- concerns by providers that the patient’s trust will be compromised, 29%
- concerns by providers that the information will be used punitively against their client, 16%
- perception of treatment providers that their feedback will not make a difference in case handling, 6%

Resources

How many of the judges have targeted resources/mechanisms for cases in which children have parents identified as substance abusers? Over half (58%) responded affirmatively (Table 10). That means a substantial number (42%) do not have resources. For those who have targeted resources or mechanisms, what are they (Table 11)?

- Multidisciplinary teams, 63%
- Case manager, 51%
- Prehearing meetings/conferences, 41%
- Task forces, 32%
- Family drug courts, 29%
- Special training for judges on these types of cases, 29%
- Joint training among disciplines that includes:
 - judges, 25%
 - substance abuse treatment providers, 25%
 - attorneys, 17%
 - others, 5%

- Targeted prevention programs to:
 - treat substance-abusing parents, 64%
 - treat children who are substance abusers, 49%
 - help children from becoming substance abusers, 34%
 - help children cope with substance-abusing parents, 26%

- Other resources/mechanisms, such as court counselors, interdisciplinary training, training, and CASA, 9%

Special Approaches to Cases in Which Parents Are Substance Abusers

Over three-quarters (77%) of the judges said their court does not have special approaches to cases in which parents are substance abusers (Table 12).

Conclusion

Very few judges exclusively handle dependency cases. Most judges have received training on ASFA issues but fewer judges have been trained on substance abuse issues. Many obstacles were acknowledged as interfering with meeting ASFA timeframes when the child's parents have substance abuse disorders. Most common were insufficient treatment resources for parents; substance abuse recovery takes more time than ASFA timeframes allow; lack of effective programs for dually diagnosed patients; cost of treatment programs; waiting lists for services; and not enough treatment programs. Generally, judges thought the professionals appearing before them in dependency court were knowledgeable about how substance abuse affects the ability to parent and how substance abuse affects the recovery process. Rated most knowledgeable were child protective workers and agency attorneys, and least knowledgeable were parent's attorneys and nonattorney GALs.

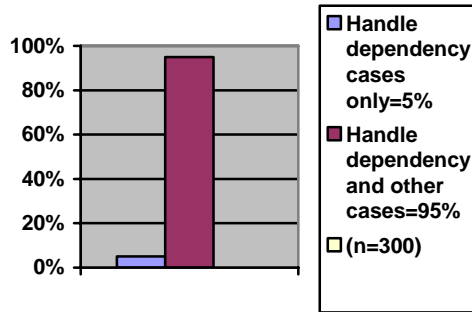
Feedback from treatment providers on the parent's progress was commonplace and generally helpful. But a number of obstacles inhibit feedback, most notably confidentiality concerns of treatment providers and resource problems. More than one-

half of the judges said resources are a problem in treating parents who are substance abusers. When resources or special mechanisms are available, they commonly include multidisciplinary teams, case managers, or prehearing meetings or conferences.

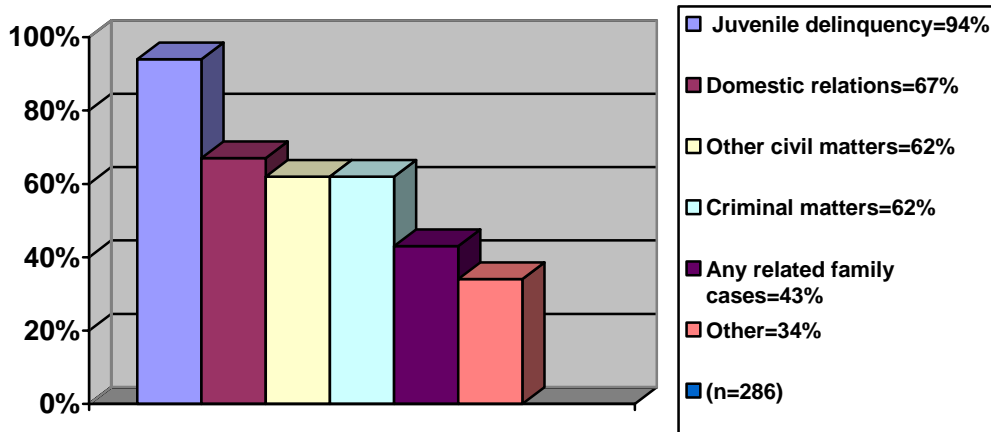
Despite the prevalence of parents in dependency court who have serious substance abuse problems, over three-quarters of the judges said their court does *not* have special approaches to cases in which parent are substance abusers.

**TABLE 1
SURVEY RESPONDENTS**

TYPE OF JUDICIAL ASSIGNMENT IN DEPENDENCY COURT



TYPE OF OTHER CASES HEARD



NUMBER OF YEARS HEARING DEPENDENCY CASES

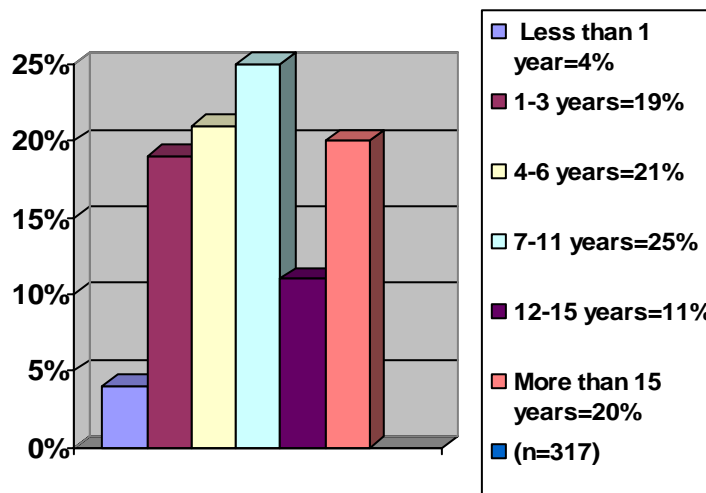


TABLE 1 (continued)
LENGTH OF JUDICIAL ASSIGNMENT TO DEPENDENCY CASES

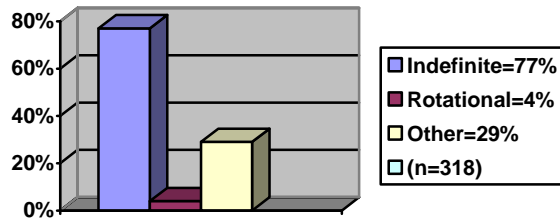
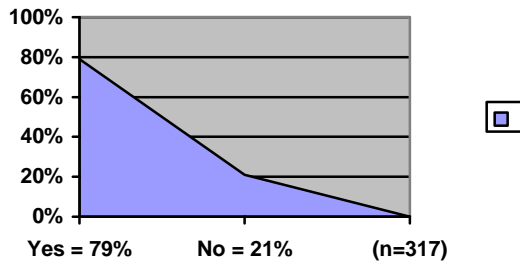
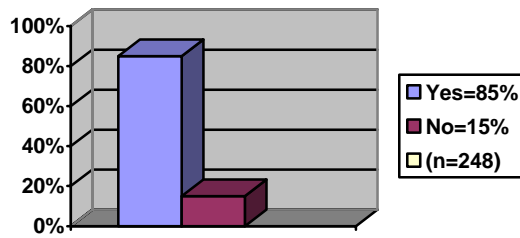


TABLE 2
TRAINING ON ASFA ISSUES

RECEIVED TRAINING



DID TRAINING CHANGE HOW THEY HANDLE CASES?



WOULD THEY BENEFIT FROM ADDITIONAL TRAINING?

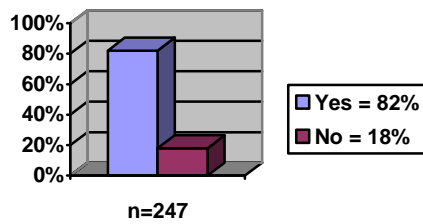
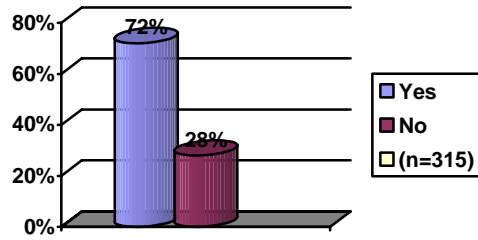
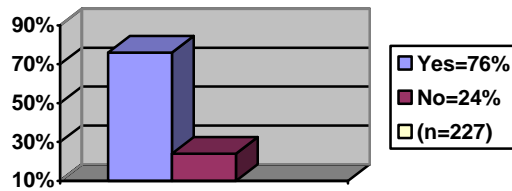


TABLE 3
TRAINING ON SUBSTANCE ABUSING PARENTS

RECEIVED TRAINING?



DID TRAINING CHANGE HOW THEY HANDLED CASES?



WOULD THEY BENEFIT FROM ADDITIONAL TRAINING?

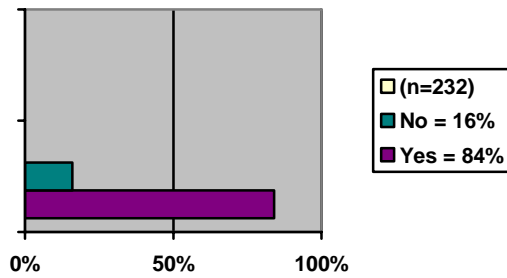


TABLE 4
OBSTACLES ENCOUNTERED IN MEETING ASFA TIMEFRAMES
WHEN THE CHILD’S PARENTS ARE IN SUBSTANCE ABUSE TREATMENT

No obstacles	12%	(n=318)
Insufficient treatment resources available for parents	80%	(n=318)
Substance abuse recovery takes more time than ASFA timeframes allow	65%	(n=318)
Lack of effective programs for dually diagnosed patients	65%	(n=318)
Costs of treatment programs	65%	(n=254)
Waiting lists for services	64%	(n=254)
Not enough treatment programs to meet local needs	63%	(n=254)
Not enough treatment programs	56%	(n=254)
Court needs to provide more intensive or continuous supervision	37%	(n=318)
Court intervention needs to be sooner in the process	29%	(n=318)
Difficult in obtaining meaningful information from providers	25%	(n=318)
Poor quality of treatments programs	24%	(n=254)
Statutory constraints resulting from ASFA	23%	(n=318)
Not enough treatment programs for non-English speaking parents	20%	(n=254)
Not enough treatments programs that are culturally sensitive	19%	(n=254)

TABLE 5
KNOWLEDGE OF COURT PARTICIPANTS
ABOUT HOW SUBSTANCE ABUSE AFFECTS ABILITY TO PARENT

	KNOWLEDGEABLE?				
	VERY	YES	SOMEWHAT	NO	
Child protective workers	23%	50%	24%	3%	(n=313)
Agency attorneys	21%	49%	26%	3%	(n=299)
Parent’s attorneys	14%	42%	39%	5%	(n=311)
Children’s attorneys	15%	48%	32%	5%	(n=294)
CASA	17%	47%	31%	5%	(n=196)
Attorney GALs	19%	47%	28%	6%	(n=176)
Non-attorney GALs	13%	35%	45%	7%	(n=83)

TABLE 6
KNOWLEDGE OF COURT PARTICIPANTS
ABOUT HOW SUBSTANCE ABUSE AFFECTS RECOVERY PROCESS

	KNOWLEDGEABLE?				
	VERY	YES	SOMEWHAT	NO	
Child protective workers	17%	47%	30%	5%	(n=299)
Agency attorneys	16%	45%	33%	5%	(n=285)
Parent's attorneys	11%	37%	46%	6%	(n=294)
Children's attorneys	12%	43%	37%	8%	(n=283)
CASA	13%	42%	37%	9%	(n=185)
Attorney GALs	13%	40%	38%	9%	(n=167)
Non-attorney GALs	12%	30%	51%	7%	(n=76)

TABLE 7
SPECIAL CHALLENGES WITH ASFA AND ICWA PROVISIONS

DO THE PROVISIONS OF THE INDIAN CHILD WELFARE ACT (ICWA) POSE ANY SPECIAL CHALLENGES IN COMPLYING WITH ASFA GUIDELINES?

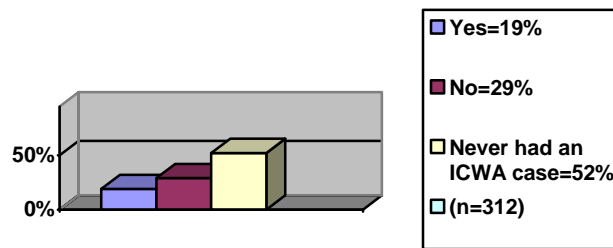


TABLE 7 (continued)

IF HAD ICWA CASE: DO THE PROVISIONS OF THE INDIAN CHILD WELFARE ACT (ICWA) POSE ANY SPECIAL CHALLENGES IN COMPLYING WITH ASFA GUIDELINES?

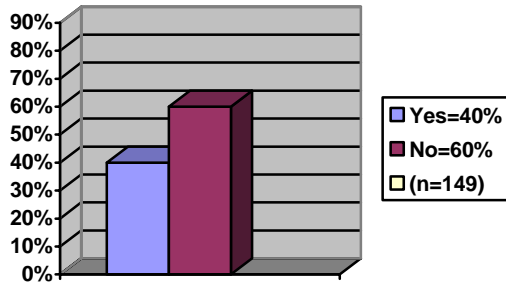
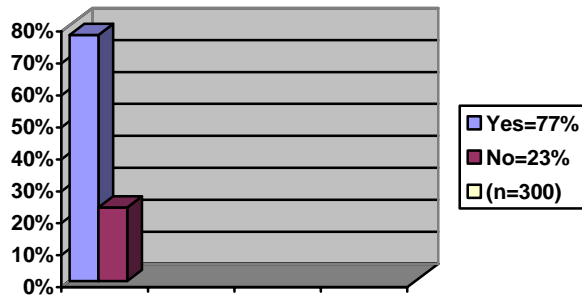


TABLE 8
FEEDBACK TO COURT FROM TREATMENT PROVIDER

FEEDBACK GIVEN BY TREATMENT PROVIDER?



IF FEEDBACK IS NOT GIVEN BY TREATMENT PROVIDER, WOULD IT BE HELPFUL?

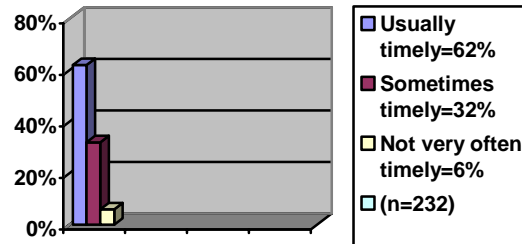


TABLE 8 (continued)

HOW FEEDBACK IS GIVEN BY TREATMENT PROVIDERS



TIMELINESS OF FEEDBACK



HELPFULNESS OF FEEDBACK



TABLE 9

OBSTACLES TO PROVIDING FEEDBACK TO COURT

None	16%
Confidentiality concerns of treatment providers	47%
Resource problems	43%
Concerns by providers that the patient's trust will be compromised	29%
Concerns by providers that the information will be used punitively against their client	16%
Perception of treatment providers that their feedback will not make a difference in case handling	6%
Other obstacles	16%
	(n=318)

TABLE 10

**TARGETED RESOURCES FOR CASES IN WHICH CHILDREN
HAVE PARENT(S) IDENTIFIED AS SUBSTANCE ABUSERS**

HAVE TARGETED RESOURCES OR MECHANISMS?

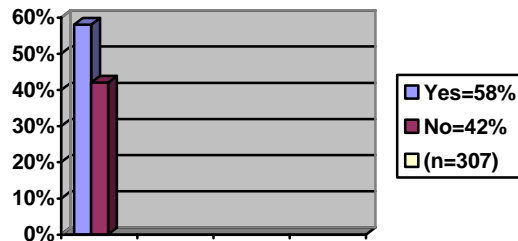
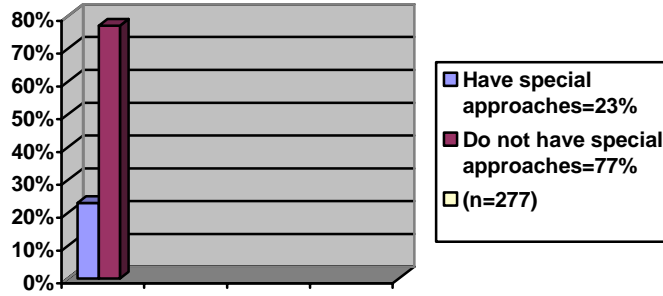


TABLE 11**TYPE OF TARGETED RESOURCES OR MECHANISMS**

Multidisciplinary teams	63%
Case manager	51%
Pre-hearing meetings/conferences	41%
Task forces	32%
Family drug courts	29%
Special training for judges on these types of cases	29%
Joint training among disciplines that includes...	
Judges	25%
Substance abuse treatment providers	25%
Attorneys	17%
Others	5%
Targeted prevention programs to help children from becoming substance abusers	34%
Treat children who are substance abusers	49%
Help children cope with substance abusing parents	26%
Treat substance abusing parents	64%
Other resources/mechanisms	9%
	(n=177)

TABLE 12
SPECIAL APPROACHES TO CASES IN WHICH PARENTS ARE SUBSTANCE ABUSERS



CHAPTER 5

RESULTS FROM TELEPHONE SURVEYS

The telephone surveys were conducted to find out more about strategies and approaches being used to respond to parents who are substance abusers whose children are in dependency court. We made phone calls to over 60 judges and 12 community members identified through the mail survey as doing something special to address these cases. First, we called the judge who completed the mail survey to discuss their approach. If they suggested we contact someone else in the community to provide more details, we phoned the person(s) they suggested.

We found a wide range of approaches to meeting ASFA timelines in cases in which parents are substance abusers. In some instances a single change in doing business as usual was made, but most involved two, or more, strategies undertaken to improve the response to parents who are substance abusers while protecting the safety of children within the mandates of ASFA.

Although we were specifically interested in hearing about approaches particular to handling cases in which parents are substance abusers, we found that many courts and communities have adopted strategies to comply with ASFA in *all* cases rather than developing an approach limited to substance-abusing parents. Given the prevalence of dependency cases in which parents have substance abuse problems, it makes sense to change how they respond to all cases rather than developing a separate approach to these type of cases. Therefore, during the phone surveys we learned a lot about how they respond to dependency cases generally, as well as some specific approaches used to address the substance abuse issue. We report both here, because much can be gleaned

from strategies used to comply with ASFA as well as those for substance-abusing parents. Among the strategies reported, we uncovered the following:

- early and frequent case reviews, particularly during the first six months, which can stimulate early provision of services and also keep the various agencies actively providing services and accountable,
- strict monitoring of court orders,
- multidisciplinary team approaches with representatives of the various agencies involved to discuss the case, exchange information on it, and work together to address parents' needs,
- comprehensive, holistic approaches to cases for children and parents,
- extensive child assessments,
- use of mediation to identify and develop agreement on issues in the case, including jurisdiction, placement for the child, conditions with which the parent must comply, etc.,
- the use of family conferencing for identifying issues, family resources, potential actions to pursue, as well as the case plan,
- the use of Treatment Alternatives for Safe Communities (TASC), traditionally a criminal case management/referral service, for providing case management capabilities for dependency cases,
- enhanced representation by parent's attorneys and parent's caseworkers, and
- the use of Family Drug Courts set up to secure, fashion, and monitor the treatment of substance-abusing parents.

EARLY AND FREQUENT CASE REVIEWS

Many judges reported that they have established expedited case hearings to strictly enforce ASFA timelines. Some said they establish even tighter timelines than ASFA requires to move cases along with due speed so children do not languish in the system. Frequent, early, and strict monitoring is especially important when parents are substance abusers, because getting them into treatment early increases the likelihood they

can be treated within ASFA timelines. In addition, parents are more likely to be motivated to obtain treatment when the shock that they may lose their children sets in.

Many courts expedite hearings to meet ASFA timelines and to identify and expeditiously treat parents with serious substance abuse problems. We provide a few examples.

Blue Earth, Minnesota: Judge Smith

Blue Earth is 85 miles west of Minneapolis. Three judges cycle through the court. One judge hears dependency cases every three weeks on the Master Calendar; those cases then become part of their individual calendar so the family sees one judge.

Blue Earth is part of the Minnesota Children's Justice Initiative spearheaded by Chief Justice Kathleen Blats in collaboration between the Minnesota Supreme Court and the Minnesota Department of Human Services (DHS). It is federally funded. The project is designed for the state Supreme Court and DHS to work closely with the juvenile courts, social services departments, county attorneys, public defenders, court administrators, guardians ad litem (GALs), and other key stakeholders in each of Minnesota's 87 counties to improve the processing and outcomes of child protection cases.

The five-year project began in December 2000 with 12 pilot counties; 16 additional counties were added in March 2002, including Blue Earth. In 2003, the plan was revised to include the remaining 60 counties by Spring 2004.

In Blue Earth, Judge Smith said they focus aggressively on accelerating services to families in dependency court to meet the mandates of ASFA and Minnesota rules,

especially for children under the age of eight, as they only have six months to place the children in these cases.

They hear the emergency protective case hearing within one-two days and immediately start working on what services the family needs. If there is a drug problem, they try to get the parent to sign an “Admit or Deny Petition” at that hearing. Within one week, they hold a Pretrial Conference among the litigants (the judge is not there) to decide what services are needed. If the parent admits to a substance abuse problem, the appropriate service provider is called to the court to meet with the parent and work out a service plan. Thus, the parent is not left to maneuver the system by themselves to call the provider and get services. Judge Smith believes it critical to “strike while the iron is hot” to move the parent into services and to take the burden off the parent to negotiate the service system. Since parents are in crisis, they are not in the best position to actively pursue help. In the past, it often took months for the parent to even get the evaluation done, much less get into treatment, which is not an option under the tight ASFA and Minnesota timeframes.

The judge convinced CPS that treatment services need to be provided quickly. Judge Smith said there was no way they could meet federal and state timelines if “we continued to do business as usual.” He gave an example of what he called a “garbage house” case. Within a day, CPS arranged to get a dumpster out there; cleaning materials were purchased; community service workers (defendants who had been sentenced to community service as part of their sentence) cleaned the house; inspectors were on standby to inspect. As a result of this proactive approach, the children were returned to the home within a week. This saved the state “thousands of dollars” and helped convince

everyone that an expedited approach is the way to go. Once the Director of Social Services saw the money that was saved, he became convinced of the efficacy of early involvement. Public defenders resisted at first, as they see their job as keeping their clients out of the system. When they saw results in terms of quick reunification, however, their resistance dissipated. In addition, parents were able to seek services and admit a substance abuse problem “without prejudice,” which also appealed to public defenders.

They have made “good progress” but Judge Smith believes they have not “gone as far as we need to go.”

Lancaster, California: Judge Valerie Skeba

This is a very rural county (population 250,000), 60 miles outside of Los Angeles. Judge Skeba has been on the bench for five years and is the only judge in Lancaster hearing dependency cases. She hears about 800 cases per year.

Although the law does not require it, Judge Skeba sets court dates every three-12 weeks in order “to keep on top” of things. The Judge employs a negative/positive sanctioning/rewarding approach. She rewards parents who are doing well with more frequent visits with their children, and penalizes those not doing well by ordering less frequent, or supervised, visits. Judge Skeba decides how often to review a case based on her “trust” in the social worker, in addition to how well the parent is doing. If she believes the social worker is diligent in providing services, she does not hear the case as often as when she is concerned about the diligence of the social worker.

They had a problem with some clients not being able to obtain free drug testing by the state because they did not have a valid California driving license or identification

(ID). Without an ID, drug testing was being delayed for six-eight months. Judge Skeba decided to issue her own ID so these clients could get tested. It has only been a challenge in a handful of cases but her creativity solved that problem.

The Department is most interested in a certificate from a treatment agency that shows the parent has graduated successfully, but the Judge trusts her own instinct as to whether the parent has changed and accepts successful progress in Narcotics Anonymous (NA) or Alcoholics Anonymous (AA), as well as more structured treatment programs.

Genessee County, New York: Judge Eric Adams

Genessee initiated a program in 2003 to address what they identified as the biggest challenge in dependency cases with substance abuse and/or mental health issues. The problem was that the case would be adjourned until the parent was screened and assessed. Sometimes a month would go by without an assessment. It regularly took six-eight months to get the parent assessed. Also, there were lots of challenges with Department of Social Services staff turnover. Judge Adams spearheaded meetings between the Genessee County Counsel of Substance Abuse Associations (GENCASA) and the county mental health association and asked for input and advice.

There is now one person from each (GENCASA and mental health) who acts as the court's contact person and as liaison to service providers. The GENCASA liaison sits in the court one-two afternoons per week, and is available daily by phone. The liaison can usually screen the parent on-site; if not, they set an appointment right then for an off-site screening. They also make all appointments for assessments, and track/monitor to see that the appointments take place. GENCASA then reports back to the judge, who puts the appointment on his calendar and contacts the attorneys. This usually happens

right at the beginning of the case. The liaisons are on the payroll of GENCASA and Mental Health. The Model Court Attorney-Coordinator also coordinates with the liaison.

STRICT MONITORING OF COURT ORDERS

Merely expediting court hearings is not enough. Court orders need to be complied with for the case to move forward. While all courts strive to monitor the enforcement of orders, we include a description of two courts that have made a special effort.

Geauga, Ohio: Judge Charles E. Henry

The Judge developed a special order five years ago that details requirements and conditions of the court's rulings so that all parties and service providers clearly understand what is required and what the timeframe is to accomplish the orders. The order is issued when court hearing is held, which must be within 90 days of the petition's filing. Job and Family Services monitors compliance with the order. The order holds people accountable for their actions, which has solved a persistent problem of a lack of compliance with court orders. While there are no statistics to document success, Judge Henry has seen much more accountability and more clear-cut delineation of everyone's respective responsibilities since he instituted the order.

Bowie, Texas: Judge William C. Martin III

This is a rural area in which the senior Judge travels a circuit, sitting in eight different counties over a 10-day period. The Texas Department of Court Administration (DCA) provided him with an "order maker" to ensure the orders he issues are signed and distributed to all parties at the end of each hearing. This establishes clearly what is

expected and the timeframes for performance so that supervision and compliance can begin immediately.

Prior to the “order maker,” orders were piling up and were not signed or issued for weeks or months. Then the DCA designed the “order maker” to relieve general jurisdiction court judges of having to oversee these cases, particularly important in light of ASFA timelines and an increasing volume of cases being filed. Although he has no data to document the success of the new orders, he has observed that the orders (a) encourage early case planning; (b) communicate to parties what is required immediately following hearings; and (c) result in dependency cases coming to the court’s attention much earlier in the process.

MULTIDISCIPLINARY TEAM APPROACH TO CASES

A number of courts employ multidisciplinary teams (MDTs) to handle the multiple challenges often present in dependency cases. One example is Kansas.

Leavenworth, Kansas: Judge Robert Bednar

Kansas statute KAS Sec. 38-1523.a permits the court’s appointment of multidisciplinary teams to investigate, address, and plan for services in cases of youth/families in need of services in a wide range of neglect and abuse situations. Leavenworth has been using multidisciplinary teams for three years. These multidisciplinary teams (MDTs) include several representatives from the school district, including school psychologists; CASA representatives; several lay people who are not involved in court or school (e.g., Postmaster, United Way, etc.); the county attorney’s office; court services; community corrections; State Department of Rehabilitative

services; and medical personnel. The court appoints members of the team and the team determines who will serve as the team leader.

COMPREHENSIVE APPROACH TO CHILDREN AND PARENTS

MDTs are one way to put together a comprehensive approach to cases. Another way is for a social worker to assume responsibilities for obtaining services for parents to address all type of issues, including substance abuse problems. This is how it is done in Meade, South Dakota.

Meade, South Dakota: Judge Jerome A. Eckrich

A social worker is designated to meet with parents immediately after a hearing to review services. They started this approach in September 2003. They received a \$10,000 grant from the state Administrative Office of the Court (AOC) to provide a one-stop shopping service for parents in the dependency process to promptly link them with services and make arrangements for their delivery. They implemented this program because they recognized that parents often do not have the persistence, savvy, or transportation necessary to obtain services. The social worker has an office in the courthouse where litigants are sent to immediately arrange for services and provide other assistance to promote their attendance in services. The social worker has a cell phone, a laptop computer, and all the forms necessary to apply for services. The social worker sets up meetings, arranges transportation, provides gas vouchers, etc. The social worker also arranges for a urine analysis to be done immediately across the street at the community corrections center.

This approach removes a big issue at the TPR hearing – were services made available by the agency? They have seen a big improvement in getting parents into

treatment earlier. Because the approach has been deemed a success, Children and Family Services have taken over the program.

MEDIATION

Mediation is gaining ground as one avenue to resolving issues between parents, the child welfare system, and the courts to achieve permanency for children. Mediation formalizes structured negotiations involving all stakeholders (attorneys for agency, CPS, parents, caseworkers, and other interested parties, such as relatives). Mediation's goal is to find a mutually acceptable approach to conflict that considers everyone's interests. The mediator is a trained facilitator with no stake in the case decision.

In some jurisdictions, mediation is accomplished among professionals only; in others, parents are included in sessions after the professionals have met. Mediation may be accomplished in several stages and varies in communities around the country.

Common features include:

- preparation by mediator to learn the case particulars,
- introduction of mediator and explanation of the role of the mediator and mediation,
- statements of the problems faced by each participant,
- direct discussion between parties, guided by the mediator,
- mediator synthesizes issues and problems identified by the parties,
- suggestions and options offered by parties to address problems,
- written agreement of terms, signed by parties, and
- agreement stipulated in court.

Mediation may be pursued pre-filing, pre-trial, or at any point in the case.

Unresolved cases remain on the court docket. Purported advantages of mediation include: expedited case processing, need eliminated for contested hearings, cost savings of fewer contested hearings and trials, empowerment of parents and family members, and enhanced buy-in and cooperation of parents. Mediated issues may include: whether the

parents are assessed for alcohol/drug use; developing treatment or service plans; whether the child needs to be removed from the home; custody; visitation; resolution of intra-family cooperation; support of children's service needs while in foster care; or a decision of whether the case should be closed. Mediation may or may not include jurisdiction and termination of parental rights, depending on state law or local practice. Decisions of which cases are assigned to mediation are left to individual jurisdictions, which develop their own set of criteria.

Mediation is not universally accepted in child welfare case decision-making. Concerns may be raised about: fully protecting the best interests of the children during negotiations; the inherent power imbalance between parents and professionals; and whether the child was or was not neglected or abused is not an issue for mediation.

Here are two examples of communities that use mediation.

Payne, Oklahoma: Judge Robert M. Murphy, Jr.

Payne, OK has a number of strategies to provide intensive services, case management, support, and supervision of dependency cases. They bring in a wide range of multidisciplinary services, including attorney representation and mediation; try for kinship placements if at all possible so that the child remains in a family situation and retains family relationships; schedule hearings weekly if necessary to review case progress and address issues that emerge; use a comprehensive family-based service delivery system that sends homemakers into the home to teach and work with the parent on basic home management functions; and uses mediation. In this section we discuss the mediation component of their approach.

In Payne, they have used mandatory mediation for all cases involving children for about four years. They saw the success that Landlord/Tenant mediators were having and went to them to recruit their best mediators. However, they recognized that they needed to understand the dynamics and issues of dependency cases; therefore, mediators are very well trained in dependency issues.

They schedule mediation at the time of the shelter care hearing. Mediation takes place 30 days out. That gives the agency time to develop a plan. They may also have a follow up mediation if the mediators think it appropriate. All issues are mediated, including jurisdiction, placement, treatment, conditions, services, and any other issues that the parties bring up.

Many people coming into the dependency court process are distrustful of the court system, so the mediation provides a nonthreatening and constructive opportunity for participants and others (relatives, etc.) to participate in addressing the issues. They have been getting very positive feedback from family members and from the community.

Umatilla, Oregon: Judge Rudy Murgo

For the past four years, the Umatilla Circuit Court has used mandatory mediation for all cases involving children. They schedule the mediation at the time of the shelter care hearing. It was modeled after the mediation for divorce cases Judge Murgo instituted when he was the presiding judge. Mediators are very well trained in dependency issues. Mediation takes place 30 days after shelter care to give agencies time to develop a plan. All issues are mediated – jurisdiction, placement, treatment, conditions, services, and any other issues raised by the parties. A follow-up mediation is scheduled if the mediator thinks it appropriate.

Judge Murgo has been getting very positive feedback from family members and from the community. Mediation is seen as a noncoercive process by which participants can engage in developing a viable treatment plan.

COMPREHENSIVE CHILD ASSESSMENTS

Children who appear in dependency courts may suffer from a variety of challenges resulting from their abuse or neglect. Marion, Ohio serves as an example of a juvenile court that pays attention to the developmental progress of the child.

Marion, Ohio: Judge Pamela Abernathy

Judge Abernathy feels it is critical to conduct a developmental assessment of each child from the start of the case and to build the results of this assessment into the case plan. She is very concerned about the lack of adequate screening of children in dependency cases, for developmental and cognitive problems, fetal alcohol issues, as well as the frequent lack of integrated substance abuse and mental health services. Because Judge Abernathy felt social workers were concentrating more on assessments of parents than children, she made it a requirement that a child-centered assessment plan be conducted for each child involved in the dependency caseload.

FAMILY CONFERENCING

Family Group Decision Making (FGDM) (or Family Group Conferencing, FGC) involves families in making decisions to protect and ensure safety for the abused/neglected children. As with mediation, Family Group Decision Making/Family Group Conferencing has different faces around the country. In general, the approach allows the family to define itself, and include extended family members; respects what the family knows about its members and the best approaches to safety for the children;

empowers the family to make their best decisions and to be accountable for those decisions; and acknowledges the support and strength of communities. The approach assumes that empowerment of the family will translate into “buy in” to permanency plans, thereby ensuring the children’s service plans will be adhered to, and the children ultimately placed safely. Participation in FGDM is voluntary in some jurisdictions and mandatory in others. The caseworker refers the family to FGDM.

Once the family is signed on to FGDM, the coordinator makes preparations. The coordinator, like the mediator, is an unbiased professional. The coordinator works with the family ahead of time to identify “family resources,” including immediate and extended family members, those who live far away, and those people who are “like family.” The coordinator contacts all family resource people to invite them to the conference, and uncover unresolved issues. The coordinator selects an appropriate site for the meeting, and makes all logistical decisions.

When the meeting is convened, the coordinator introduces all the participants, and lays out the meeting process, participant roles, and goals, to which all members agree. The primary goal is to ensure a safe environment for the child. The strengths of the family are identified. At this time, family members may meet for “alone time,” without professionals or nonfamily members, to discuss what the family can do to care for and protect the child. The plan is then reviewed by the larger group, and strengthened by addressing unmet needs. It is then accepted by all participants, including the caseworker, and may be presented to the court as well. Follow-up meetings may be scheduled regularly or as needed, when family situations change, to ensure safety for the child.

FGDM may reduce the number of children in non-relative foster care, as children who leave their home may move in with appropriate extended family members. FGDM also may provide the caseworker with more family members to contact for assistance, and with community support systems as well.

Adair, Missouri uses FGDM (as does Tarrant County, Texas, and Allegheny County, Pennsylvania, which were selected as case studies; see Chapters 7 and 8).

Adair, Missouri: Judge Russell E. Steele

This family-centered approach is a pilot project instituted under the auspices of the state AOC and entails having a multidisciplinary team of service providers meeting with the family early in the process to review the situation, determine what needs to be done and develop a plan to achieve these goals in a nonadversarial setting. The team includes GALs, counselors, and other service providers, as necessary, to perform case management, review problems, and discuss goals; the judge does not participate.

The family-centered approach entails an in-group setting review every 30 days and then at court every 90 days (they are statutorily only required to review cases once a year). The approach includes case management and periodic staffings involving family and other supporters who can be their advocates. More frequent court hearings promote greater accountability of all the agencies and participants. Traditionally, activity occurred because there was a court hearing. This approach moves activity up front and tries to get services and other necessary action beginning much earlier in the process. It also resulted in approaches being sustained because of earlier and continuous court review.

The Judge believes their approach results in children being returned to home and permanency plans being implemented more quickly. This is because it is easier for the court to determine whether unification is viable. Traditionally, most activity occurs right before the hearing. Now with more frequent hearings, more things are happening up front, and service plans are developed early on. Therefore, permanency goals, with reunification whenever possible, are achieved more quickly.

TREATMENT ALTERNATIVES FOR SAFE COMMUNITIES (TASC)

TASC was initiated in 1972 to assist criminal offenders break their drug/alcohol addictions, and prevent future crimes. Beginning in the 1980s, TASC began expanding their services to juvenile justice clients, welfare recipients, pretrial detainees, drug court participants, public housing residents, and child welfare families (both children in the System of Care initiative, and parents in the Recovery Coach Program). There are currently more than 200 TASC programs in the U.S., including a statewide initiative in Illinois. TASC programs typically provide: assessment of substance use/dependence; placement into appropriate treatment; monitoring of progress; and reporting to courts.

We include the Cook County, Illinois program as one of our five case studies (see Chapter 9). During the telephone interviews, we had the opportunity to learn about other courts using TASC.

Rowan, North Carolina: Judge Beth Dixon

In 2003, Judge Dixon secured services from TASC to conduct a substance abuse assessment/evaluation of litigants in dependency cases for which it appears substance abuse may be the primary problem. TASC provides drug testing, case management and supervision to provide the Court with more accountability regarding both services being

provided and participants' progress. The Judge turned to TASC because she saw the need for regular, random drug screens to detect recurring use. Before TASC, she ordered service by "any state approved agency," but since no specific agency was designated, accountability was difficult to achieve. No formal evaluation has been done, but Judge Dixon has seen greater accountability, both in terms of services provided and participants' compliance.

ENHANCED REPRESENTATION OF PARENTS

The state's representation can sometimes be much stronger than the parent's representation in dependency court. Benton, Washington has addressed this issue.

Benton, Washington: Judge Lonna K. Malone

Benton, WA has a pilot project designed to put the parent's representation on equal par with the state's representation. They accomplish this through the addition of more panel attorneys, more caseworkers for parents, and service providers to assist parents. Their program ensures that parents meet regularly with their attorney and their caseworker; makes them aware of available services; and makes sure they receive adequate services. Judge Malone believes that adding resources for parents results in (a) the prevention of court delays; (b) better case preparation; and (c) quicker resolution of cases.

The program has been reviewed by the National Council of Juvenile and Family Court Judges (NCJFCJ), "Improving Parent's Representation in Dependency Cases: Washington State," August 2003. They found that the program has sped up the timeframe needed to resolve cases and better compliance with ASFA.

FAMILY DRUG COURTS

Family drug courts have emerged in response to the growing awareness that traditional responses to parental drug addiction often do not work well. These courts are designed to address the needs of families involved in the child welfare system where parental substance abuse is a factor. Under the supervision of a judge, family drug courts offer intensive drug treatment intervention and supportive services, within a structure of sanctions and incentives.

The family drug court concept has components similar to adult and juvenile drug courts. Although the court processes may look different from jurisdiction to jurisdiction, family drug courts generally share the following characteristics:

- **Judicial Leadership.** The civil court judge takes a leadership role in working with the parent of a child in a dependency, abuse or neglect case. Over time, the judge develops a relationship with the parent that is part authoritative, part supportive. Only the judge has the power to invoke immediate sanctions and rewards in these cases.
- **Goal of Reunification.** The goal of the court is to provide intensive treatment and service delivery to reunite the child with the parent in a safe and healthy environment.
- **Intensive Treatment Services.** The court helps the addicted parent become emotionally, financially, and personally self-sufficient and develop parenting and “coping skills adequate for serving as an effective parent on a day-to-day basis.”
- **Interdisciplinary Team Involvement.** The team assesses the treatment and service needs of the parent and provides intensive supervision. Substance abuse treatment and other rehabilitative services are the result of a collaborative effort between the courts (including judges and attorneys for parents and children and agencies), social services caseworkers, law enforcement agencies, drug and alcohol treatment providers, and other counselors and service providers.
- **Early Identification and Eligibility.** Identification and eligibility criteria determine which cases are appropriate for immediate drug court intervention. Drug court participation in a civil dependency case requires the parent to sign a waiver that acknowledges the imposition of sanctions without a “show cause” hearing, following noncompliance with the treatment plan. Eligibility

determinations include assessing the “degree of addiction” and whether addiction requires court intervention and treatment.

- **Judicial Monitoring of Progress.** Progress and compliance are monitored and supervised by the judge, with input from the team. Treatment providers, caseworkers, and other service providers report on the participants’ progress to the court.
- **Rehabilitation of Parent.** Treatment and rehabilitative service programs are developed to meet the parents’ needs. Parents in these cases are often multiply disadvantaged; drug addiction is only one of their problems. Services for the parent, therefore, offer a range of supports in addition to drug and alcohol programs.
- **Agreement to Program Conditions.** The parent signs a contract outlining the conditions of program participation.
- **Sanctions and Incentives to Ensure Compliance.** Relapses are expected and addressed immediately. While judges can anticipate setbacks in addiction recovery, a graduated system of sanctions, delivered immediately, may jump-start the recovery process. Contempt powers are available to mandate jail time for noncompliance with a treatment plan, although incarceration is often used in conjunction with other incentives. Judges also provide incentives for compliance with family drug court requirements. Reunification with one’s child is the strongest motivator for compliance. Other incentives include progressing through the phases to less-frequent urinalyses and court appearances; positive reinforcement and encouragement; dismissal of any criminal charges; and more frequent visitation with children.
- **Program Completion and Follow-up.** The family drug court is generally a one-year program commitment, with up to six months aftercare often available. The judge determines the need for, length, and specifics of aftercare services.
- **Reunification Following Successful Completion.** If the parent successfully completes the treatment program, and takes advantage of other services (parenting classes, employment counseling, therapy, housing assistance), reunification with her or his children is possible. If the parent declines treatment, the case is litigated in the traditional manner.

San Diego, CA is included as one of our five case studies as an example of a family drug court (see Chapter 10).

CHAPTER 6

HALIFAX COUNTY, NORTH CAROLINA (NC)

Halifax County is a rural county, with a population of approximately 60,000. The racial composition is 55% African American, 45% Caucasian, and 5% other races, including Asian, Indian, Hispanic and Native American. The population is small, but the total area in the county is large: Halifax County is the third largest county in the state, with an area of 2,000 square miles. It is the fourth poorest county in North Carolina.

Currently, there are 100 children in the Department of Social Services (DSS) custody in Halifax County. In 65% of the cases, one or both parents have a substance abuse problem identified as the primary or secondary reason for the dependency action. Most common substance abuse problems are cocaine, crack cocaine, marijuana, and alcohol.

Judge H. Paul McCoy, Jr., Chief District Court Judge, presides over all juvenile cases in Halifax County. He is also the Chairman of North Carolina's Court Improvement Project. Halifax County is one of nine Family Court Districts in North Carolina and was one of the original pilot sites because of its strong judicial leadership and having practices in place consistent with the principals of a Unified Family Court. The Unified Family Court handles juvenile and domestic matters in one court and utilizes the one family/one judge case assignment system. The Court began five years ago in Halifax County with \$75,000 from the state of North Carolina to pay operational costs and hire a Family Court Administrator who would also serve as Domestic Case Manager. A Juvenile Case Manager was added in 2004 with federal grant funds.

A key component of the Juvenile Court is the Child Planning Conference. They believe the best way to expedite cases is to get everyone together early to talk about the case and begin services. Under the old system, it took 30-60 days at the Adjudication Hearing before everyone became aware of the issues in the case and began to seek a resolution. At the Child Planning Conference, they attempt to obtain a Memorandum of Agreement that may lead to a Stipulated Adjudication, if possible; or, if not, to agree on as many points as possible. Following the Child Planning Conference, they go into the courtroom to appear before the judge who reviews the agreement, or hears contested issues, and makes a determination. The next court date is set at that time, which is within seven days after this conference. This is sooner than required by ASFA rules and is intended to fast-track the cases.

Child Planning Conference

Child Planning Conferences are held Monday mornings within seven days of when a nonsecure custody order has been entered, resulting from a petition filed by the Halifax County DSS. Most often, the Conference occurs within three days of the issuance of the nonsecure custody order. There are five objectives:

1. To bring all the key parties together, including the Facilitator (the Juvenile Case Manager serves in this role); the DSS attorney; the DSS caseworker; the DSS foster care worker; the parents; friends or family members of the parents; the minor child (if the child is 13 or 14 and wants to come to the Conference); the parents' attorneys; a mental health provider; a substance abuse treatment provider; the Guardian Ad Litem (GAL) attorney; the GAL Supervisor; and if appropriate, a school representative (for example, if there is a need to transport the child from their temporary placement to the school in the district where they use to live—the intent is to limit as much disruption as possible in a child's life) and a health department nurse who offers prenatal services and general health assessments.
2. To reduce the adversarial nature of the court process by emphasizing that everyone is there to help the family (a video is shown to parents to stress that point and explain the process—see below); parents' attorneys told us that they

- believe the Child Planning Conference setting helps parents see that everyone wants to help them reunite with their children.
3. To identify relatives who may accept placement of the minor children until reunification can be secured or adoption determined; the preference is to place the children with a relative or friend rather than a stranger, as they believe this is less traumatic for the children.
 4. To establish visitation (supervised initially and unsupervised, if supervised visitation goes well) with children who have been placed outside the family.
 5. To determine what services the family, the children and parents need to reunify the family, including substance abuse treatment, mental health treatment, educational programs, job training, etc.

Observation of a Child Planning Conference

We observed a Child Planning Conference. Present were the juvenile case manager, DSS foster care supervisor, DSS foster care caseworker, DSS supervisor, DSS investigator, the DSS attorney, the GAL attorney, the GAL supervisor, the mother and her attorney, the mother's father (who is grandfather of the other three children the mother gave up for adoption), the father, and the father's attorney. The Conference was conducted in a small room (used for jury deliberations) in the courthouse.

Most of the participants at the Child Planning Conference already had a copy of the DSS report; those few who did not received a copy at the Conference. Everyone in the room was required to sign a Confidentiality Agreement that they would not disclose what was said during the Child Planning Conference.

The DSS attorney summarized the allegations in the DSS report. The case involved a three-month-old boy who was placed in foster care six days earlier. He was initially placed with his grandparents, but they were not able to care for the infant. The grandparents were already raising three of the boy's siblings (who they had adopted following a TPR determination). They just could not take on the responsibilities of

another child. Prior to the removal of the child, the baby boy had been in the temporary custody of the father. Six days earlier, DSS received a report that the baby boy was being neglected. The reporter told DSS that the father had left the baby boy outside a crack house on one occasion and by the side of the road on another. According to the temporary custody agreement, the father was not supposed to have contact with the mother while caring for the child, due to her alleged drug abuse. The reporter told DSS that the father violated that agreement on several occasions by bringing the baby boy to the mother's residence, and the mother left the baby unattended. As a result of the neglect report, DSS removed the baby six days prior to the Child Planning Conference.

DSS's recommendations were that: (1) the baby boy remain in DSS custody in his current foster care placement; (2) relative care placement be pursued; (3) supervised visits with both parents be arranged; (4) both parents receive drug and mental health evaluations (the mother and father were given assessments immediately following the Child Planning Conference, which was possible as the Mental Health Assessment provider was at the Child Planning Conference); and (5) they plan for reunification. The parents agreed during the Child Planning Conference and signed the Memorandum of Agreement after conferring with their attorneys. At the Child Planning Conference, the parents were also asked to list possible relative care placement options.

Following the 25-30 minute Child Planning Conference, the parties assembled in the courtroom before Judge McCoy. The Judge explained to the parents what was going on in a very respectful manner, using plain language, telling them that:

- The DSS report contains allegations not yet proven as facts and they would have the chance to dispute those allegations at later hearings.

- The law requires courts to reunify families whenever possible and the court would provide services to help them reunify. He explained, however, that he had an obligation to notify them of the “worst case scenario”—if the allegations are proven to be true and if resources are not successful in resolving the problems they have within the next 11 months, TPR and adoption may be necessary: “while that is the worst that can happen, it is not the goal of this court.”
- Relative care is the preference, and DSS would check out the people they nominated and do a Kinship Care Assessment to see if they were in a position to care for the baby.
- They needed to watch the videotape “The Choice is Yours” when they were done in court before they left the courthouse.
- The next court date would be April 28 (13 days later).
- The mother would have a chance to participate in the Family Treatment Court. He explained that the Family Treatment Court is a voluntary court that helps with drug abuse treatment, transportation, education, and job training. He said she might find the Family Treatment Court helpful but it does involve giving up certain rights (e.g., the court can mandate drug testing at any time) and, therefore, she should discuss it with her lawyer and let him know what they decide (the lawyer later told the judge that the mother was interested).

After the Judge explained what was happening, he asked the parents if they had any questions. (Even though this mother had appeared before the same judge when she lost her three other children to adoption, he patiently explained the process as though she was hearing it for the first time.) The father (who was not the father of the other three children given up for adoption) asked how soon they could check out kinship placement. The DSS attorney said it would take a few days, as one of the people was out of the county and the father did not know the address or phone number of the aunt he nominated as a care provider (the father said he would get that information to them). The court hearing lasted about 15-20 minutes.

Perceptions of the Child Planning Conference

We asked key players about Child Planning Conferences. Universally, we were told that the Conference is a good concept and a major improvement over the traditional way cases were handled before because:

- It alerts everyone to what the case is about and what the challenges are. In the past, this did not come out until after the first appearance, which was largely limited to assigning counsel to parents and scheduling the next hearing. Now, a lot of services and assessments can take place beginning the first day. This “front-loading” of services in an amenable, nonadversarial setting is well worth scheduling this additional meeting, according to all we interviewed.
- Knowing that Monday will be the day for the Child Planning Conference makes scheduling easy, as they just leave Monday mornings open for Conferences as needed.
- Although parents sometimes want to argue the allegations in the petition at the Child Planning Conference, they are told that this is not the time for such arguments—they can do that at later hearings. Once parents understand that, there is usually a 95% success rate in achieving a Memorandum of Agreement that leads to Stipulated Adjudications. The nonadversarial atmosphere helps achieve a high stipulation rate.
- The Child Planning Conference empowers families to participate in plans. The empowerment fosters success.

One of the side benefits of the Child Planning Conference has been that the relationship between social workers and parents has been improved. By bringing everyone together in a nonadversarial setting, parents are less likely to see the social worker as the enemy who removed their children. The video (described below) also helps the relationship between social workers and parents.

VIDEO: “The Choice is Yours”

Halifax County received a \$34,000 grant from the state’s Court Improvement Project to produce a videotape that explains the dependency process to parents in a nontechnical language they can understand. “The Choice is Yours” is a 20-minute video

produced in English and Spanish and is also closed-captioned. It uses professional actors and moves between two venues. First, there are a group of “parents” (actors) talking to each other (much like “reality” television) about the process. Two “couples” have been through the process before and one “couple” is new to the process. The discussion among these parents alternates with a “judge” who delineates the stages in the process using the legal terms and explaining it in non-legal terms.

The video begins with couples whose children were taken away over the weekend and were in court for the first time. The father is especially angry and expressed how he will get his children back and prove how wrong they were to take his children away. The couples who have been through the system before (one couple lost their child for not doing what was required and one couple did what was expected and kept their child) urge him to calm down and listen—all the screaming in the world will not get their children back. They need to listen to what has happened and why, and hear about what services are available to get their children back. This discussion goes on for several minutes. A commentator weaves in and out and explains all the steps (the Child Planning Conference, the Non-Secure Custody Hearing, the Adjudication Hearing, the Disposition Hearing, the TPR hearing), and professionals involved (the DSS caseworker, the DSS attorney, GAL, attorney for the GAL, court administrator, case manager) in dependency actions.

CIP produced numerous copies of the video for distribution across the country. It is meant to be generic and apply to dependency courts around the country. At the beginning of the video, they explain that terms for hearings may vary in different places, and not all events may occur, e.g., Child Planning Conference.

The video won a national award, The Silver Reel of Merit from MCAI, in the External Communications category. In our opinion, the video did an excellent job of reaching parents in a language and tone they can understand. During our interviews with professionals, including parent's attorneys, GALs, and DSS workers, we were told parents relate to, and understand, the video and it is a very useful tool in explaining the dependency process to parents. These positive reports are confirmed by the evaluations parents complete after they view the video. Although they have not formally tallied the evaluations, each is reviewed and the consensus is that very positive evaluations have been received from parents.

Family Drug Court

In March 2005 (a few weeks before our site visit), Halifax County started a Family Drug Treatment Court as part of a Pilot Program funded by the state. Halifax County received \$43,000 from North Carolina to pilot the project through June 30, 2005, and applied for and received a Governor's Crime Commission Grant to operate the court from July 1, 2005 through June 30, 2006. The funds will pay for transportation to and from court and treatment appointments, treatment for the uninsured, incentives for the program, temporary housing and utilities, and the program operational costs.

The purpose of the therapeutic Family Drug Treatment Court is to help substance-abusing parents who have had their children removed from their care by the Department of Social Services. This court will assist these parents in getting clean and staying clean through intensive case management, frequent judicial oversight, and access to treatment providers for treatment. The desired outcome is that parents will overcome any substance

abuse dependency and be reunited with their children within a year of the child's placement into DSS custody.

The goals of the Family Drug Treatment Court are to:

- Help parents “get clean and stay clean” through a strong judicial intervention program with intensive case management that monitors progress in treatment, insists upon random and scheduled drug testing, and demands that participants appear before the judge twice each month.
- Achieve permanence for children, whether it be reunification with the family or in another permanent home as mandated by the ASFA timeline.
- Provide a wide range of services (mental health, substance abuse, education, job training, housing, etc.) to parents and children to help the family reunify.

The Family Drug Treatment Court's Mission Statement is:

“We see, but cannot now reach, a time when all abused, neglected, and dependent children of substance-abusing parents who come under the jurisdiction of the courts of Halifax County are safely returned to the legal custody of substance-free parents or caregivers within a reasonable time.

We can further see a time when substance-abusing parents are helped, and not punished, by a well-designed judicial intervention plan which acknowledges the power and dignity of each parent, and which facilitates effective collaboration among diverse community agencies and resources.

When this vision is realized, life will be better for all citizens of Halifax County. This is our vision. This the 3rd day of March 2004.”

Observation of Family Drug Treatment Court

As of the time of our site visit, only one person (Ms. Jones, a fictitious name), a mother of three children, was in the Family Drug Treatment Court (although two others signed up the day we were there). One-half hour prior to Ms. Jones's scheduled review hearing, the Family Drug Treatment Court team met informally in the courtroom: the Judge, the GAL, the GAL's attorney, the GAL supervisor, the mother's attorney, the Juvenile Case Manager, the Juvenile Court Coordinator, the DSS caseworker (and several

others from DSS), the DSS attorney, and the mental health/substance abuse providers. We observed the team meeting, which lasted about 15-20 minutes.

The case involved a young mother with a long history of substance abuse. She also has a very serious asthma problem, resulting in trips to the Emergency Room (ER) several times over the last few months, inhibiting her going to drug treatment. She appears to be making some efforts but it is unclear whether her asthma actually prevents her from going to treatment or she is sometimes using it as excuse not to go to treatment. She was due in court the day we observed, but had not yet arrived. In addition to her asthma, transportation is a challenge. Because Ms. Jones missed several treatment and court dates, her bus voucher may no longer be valid (vouchers are issued for parents who cannot afford the bus to take them to treatment). How can she get to court on her scheduled court date? Maybe the bus company can be persuaded to give her another chance and issue more vouchers (if a person fails to be at the bus stop when arranged 2-3 times, the bus company cancels the voucher). Ms. Jones's attorney volunteered to pick her up and bring her to court, if necessary.

There was considerable discussion about what to do to impress upon Ms. Jones that she had to go to treatment or she would lose custody of her kids. It was an open discussion, with the Judge withholding his opinion until everyone had a chance to speak. They discussed the possibility of having her write a "goodbye" letter to her children (a technique used to impress on parents that they will have to say goodbye to their children if they do not straighten out), and some agreed that would be a good idea. It was also discussed that Ms. Jones lives in a neighborhood filled with "druggies" and drug dealers, and thus it is hard to stay "clean." The possibility of in-patient treatment was discussed.

The Juvenile Case Manager knew of a place that takes pregnant women (Ms. Jones is newly pregnant) and clients with asthma. She qualified because she has Medicaid due to her disability. The Judge asked the Case Manager to check into that. All agreed, including Ms. Jones's attorney, that in-patient treatment was the appropriate placement.

Ms. Jones failed to show up for her hearing, and it was suggested that she may be in the hospital as she had called earlier and could hardly breathe. The Judge called the hospital from the courtroom. He spoke with the ER nurse and learned Ms. Jones was in the ER; he asked to speak to her. The Judge asked Ms. Jones if she was coming to court. She stated she did not have transportation. He told her they discussed her case and believe the best thing may be for her to go to in-patient treatment. She expressed interest, and he said they will talk about it on her next court appearance the following week. The Judge spoke to the nurse again and asked how bad Ms. Jones's attack was. The nurse said that every time Ms. Jones is due in court, she ends up in the ER. The nurse does not believe Ms. Jones's condition is much worse today than any other day and she believes Ms. Jones is probably using her asthma as an excuse not to come to court. The Judge thanked the nurse and hung up. The team members were told about the phone call and dismissed. The Juvenile Court Manager agreed to follow up on the in-patient treatment.

Later that day, we learned that an in-patient placement was found in a neighboring county and they could take Ms. Jones in three days. The Judge called the bus service and arranged transportation for Ms. Jones. The Judge called Ms. Jones that night from home to let her know they found a treatment placement for her to go on Friday and the bus would pick her up at 8:30 a.m. Ms Jones agreed.

Challenges in Obtaining Treatment in Halifax County

During on-site interviews, several obstacles were identified in providing services to parents and children in Halifax.

Lack of treatment providers. North Carolina implemented a mental health services reform four years ago. Prior to the reform, there had been a mental health agency in every county to provide services. After the reform, mental health services were contracted out to a private company/agency in every county. Halifax County contracted with an independent treatment group to serve parents and children. Unfortunately, that group notified the court that they are terminating the contract at the end of June, but while we were on-site in April, the provider assigned to the county notified the court that he was accepting another job. Therefore, the county had to scramble to secure another provider. They had already been working with an individual provider in the county to take over in June, but now the timeline was abruptly moved up. They believe the individual provider (who holds a Master's Degree in Social Work with a background in substance abuse and mental health treatment and who is a long-term county resident) has the skills in mental health and substance abuse to handle their litigants, but they have to expedite signing the contract. They acknowledge having a problem retaining providers in the county, as many leave in pursuit of higher salaries in urban settings. They believe that this local provider, who has strong community ties, has a commitment to stay in the county long-term.

Even when they had the contract with the treatment agency, several problems were commonly mentioned as inhibiting treatment, including the following.

Parental loss of Medicaid. When parents lose custody of their children, they also lose their Medicaid rights (unless the parent has a disability that entitles them to Medicaid). When children are removed and Medicaid withdrawn, it is difficult for many parents to get the services they need.

Transportation. Transportation is a huge challenge in Halifax County. The county encompasses a large geographic area, public transportation is virtually nonexistent, and the population is very poor. All this creates a transportation nightmare for parents who want to go to treatment. There is a public bus service that can be arranged for transport, but the service runs infrequently and stops often. Therefore, it may take a parent one to one-and-a-half hours to get to the provider and then they may have to wait for several hours after their treatment is over to get a bus back to their home. This often translates into a whole day being spent for a one-two hour session.

Lack of services. Even before the contract provider agency pulled out during our site visit, there were not enough substance abuse and mental health services for parents and children. For a six-month period, services were so lacking that they had to excuse parents from not going to services as they simply were not available. This extended court timelines, as it was not the parent's fault that they could not comply with ordered treatment. They experienced more problems with psychological services than substance abuse services. There were no services for children except what they might be able to get through the schools. DSS has had to "pull people out of the woodwork" to work with children and parents.

Difficulties of avoiding drug dealers in small communities. Halifax County is a cluster of small communities where "everybody knows everybody." It is hard for

substance-abusing clients to get away from their dealers, as the dealers know where they live and hang out. The dealers are aggressive. We were told of one case in which the dealer drove the substance-abusing client to the courthouse (because of the lack of public transportation and because dealers are often the only “friends” parents have), and waited on the courthouse steps until the person came out of court. The dealer then tried to sell the person drugs. Sometimes, the only hope to keep the dealers away is removing the substance abuser from the county and getting them enrolled into a residential treatment program.

Keys to Success in Meeting ASFA when Parents are Substance Abusers

Prior to ASFA, social workers were spending much of their time rehabilitating parents. ASFA put the emphasis where it should be, on children. ASFA was needed to put the priority on finding a safe, permanent placement for children and serving the “best interests of the child.” Reunification is the goal. The DSS Attorney estimated that fewer than 10% of cases result in a TPR. How are they meeting the demands of ASFA, especially when parents are substance abusers?

Detailed orders. Detailed orders, rather than standardized forms with a checklist, specify exactly what each person must do and within what timeframe. By removing ambiguities, excuses used by parents, DSS workers, service providers, or parents’ attorneys are largely eliminated. Judge McCoy issues detailed orders with the help of the DSS attorney who often writes drafts of the orders.

Leadership of the judge. Judge McCoy is dedicated to improving the processing of dependency cases. He is the chairman of NC’s Court Improvement Project. He decided that courts needed to change the way they do business if children are to be placed

in safe, secure, and permanent placements. He respects professionals, families, and volunteers in his court and also holds them accountable for their responsibilities. Continuances are rare and excuses for not doing what is ordered are not tolerated. The Judge sets the tone and culture in the court. Judge McCoy works long hours and is usually the last one to leave the building, often after 7:00 p.m. Everyone we interviewed agreed he garners the respect of all (even when they disagree with him) and is the charismatic leader that makes their court work well.

Joint training and a team approach. Halifax County Family Court received a Bureau of Justice Assistance Grant to participate in implementation training for a Family Drug Treatment Court in 2004. The grant-funded training was provided by the National Drug Court Institute and was comprised of trainings at three separate sites. An initial training was held in Destin/Pensacola, Florida in March 2004 with subsequent trainings in Kansas City, Missouri in June and in Charlotte, North Carolina in September.

The local team participating in this training was comprised of Chief District Court Judge H. Paul McCoy, Jr.; the Family Court Administrator, DSS Staff Attorney, DSS Social Work Program Manager, Psychological Program Manager from RiverStone Counseling and Personal Development Center, District Administrator for the GAL Program, Director of Nursing with the Halifax County Health Department, Director of Exceptional Childrens' Programs with the Roanoke Rapids Graded Schools District, an attorney who represents parents, and the State GAL Administrator with the Administrative Office of the Courts.

Topics covered in the trainings included:

- Team Roles and Responsibilities
- Introduction to Addiction and Relapse

- Development of Mission and Vision Statements
- Judicial and Team Leadership
- Building the Team
- Treatment Court Characteristics
- ASFA and ICWA
- Basics of Substance Use, Abuse, and Dependence
- Building Blocks of Healthy Child Development
- Targeting, Eligibility, and Screening
- Developing Eligibility Criteria
- Managing Information and Management Information Systems
- Evaluation
- Drug Testing
- Case Management, Process and Structure, and Legal, Child Welfare, and Treatment Systems
- Development of Programmatic Structure and Requirements
- Intergenerational Issues in Substance Use, Abuse, and Dependence
- Managing Participant Behavior
- Developing Sanctions and Incentives
- Quality Assurance and Sustainability of the Family Drug Treatment Court
- Developing a Long-term Funding Strategy with Community Resources
- Confidentiality and Ethics
- Written Protocols for Memoranda of Understanding and Consent Forms
- Issues Facing Rural Courts

At each training site, the teams visited a model court and observed a session of Family Drug Treatment Court in operation. The host courts also participated in question-and-answer sessions to provide additional insight. Each of the three trainings also provided time for teambuilding experiences for the local team to work on developing their own rules, forms, mission and vision statements, committees, etc.

The trainings helped foster a team approach and helped them understand the substantial amount of time needed to accomplish treatment and the expected relapses along the way. This changed how they process cases and respond to relapses. For example, the Judge does not automatically discontinue supervised visitation with children if the parent tests positive for drugs, as he did before he was educated about relapses. It also fostered a team approach with mutual respect for each other's roles and

responsibilities. From our observations, it was obvious that the professionals and volunteers in Halifax County respect each other, hold each other accountable, and understand the importance of a team approach to address the many complexities in dependency cases when parents are substance abusers.

Dedication of key players. For the expedited process in Halifax to work, many people had to be committed to the program. With state funds, they hired a Family Court Administrator, and with grant funds, a Juvenile Case Manager who is critical to the operation of the Unified Family Court. Others who had already played a role in dependency matters had to make these cases a priority and work within agreed-upon deadlines. For example, the Sheriff agreed to give priority to serving petitions on parents and subpoenas on witnesses for court dates. DSS workers and GALs have to get their written report into the court 14 days prior to the hearing so all parties have a chance to review the report and be prepared on court day. GAL volunteers have to fulfill their obligation to meet with parents and conduct appropriate interviews. Clerks have to maintain accurate and up-to-date court calendars. A new system, J-Wise, is being implemented to allow tracking of timelines in cases and to generate the Judge's docket. It will tell the Judge how many days remain to meet each of ASFA's guidelines and it will eventually be linked to the DSS and GAL systems. Mental health providers have to get treatment done within mandated timelines. DSS attorneys have to come to court prepared. Court delays have to be strictly limited to keep cases on track. Judge McCoy is very strict about allowing continuances and expects people to come prepared and stick to deadlines.

A strong GAL system. In Halifax County, there is one full-time GAL supervisor, a GAL attorney, and 35-40 GAL volunteers. Potential GALs are screened through the state criminal background check system (and a few other states with which they have a mutual agreement). If a potential volunteer has a nonviolent misdemeanor charge or conviction, the GAL supervisor asks the Judge to make the final decision as to whether that person can be a GAL. They do not have the ability to conduct either a DSS check or drug screening on applicants for the GAL position.

GALs receive 30 hours of training (10 sessions of three hours each) on how to be a GAL. Training includes how to write a report, how substance abuse affects a family, a review of mental health problems and treatment, a history of the juvenile court, etc. The GALs must take six additional hours of in-service training per year to remain certified. Most GALs handle one to two children at a time; but some experienced GALs can work with up to eight children. The minimum time commitment of GALs is one day per month. The supervisor tries to match the GALs with the types of cases they are good at and like to work with (e.g., some like to work with small children and some with teens; some are especially good with male children and some female).

All children in dependency court receive a GAL. If no GAL volunteer is available, the GAL supervisor takes the case herself. The GAL is usually at the Child Planning Conference, but the GAL supervisor is always there. The GAL has access to any and all information that can help them make recommendations on safe placement for the children. They are armed with a court order, allowing them to speak to and review anyone, or any materials, they decide are relevant to the case, including health/mental health records, school records, and fathers in prison and/or their parole officers. Their

focus is to help clarify what is likely to happen to the child given a particular placement.

GALs are given a lot of respect by the Court.

After they are assigned to a child, they try to meet the child right away. They have a lot of leeway as to how they do their job. The biggest problem they see with parental substance abuse is that the parent is not getting treatment. In order to make a recommendation for reunification, they need to see the parent making progress.

Indicators of progress include: parent keeps appointments to see the children; two months' employment in the same place; participation in therapy; and having their own place to live. They feel their success is due to the court adhering to the ASFA timeframes; GALs having authority to work cases and present their best recommendations to the court (which respects their recommendations); and having the attorney advocate. As previously discussed, the biggest single challenge is the lack of mental health and substance abuse treatment options.

Suggestions to Improve the Response to Dependency Cases when Parents are Substance Abusers

While Halifax County has adopted many practices to meet ASFA timelines when parents are substance abusers, many gaps were identified, and suggestions made, to improve the response, including:

- faster service delivery to children and parents,
- more local treatment options for women, children, teens, and men,
- substance abuse provider who is consistent and well-funded for women, children, teens, and men,
- ALANON, as they have AA and NA, but no local ALANON chapters,
- halfway houses, as there is no transitional treatment from in-patient and out-patient care,
- housing,
- therapeutic foster group homes,
- more foster families so children are not shipped to other counties,
- better education of foster parents regarding substance abuse,

- public transportation, and
- a coordinated system throughout the state, so if a placement changes to another county, service continues without interruption.

Conclusion

Halifax is a small, rural, economically depressed county struggling to respond to the large number of dependency cases in which parents are substance abusers while meeting ASFA timelines. They have received limited state funds for a Unified Court system and just recently, for a Family Drug Treatment Court. Treatment providers, and options, continue to be a major problem for them, as does transportation. Yet, they seem to be making great strides in responding to dependency cases in general, and those cases with substance-abusing parents in particular. How? First, they recognize that the way courts traditionally were handling these cases was not working. Second, they sought out answers and received training about substance abuse, unified family courts, family drug courts, and other strategies to improve the response to these cases. Third, they instituted changes, with the Judge assuming the primary leadership role.

But the Judge did not do it alone. Others, out of concern for these children and parents, and with the encouragement of the Judge and their colleagues, also changed the way they had traditionally handled cases. Key people in this process were the Judge, DSS workers, the DSS attorney, the parent's attorneys, GALs, mental health clinical assessor and treatment providers, clerks, sheriff, Family Court Administrator, and the newly created position of Juvenile Case Manager. They had to be willing to try new practices, give priority to these cases, and to go beyond their written job descriptions to make it work. For example, the Juvenile Case Manager took on the additional role of the

Family Drug Treatment Court Case Manager. This added to her responsibilities with no increase in pay. Just during our on-site visit, we observed:

- A parent's attorney (during the Family Drug Treatment Court meeting prior to the court hearing) volunteered to drive her client, who lives in a dangerous drug neighborhood, to court. A lack of transportation had resulted in the mother not appearing on previous court dates.
- The dependency court Judge called a drug court participant at the hospital to see how she was feeling and whether she was planning to come to court. He also personally arranged transportation for her to go to in-patient treatment. Then, from his home that night, he called the mother at home to tell her about the arrangement. Surely, none of these things are included in a judge's job description.
- A mental health clinical assessor arranged for a mother addicted to heroin to receive in-patient treatment. The mother was pregnant and received preference at the treatment center. Because of her pregnancy, a bed was secured for her three days later. In some places, being pregnant makes it more difficult to obtain in-patient treatment, but not in Halifax.

The clinician did more than obtain a treatment bed. She also arranged for the mother to see her children before going into treatment. The mother has two children, ages 7 and 10, who had assumed the parenting role and were taking care of their mother. The clinician thought it was important for the children, and the mother, to see each other before she went into treatment so the children could understand that their mother was going somewhere she could get help. The clinician hoped the visit would help soothe the fears of the children and free them from the parenting role they had assumed. The clinician offered to bring the children to the DSS herself, if necessary, the morning before the mother left for treatment, because she thought it was the right thing to do. This is another example of a person in Halifax County going beyond her job responsibilities to serve children and families.

Resources are important, but much can be accomplished with limited resources when there is a team effort among professionals and volunteers working in a dependency court to truly serve children and families.

CHAPTER 7

TARRANT COUNTY, TEXAS (TX)

Tarrant County, Texas, was chosen as a site for several reasons, including the Family Group Conferencing (FGC) approach, their Department of Families and Protective Services (DFPS) IMPACT Unit, the Unit's Methamphetamine Specialist Caseworker, and the numerous treatment programs for women and their children. A site visit was completed in August 2005.

Tarrant County is mostly urban, and its major city of Fort Worth is home to some 1.4 million people. The county has 35 law enforcement agencies. About 60% of their population are Caucasian, 20% are Hispanic, and 13% are African-American. Of the 437,000 children in Tarrant County, some 1,500 are in the legal custody of DFPS. Child Protective Services (CPS) cases filed in Tarrant have been on the increase, doubling from 2000 to 2004 (222 to 451). There has also been an increase in the number of cases resulting in removal of a child due to drug abuse (including alcohol): from 44% in 2003 to 57% in 2004. And while cocaine is often the drug of choice, methamphetamine is making inroads in the county, and is, in fact, impacting investigative and treatment practices. All professionals interviewed said substance abuse, particularly methamphetamine, add a pernicious element to the handling of child abuse and neglect cases.

Child Protective Services

Tarrant County's Department of Family and Protective Service has 30 direct service units, employing 315 caseworkers, supervisors, and staff. There are units devoted to six specialty areas: Conservatorship (CVS) workers handle cases where CPS has legal

custody of the children; Investigations (INV); Family Based Social Services (FBSS) works on family preservation by referring the families to any services they need, pre- or post-removal for three to six months; Skilled Response Team (SRT) investigators are tenured staff with low priority cases; Alliance For Children (AFC) and Teamed Investigation Project (TIP) and Sex Abuse (SXAB) work as a multidisciplinary approach to allegations of child molestation, and may be housed at the local child advocacy center (AFC).

In addition, Tarrant has an IMPACT Unit, which has both investigators and FBSS caseworkers. This unit works primarily on cases involving drug-exposed infants, and children up to the age of three. Most referrals are from hospitals, who report positive toxicology babies, or when the mother admits using drugs when she delivers the child. There are seven workers in this unit, three for drug-exposed infants (handling 42 cases per month— about 14 cases per worker), three who work on family preservation issues (25 cases per month), and one methamphetamine specialist (15 cases per month). Of the approximately 56 cases per month that are open at any one time, about eight result in removal and, potentially, termination of parental rights if they fail to complete services such as drug treatment.

Methamphetamine Specialist

The “meth” specialist, or D.E.C. (Drug Endangered Children) Investigator, is a brand new position in the IMPACT Unit, and was created to address the reality in Tarrant that methamphetamine is fast becoming the new drug of choice. The current specialist has a Bachelor’s of Social Work, and worked in the IMPACT Unit on drug-exposed infant cases for three years. The Unit found that methamphetamine is more accessible

and cheaper than crack to manufacture. They report there is more denial about addiction among family members and addicts, and more children are negatively affected by methamphetamine than by other drugs due to the way the drug is manufactured and the dangerous chemicals used. One of the problems from the perspective of CPS was that when they were “busting labs,” narcotics law enforcement officers were reportedly placing children in the home with “anyone.”

To address that challenge, the specialist is supposed to be referred to cases where police are working on a “meth lab” case and know that children live in the home, or if methamphetamine use is involved, regardless of the age of the children, to find suitable relatives to care for the children. The specialist is available 24 hours a day to go to a suspected methamphetamine lab with the police to remove any children. However, she has received no calls from police so far. She does not know if the police are not finding children at the labs, or if they are not complying with the policy to contact her. With time, education, and awareness this will hopefully change, according to administrators in Tarrant.

However, as a result of her trainings from narcotics officers and police captains, she has become quite adept at identifying methamphetamine-making supplies in a home that would likely be missed by other caseworkers. These supplies may include: boxes of pseudoephedrine or Sudafed, bottles of iodine or iodine stains on the carpet, bottles of hydrogen peroxide, Coleman lanterns and fuel, fertilizer, stains around ceiling vents or the ceiling due to the cooking of methamphetamine, and butane tanks with stains around the nozzle. These are often located in closets and kitchen cabinets. Also, pornography is often visible in the home. (Methamphetamine and pornography “go together,” according

to caseworkers interviewed. Methamphetamine reportedly increases both sexual urges and aggression in users.) Other CPS workers will ask her to accompany them to visit a home due to her knowledge. While CPS acknowledges that caseworkers can be trained in identifying methamphetamine in the home, “one worker...can focus [her] time on just the specific needs of children in meth labs. The D.E.C. Investigator position was created so that we could have someone who has been specifically trained to investigate methamphetamine labs where children are.” The IMPACT Unit has also developed a packet of resources that is distributed to CPS staff on methamphetamine issues.

When children are found in homes with methamphetamine labs, they require special handling due to the toxicity of the drug. Children need to be stripped of their clothing and washed down due to contamination, and children may not bring any toys or objects from their home for the same reason. The meth specialist has not had to do this to date. The IMPACT Unit has a county-donated van with teddy bears, clothes, and diapers. CPS provides white t-shirts and other clothes through its Rainbow Room. The Rainbow Room has supplies children may need after they are removed from home. They are looking at purchasing a tent to give the children a private place to wash down outside the home before getting in the van. This is in response to a privacy need for children, especially boys, who may be understandably uncomfortable undressing and washing up without privacy. Several agencies (CPS, treatment, law enforcement, child advocacy, and other stakeholders) have started a committee that meets monthly on Drug-Endangered Children specific to methamphetamine. The local Children’s Alliance (the Child Advocacy Center) is helping to coordinate the efforts of the committee.

Case Processing

All reported cases of child abuse and neglect are collected through the statewide Intake's 800 number. Tarrant County's calls taken by the statewide intake are assigned as Priority 1s (must be investigated within 24 hours) or Priority 2s (must be investigated within 10 days), and route them to the appropriate CPS unit.

The investigation stage may take 30-60 days. The worker actively encourages the parent to recruit a family member with whom to place the children. This is a "voluntary placement" by CPS, and the agency's attorney (the Assistant District Attorney, Chief of unit representing CPS) considers it a "creative but not permanent solution." According to CPS administrators, "an appropriate relative is one we have done a CPS and criminal background check on. We will not consider those with assault or drug charges. The relatives or families provide for the children. The parents are referred to FBSS and offered drug treatment. If the family can no longer care for the children because they are still actively using, we remove the children. We conduct Permanency Planning Team (PPT) meetings on all removals in 45 days of removal to determine what our permanency plan is going to be."

Because legal custody is not taken by CPS at this time (the agency did not place the children), there is also no legal protection for the placement. In other words, if the parent changes her mind, she can take the children back from the relative. If CPS is alerted by the relative, CPS would then step in and take legal custody if necessary, after another assessment of the situation. The attorney notes that legal intervention is their last resort. Most importantly, ASFA timelines do not apply in these situations, as legal custody has not begun.

So although the children are considered endangered, and the parent has a substance use problem, the bottom line for CPS is that the children are in a safe placement. According to CPS administrators, “if the parents do a voluntary placement, the risk is lowered with a relative supervising, [allowing us] to offer drug treatment.” Thus, the parent may begin to work on treatment. “Relatives are told to alert CPS if the parents return and have not sought treatment and they take [their] children. They are also encouraged to file a power of attorney,” according to CPS. The agency attorney notes that drug use alone is not the standard for legal intervention; it must be linked to abuse or neglect and the drug use must impact on the parenting. If the child is considered in a safe voluntary placement, the case may be closed. The Judge notes that the preference is to keep children safe without taking legal custody.

Child Advocates of Tarrant County (CASA) is automatically involved in all cases, some four-six weeks after a case goes before the judge. There are 167 CASA volunteers in the county. Each CASA handles approximately two cases at a time. CASA has access to CPS files and meets all parties, establishes a relationship with the caseworker, and sees the child twice a month. They also attend PPT meetings in the first and fifth months of the case and all court hearings. PPT meetings are held by CPS to determine the direction of the case. The team consists of all pertinent parties in the case, including the caseworker, attorneys, foster parents, therapists, parents and family members. The Judge asks for CASA’s input and recommendations, and at the final hearing they provide a written report to the Judge and all parties.

The worker refers all parents with suspected substance abuse issues to a treatment facility for an assessment, using a Substance Abuse Subtle Screening Inventory

(SASSI) assessment tool, or a verbal interview with a general history taken. Urine drug screens (UA) are conducted as a part of the admission process if the client is going to inpatient treatment. If the treatment modality is out-patient, the UAs are paid by the agency, when CPS is monitoring the client. Assessments are made by Community Addiction Treatment Services (CATS) outpatient program. This usually occurs within 1-2 weeks. There is no transportation or other assistance beyond a case aide who can help with some transportation; it is mostly up to the parent to get to the treatment provider for the assessment. The provider then makes the recommendation for the type of drug treatment needed. When a CPS referral is made, it may take 10 days to four weeks to conduct a screening, unless it is an emergency or relapse. Tarrant County Alcohol and Drug Addiction (TCADA) is available to refer to both outpatient and inpatient treatment.

The caseworker may refer to other services as well, including the Parenting Center for parenting skills and anger control classes, homemaking, and domestic violence education. Until the mother is assessed, she cannot participate in the parenting classes. CPS offers the ROADS group every Wednesday; the first hour is an AA meeting, followed by an hour of drug education. Anyone with a drug problem may attend. Caseworkers refer an average of 20-25 clients to ROADS weekly. Eight classes are required, and each participant receives a certificate when they complete the classes. Random urine tests are also provided by a contractor. However, there is some question whether those screens are accurate, as the screener does not watch the test, and there is some evidence the urine tests are being watered down, or that children's urine is being given in its place, according to self-reports and contractor reports.

If the parent is participating in the investigation and needs services, the case is referred to the Family Based Safety Services Unit (FBSS). “Some parents are noncompliant and do not want services,” according to CPS administrators. Those cases are brought up at staff meetings to see if they are appropriate for legal intervention. FBSS can work with the family for three to six months, or up to one year, while the children are in voluntary placement. The goal is to lower the risk for reabuse or neglect by providing group and individual therapy and treatment.

If the parent does not cooperate, by denying drug use, not voluntarily placing the child with a safe relative, and not going into treatment, the child is removed from the home. The case is filed in Juvenile Court, and the Court may order a relative home study or foster care placement. The 323rd Juvenile Court, headed by Judge Boyd, hears all new cases of child abuse or neglect, so long as there is no pre-existing divorce, custody, visitation, or paternity case. If so, the child abuse and neglect allegation will be heard in whichever of the six family courts are handling the existing case. Those cases with a previous history are heard at the downtown courts.

History of Family Group Conference

FGC was implemented by Tarrant County’s Child Protective Services in collaboration with Child Advocates of Tarrant County, and the Tarrant County Juvenile Court (323rd District Court). In 2000, Judge Boyd of the Juvenile Court, CPS and CASA collaborated on a proposal to the Children’s Justice Act (CJA) to fund their FGC approach. A grant from CJA provided a three-year, \$56,200 project, followed by a second grant awarded to CASA. The State of Texas DFPS began a statewide initiative

with an infusion of CAPTA funds and a partnership with Casey Family Programs, and the Tarrant County project was folded into the statewide project.

Tarrant looked at several Family Group Decision Making models, and adapted the approach best-suited to Tarrant's needs. The FGC goal in Tarrant is to:

“prevent, or shorten, the time children spend in foster care, by identifying family strengths and resources to shape and support the family and child plan and to form an alliance between the family, community and CPS. It is anticipated that there will be an increased number of viable family resources and placements identified resulting in an accelerated permanency for the children. It is also anticipated that some removals of children will be diverted altogether with the children being able to stay safely within the family unit.”

They decided to hold Family Group Conferences in cases prior to removal hearings as well as post-removal. At the beginning of the statewide initiative, FGCs were only held in post-removal cases due to factors determined by state administration. Tarrant County continued to operate as always. Now, FGC may be offered at all stages of service. Two CASA staff attended the “removal staffings” (staff meetings following the removal of children where the cases and issues are discussed) to ensure that FGC was suggested in appropriate cases. Buy-in from CPS was critical. In fact, while CPS management was supportive, caseworker supervisors and line staff thought the four-hour conference would be burdensome. CASA staff contracted with facilitators (former CPS supervisors) to run the Conferences. They were eventually able to get support from CPS staff, as they saw the benefits of a more cooperative family and more positive results for the children.

Family Group Conferences may be recommended at any point in the process, during the investigation stage, FBSS stage, or pre- or post-removal. Although criteria for referral was outlined in the initial project, in practice the caseworkers and others

interviewed said referrals are made on a case-by-case basis. Initial criteria were developed to select appropriate cases for FGC, including:

- a family support system is available to the client,
- the family is willing to cooperate,
- the conference is logistically feasible,
- there is a potential gain for the family,
- the family wants to care for the child or wants the child cared for in their own family system,
- relatives and kinship express interest in helping family or caring for children about to be removed or who have been removed from family or are in foster care, and
- CPS can engage the energy of the family to help address the crisis that brought them to the agency's attention.

According to the caseworkers, families and cases deemed appropriate are chosen because: “they have particular family strengths” the caseworkers thinks may be useful; the caseworker “is having problems with the mom and thinks the family can help find a safe placement;” the worker “feels some family members are being left out of the loop or the mom is not being honest” with the family about her drug use; they “want to get everyone together on the same page;” “family conflict is interfering with progress;” they want to “discuss what happens with the children post-CPS involvement;” they are “trying to prevent children from coming into care;” or they are “trying to find outside supports to either preserve the placement, or prevent entry into foster care.” FGC is offered to families on a voluntary basis. FGCs should not be court-ordered, but that has occurred on some occasions. According to FGC administrators, “we ask judges to only recommend if [they believe it is] needed.” Approximately 80% of families agree to participate.

FGC has three staff dedicated to Tarrant County. The conference specialist with a Master's degree in Social Work, and two facilitators, paid for by DFPS. FGCs may be

held completely in Spanish, if needed. FGCs are held at CASA, at churches, and the YMCA, but not at CPS offices, to give the proceedings the important sense of neutrality. It takes about 15 hours to coordinate in advance, and 3-4 hours to conduct a meeting. Once a case is referred to the FGC coordinator, they have access to the CPS case file. The coordinator amasses basic information on the family by talking to the mother or father, and asks her who she would like to invite (including relatives and “resource people,” such as friends and others who she can turn to if she was in trouble). A release is signed by the mother to allow them to call these people. As the coordinator contacts people, she asks for referrals to other family and resource people in a “snowball” fashion. If there are multiple fathers, she contacts them all. She also asks about family customs and rituals, which can be woven into the FGC. Dates and times are worked out; FGCs may be held evenings and weekends, if necessary. The facilitator is then given the complete packet, which includes information on the meeting location and any amenities offered there.

The facilitator brings easels, flip charts, snacks, and drinks, and may provide a meal. She prepares everyone for the meeting, reminding them this is about identifying family strengths. They go over the agenda and the rules, including time-outs if necessary. Mothers often come in with an “attitude” (arms crossed, etc.), but usually become more at-ease and participatory during the meeting. Participants may include CASA, the caseworker, the treatment provider, mental health, medical professionals, foster parents, school officials, a pastor, children with their support person, and godparents. No attorneys or judges come to the meeting. A sign welcomes them to the

meeting, and pictures of the children are on a poster, reminding people why they have been invited.

A typical agenda includes the following:

- Welcome (family ritual, such as a prayer)
- Introductions (how each person is related to the children or the family)
- Description of FGC (confidentiality, go over ground rules: everyone participates; only one person speaks at a time; no interruptions; focus on strengths and solutions; treat each other respectfully; time-outs are okay)
- Purpose of conference (caseworker sets out her goals; family members define their goals)
- Hopes and dreams for the children (as identified by each member)
- Family strengths (as identified by each member)
- Concerns and facts (caseworker gives history and reason for removal; explains ASFA timelines and concurrent planning; family gives history)
- Specific needs of the child (medical, educational, psychological, developmental, special needs; siblings and visits)
- Resources, requirements, and restrictions (caseworker explains essential service plan requirements and options not available to family; defines the requirements for successful home assessment; outlines available resources)
- Private family time (family processes information and develops action plan for each goal while CPS, etc., are out of the room; family spokesperson is selected to present the plan)
- Presentation of plan and negotiation (meal or refreshments; family spokesperson presents plan, especially who will be responsible for meeting each of the child's needs; CPS agrees, disagrees or negotiates conditions; timeframes given and agreed upon)
- Close (all participants and facilitator sign the case plan)

During the meeting, ASFA timelines are explained if the children have been removed, or if there is a potential for them being removed, as are any legal requirements. Families are asked to think about who can take the children while the mom is going through treatment. There needs to be recognition that this might be permanent, as there is no guarantee of recovery. After the discussion, the professionals leave the room to give the family time to create a plan. The plan must include legal requirements (including meeting timelines), how service requirements will be addressed, including resources such as who will provide transportation, placement, visitation issues, etc. The GALs and

attorneys get a copy of the plan, once it is approved by CPS. A follow-up conference may be convened to review the plan and make changes to it, if implementation of any aspect of the plan needs to be revisited. According to the FGC administrator, “anyone may ask for a reconference.”

Caseworkers and the FGC Director suggested various indicators of success. Success may be measured as: “finding a kinship placement, and keeping children out of foster care;” “opening up communication in the family;” “increasing the participation of the paternal side;” and “having something good come out of it.” The IMPACT Unit’s Director notes that success is measured by “having a safe child,” regardless of whether the family is eventually reunified.

Evaluation of the Family Group Conferences

Child Advocates of Tarrant County, Inc., collected data from July 2003-June 2004. According to their data, 407 families were assessed by CPS to determine if they were appropriate referrals for an FGC. Fifty-four FGCs were held. They were able to contact 42 families for a follow-up after three months. Of those, 55% resulted in family reunification: children were not removed from home in four families; were reunited in seven families; and were placed with relatives in 12 families. However, the FGC administrator questioned these figures, noting that “we take all referrals, and only a couple each month are declined by us or the family.”

Statewide evaluators have prepared findings from the first two years of the statewide Texas initiative. The initiative is in place in 37 counties. Findings include:

- 993 families were offered FGCs. 594 conferences were held (60%), most (63%) within 30-45 days following a child removal.

- Most of the family’s placement recommendations were to place the child with a relative; CPS accepted the recommendation 95% of the time.
- Of the 373 families who participated in the FGC, prior to the FGC 54% of the children were in foster care, 24% in relative care, and 3% were returned home. Following the FGC, 45% were in foster care, 39% in relative care, and 10% returned home.
- On factors of satisfaction, family support, and caregiver and child well-being, parents and relatives give higher marks to FGCs than to PPTs. They score higher on feeling empowered, on understanding expectations, and identifying key issues in the family plan, than they do at PPTs.

Qualitative data are available thus far from Dallas and Bexar (San Antonio)

Counties only. The report notes that:

- Dallas CPS staff are receptive to the program but concerned about caseloads, length of the conferences, and “potentially tenuous commitments on the part of the family members.” They do like the “greater participation by family members, increased awareness of the issues surrounding the case, lessened hostility, and increased cooperation.”
- San Antonio staff are concerned about control by family members, and nontraditional methods to deal with these issues due to it being harder to verify. They like that CPS must interact with families and community members more respectfully, which encourages client involvement and taking “greater ownership of their problems.”

Accolades and Criticisms of FGCs

Comments we heard from professionals in Tarrant on the Family Group

Conference included:

- The Assistant District Attorney/Chief of CPS unit’s legal team is very supportive of the FGC. He sees the conference as a method to keep children out of foster care and into relative placement. The FGC allows the whole family to “hear the official version of why the children were taken,” often for the first time, as the substance-using mother has often lied to her family or otherwise downplayed her problems. It is a great tool to give the family a better picture of the issues and allows them to step forward and take control.
- The ADA, caseworkers, and the FGC’s Director used the word “empowerment” to describe the impact of the FGC on families. The ADA is “amazed at what parents agree to” in terms of placement and what is best for the children. He is

also in agreement philosophically that lawyers should not be included in the FGC, as this is not mediation. He receives a report from the FGC and “does not have to deal with the family anymore.” The ADA is satisfied with the information obtained during the FGC, and acknowledges it “is not necessary for the ADA to interview or track down family members to determine their role in the case.” Plans do not break down and placements stand because the relatives feel they have buy-in. Also importantly, in the past cases would be two weeks from the trial date when an out-of-state relative would be located. They would have to obtain a time extension to review this relative’s standing and appropriateness for placement. This would extend ASFA’s timelines as well. Now ASFA timelines are either not invoked, due to the voluntary placement issue, or if it is a legal custody case, CPS can show that all reasonable efforts have been made to locate relatives and secure services.

- CPS investigators and FBSS staff are also “very supportive” of the FGC. Before, the numbers of children in kinship placements were low, and there were no home studies done of those relatives. Now, Judge Boyd requires an approved home study of any relative who will take in the children in cases where CPS has legal custody. FGC staff do attend post-removal staffings, and help them assess which families are appropriate candidates for a conference. The “investigators do a great job of searching for [relative] placements.” FGC staff “find outside supports to preserve placements and prevent entry into foster care.”
- CPS staff believe the FGC “shows the family the truth of the situation if the mother has been lying to them, and gets all the family on the same page so they can help the mother.” They also feel the mother is “more successful in treatment due to the family support.” They feel “the family works as a unit and this is very powerful.” It is usually the first time everyone understands the extent of the problem. It “helps to build the first bridge to recovery and start accountability.” Substance users tend to be “self-centered and self-focused;” this can change as a result of the meeting.
- Importantly, the caseworkers’ awareness of family issues is enhanced as well. The caseworker “can learn about family histories of mental illness, intergenerational abuse or substance use, and who can be depended upon” within the mother’s support system. Often, the mother says she has nobody to rely on. The FGC shows that they still have relatives and friends on whom they can depend.
- Judge Boyd sees FGC as empowering the family by allowing them to create their own plan for the children, which she sees as better than “forcing a plan on them.” She notes that “families know things the system does not know about certain family members, and about family dynamics, and can suggest to the group that those placements might not be optimal.” They can also identify family members who can hold the mother accountable, and who has transportation. She notes, “before the FGC, families often did not know that the mother and children were

involved with CPS. Now they are engaged earlier in the process.” She feels families are “very receptive” to the FGC. She also feels strongly that she should not sit in on the conference or receive a report, as she considers that *ex parte* communication.

- The only criticism of the FGC came from the caseworkers who do not like the four-hour FGC meetings.

Treatment Options

There are numerous treatment options available for pregnant women and those with children in Tarrant, both prior to and after legal custody of children has been taken. Clients of treatment providers sign waivers of confidentiality both at CPS and at the treatment provider. This allows CPS and treatment professionals to communicate about clients’ progress in treatment. CPS may visit the provider weekly, and are available to talk with treatment professionals. Notes on a client’s progress in treatment are made available, but will only be submitted to court if they receive a subpoena to do so.

Pine Street provides a detox center, which may take up to two weeks to find an available bed. It is up to the mother to contact Pine Street every day to see if a bed is available. Nexis in Dallas, which is close to Fort Worth, takes mothers and up to three of her children for three-to-four months of treatment. Lighthouse, Volunteers of America, Kirkpatrick, Homeward Bound, and Beaumont also provide treatment. All clients from CPS are eligible, although CPS does not know the exact number of clients served by the treatment providers.

Community Addiction Treatment Services (CATS) provides assessment for a majority of CPS-referred clients. This state-funded program works with approximately 500 CPS clients per year. All CPS clients willing to seek drug treatment are eligible. They offer an inpatient 30-day program (no children allowed), and an outpatient program

that meets four times a week for as long as appropriate, depending on the client's needs. Individual and group therapy is provided daily. Pregnant substance-abusers, intravenous drug users who are pregnant, and pregnant substance-abusers with HIV are given priority.

The women's outpatient program allows the client to bring her children under the age of 15 months old, and childcare is provided for older children. Twenty-four groups meet three times a week for as long as is appropriate for the client. The groups are open, so women at different stages of recovery meet together, providing motivation for those new to recovery. Often, they arrive in deep denial of their substance-abuse problem. Treatment staff are in telephone contact with the caseworker and provide monthly progress reports. Staff feel CPS is supportive of their efforts. Training is provided by CATS staff to CPS at the academies for new caseworkers, at retreats of 20 CPS units, and at staffings periodically because staff turnover requires training of new staff.

In the groups for women who have children, the focus is on the following:

- Begin to address delusional thoughts and thinking errors concerning their addiction, its effects on their children/parenting, and how it led to neglectful supervision and placed their children at risk.
- Assist with appropriate anger management towards caseworkers and encourage ownership of the problem.
- Educate clients on personal triggers, relapse prevention skills, and techniques; role playing; and the idea of addiction as a disease.
- Educate clients on components of successful recovery, and encourage 12-Step groups, sponsorship, or support group of their choosing.
- Utilize motivational interview techniques to assist clients on stages of change.
- Maintain close contact and communication with caseworker to monitor urine screens and progress with services; attend PPTs and judicial reviews when possible or needed to improve prognosis.

- Focus on women’s issues: boundaries, esteem, abuse issues, domestic violence, parenting sober, how to cope with “using relationships,” and coping skills.
- Offer parenting groups by Parenting Center bimonthly.
- Stress accountability.
- Stress empowerment.
- Develop a continuum of care plan.
- Facilitate entry into transition groups; once a week for a month, can be extended if needed, addressing what is working and what is not, what are their strengths and weaknesses in their recovery.
- Focus on recovery while parenting.

CATS has developed a separate methamphetamine protocol to work with these mothers. Methamphetamine users tend to be delusional, excessively paranoid, and often psychotic from their use of methamphetamine, even after a year off the drug. They have a grant from the Substance Abuse and Mental Health (SAMHSA), and are using the Matrix Model, which employs intensive outpatient therapy that integrates treatment elements from a number of strategies, including relapse prevention, motivational interviewing, education, family therapy, and 12-step program involvement, that lasts about six months.

Staff interviewed noted that mothers whose children have been removed into the legal custody of CPS “are more motivated, as they only see their children during visitation once a week.” Those who have voluntarily placed their children and have more access to them “tend not to work as hard in recovery” (because they are living with a grandparent, for example, where the mother may also be staying). Treatment staff will only participate in the FGC if there is a problem with the family not being supportive of the mother in treatment.

First Choice takes mothers and two-three children for 9-12 months. First Choice has long-term space for 13 women and up to 22 children (under the age of 10) in efficiency or two-room apartments. There are four phases of the program:

- Phase I: orientation (education, sex abuse, domestic violence, parenting, life skills for 20 hours per week; AA; kids to off-site daycare or to school, with bus from door to door)(takes 3-4 months);
- Phase II: look for job, get GED, continue education (2 months);
- Phase III: half-way house-like process (work/school; work toward move-out plan; in-house therapy—individual and group)(2 months);
- Phase IV: aftercare (Fort Worth Shelter Plus Care provides affordable apartment up to five years for 30% of income; continue weekly therapy, random urine tests, home visits, and other conditions).

There is a waiting list of two weeks, but intravenous substance-abusers who are pregnant are given priority, as are substance users who are pregnant, and IV users. First Choice staff interviewed said that methamphetamine addiction is more difficult to treat, often requiring “twice as long for the women to be able to comprehend” what they are trying to teach them about sobriety. They have trouble concentrating, and may have visual and auditory hallucinations in the first weeks they are not using methamphetamine. They also show evidence of anger issues, and are more prone to violent outbursts.

First Choice staff members perceive that CPS closes cases too soon in a woman’s recovery. They note that a client may be sober for a year, but is able to be so because of the structured environment that First Choice provides. They see women relapsing almost as soon as their CPS case is closed, and would like CPS to stay involved for another six months after the mother is stabilized in recovery. Methamphetamine users may need two years in recovery before they are ready to have their cases closed.

Mental Health and Mental Retardation (MHMR) of Tarrant contracts with First Choice to work with children by assessing their needs weekly, and referring to outside

services. MHMR also provides counseling for the children. They make sure they get the children's Medicaid benefits right away through First Choice's on-site benefits specialist.

Texas Wesleyan Law Clinic. Beginning in 1998, Texas Wesleyan began a law clinic, with one supervisor and eight students, mostly handling social security cases. They received a Department of Justice grant in 2003 to handle domestic violence cases at the women's shelter. In March 2005, they received a grant from the United Way to take cases involving children staying at the Lena Pope Home (which provides services such as "family preservation, counseling, alternative education and foster care to meet the behavioral healthcare needs of children, youth, adults and families").

They are referred cases involving relatives who have possession, but not legal custody, of children whose mothers are substance abusers. Since March 2005, they have handled about 17 of these cases. The relatives are worried that the mother will "yank the children back," or the relative may be having problems getting the children into school or medical care, as they have no legal authority. Law students review the facts, and interview the adult caretakers. They are able to get copies of records if the case is in the District Court (as a result of a pre-existing divorce, custody, or visitation issue). They file suits affecting parent-child relationships (SAPCR) in the District Court to give legal custody to the relative. The parent has representation or agrees and retains some rights, usually visitation (supervised or unsupervised); sometimes there is a TPR and adoption.

Suggestions for Improvement and Gaps in Services

Caseworkers would like to see more case aides to help transport clients to drug tests and treatment. Some clients have no transportation, and do not like to use the city bus system. Also, caseworkers have to transport children to visitation weekly. They

would also like to see more community resources for the male single parents who are their clients; there is no treatment facility where a substance-abusing father can take his children. It would also be helpful to have a community-based case manager to monitor their clients in treatment.

Conclusion

Tarrant County has implemented a Family Group Conferencing approach that appears to be working well. Tarrant's evaluation shows that of 407 families assessed for FGC, 54 were deemed appropriate. More than one-half (55%) of those resulted in a safe placement for the children at home or with relatives, including those who were not legally removed from the mother by CPS. However, the FGC administrator believes those numbers do not reflect her understanding that most families assessed for the FGC are accepted by the program for a Conference.

The approach has the support of the judiciary, CPS, attorneys, and families in the county, and has been embraced by the state Department of Family and Protective Services. State assessments from two counties show an increase in kinship placements and decrease in foster care placements. CPS takes the family's recommendations on placement almost all the time, and family satisfaction is said to be higher than with the traditional Permanency Planning Team meetings.

Responding to the increase in methamphetamine use among their clients, Tarrant County's child protection agency has created a methamphetamine specialist in their IMPACT Unit. The specialist is trained in responding to children found in methamphetamine labs, and in identifying methamphetamine labs. She has become a resource for CPS workers in other units.

Tarrant has many treatment programs for substance-abusing parents. The County also offers several options for placing women with their children in treatment centers, such as CATS, TCADA, and First Choice.

CHAPTER 8

ALLEGHENY COUNTY, PENNSYLVANIA (PA)

Allegheny is the 28th largest county in the United States with a population of 1.3 million. Pittsburgh is the largest city. A site visit was completed in May 2005.

History of Allegheny County Department of Human Services

There are 8,700 children in the care of the Allegheny County Department of Human Services (DHS), with 2,500 in out-of-home placement. There are five offices around the county to help families have easy access to caseworkers.

In the mid-90s, DHS was “out of control” with bad press, high caseloads, cases that went horribly wrong, and a backlog of 1,600 children awaiting adoption. A national search produced a Department Executive Director, Marc Cherna, who turned things around. The number of children awaiting adoption dropped from 1,600 to 400. Mr. Cherna established fundamental tenants for the Department, including:

- Protecting children is the responsibility of the community. The Department gives ownership to the community and provides an open and inclusive partnership between the community and the Department.
- Consumers are given a voice through the Department’s complaint line. Complaints are given a priority and are taken very seriously.
- The Department’s goal is to empower parents and achieve their buy-in for the plan to make their children safe.
- The Department demands excellence from its staff.
- The Department’s primary goal is to *prevent* child abuse and neglect rather than to respond after the occurrence of child abuse and neglect.
- The goal is to preserve the family. When it is necessary to remove children from their parents, they try to place them in kinship care rather than with strangers. Children who are removed are placed in kinship foster care in 65% of the cases. Kinship foster parents receive the same pay as non-relative foster care providers.

- Resources have been mustered to help caseworkers provide housing, substance abuse treatment, transportation, mental health services, domestic violence services, in-home services, supervised visitation at various places (not just at child protective services offices) during the day, at night, and on weekends, and other services for parents.

In the mid-90s, there was a very adversarial relation between caseworkers and parents' and childrens' attorneys. That has changed through training, education, and frequent meetings with attorneys and DHS staff. Open communication and group decision making has been established. DHS pays for the attorneys for parents who cannot afford an attorney, for attorneys for children, and provide CASAs and GALs. The Department wants parents and children to have strong advocates and good attorneys.

Every year, DHS sponsors a Family Unification Picnic that celebrates the return of children to their family. They also host an annual Holiday Project that distributes gifts to all of the children under the care of DHS. These outreach efforts have helped to change the climate in the community towards DHS, and has provided favorable press coverage that the Department did not enjoy 10 years ago. The Executive Director said "things are far from perfect," but it is much better than a decade ago. It took nine years to institute change.

POWER Connection Program

Pennsylvania Organization for Women in Early Recovery (POWER) is a nonprofit organization, founded in 1991, whose mission is to provide gender-specialized alcohol and other drug treatment and support to women who are changing their lives through recovery from alcohol and other drugs. POWER's operating premise is that women suffer from addiction differently than men. Each of POWER's treatment and supportive programs address topics that impact women more significantly than they do

men, such as parenting, relationships, physical and mental health, self-esteem, domestic violence, care giving, under-employment and the stigma associated with being a woman battling alcoholism or other addictions.

POWER responded to a Request for Proposals from DHS and was awarded a \$1.2 million contract. Previously, they had a \$1 million budget and employed 20. Following the award, their budget more than doubled and their employees expanded to 50.

POWER provides intervention and recovery support services to clients involved in Allegheny County's Children, Youth, and Families Services (CYF). While POWER will do drug assessments of men, they only provide services to women. POWER's goals are to help women (1) get and remain clean and sober; (2) build a foundation in recovery and learn how to build support systems within the community; and (3) manage their lives and families in a safe and healthy way. Assessments are conducted in the CYF regional offices and at a local hospital with a maternity unit. POWER assessors are all certified addiction counselors with a minimum of a Bachelor's Degree and years of substance abuse experience or a Master's Degree with years of substance abuse experience. They prefer clinicians also have mental health experience, but that is not always possible.

POWER assessors are located at the regional offices. The intent was for POWER staff and CYF staff to get to know one another and build trust by locating them in the same building. CYF workers personally hand referral papers to POWER assessment staff. The POWER assessor telephones the client (who has already been informed by CYF that POWER will be calling) and schedules a home visit, usually within 24 hours of the referral. POWER administrators believe it is important to do the assessment in the client's home to minimize any inconvenience for the client and to eliminate any

“excuses” clients might come up with to avoid the assessment, such as lack of transportation or child care. It also allows the assessor to observe the client and her home environment for signs of substance abuse. The substance abuse screening takes about 15 minutes and uses a self-reporting instrument, Substance Abuse Subtle Screening Inventory (SASSI), plus the Pennsylvania Client Placement Criteria (PCPC)) to assess the level of care needed. In addition, they conduct a urine screen, an alcohol swab, and an Ecstasy screen. The entire assessment takes about 2.5 hours.

In addition to the substance abuse assessment, every woman is screened for mental health issues, using a standardized MESA screen and the Beck Depression Scale. If the client is diagnosed with substance abuse and mental health issues, they treat the women first for “whatever door she came through”, i.e., whether CYF referred her for substance abuse or mental health issues.

Following the assessment, POWER staff report the results to the referring CYF caseworker. Clients have already signed a Confidentiality Waiver before the assessment is done that allows POWER staff to share the results with CYF. If it is determined that the client has a substance abuse problem, she is either referred to out-patient treatment or to a detoxification unit, as indicated. The client is also offered a mentor; more than half of the clients accept a mentor. The mentor’s job is to walk women through the recovery process and build their social and family support systems.

Clients are told that the mentor can help them meet their service goals and help them through the system. POWER supervisors assign mentors to clients by matching by age, personality, clients’ needs, geographic location, and by CYF regional office. POWER has 14 mentors; some have college degrees, and others do not. All mentors are

recovering addicts with at least five years of sobriety. They are paid \$18-24 per hour and most work with 15-25 women at a time; this is full-time job.

Mentors are assigned within one-two days after the client expresses an interest in using this service. The mentor calls the client and makes an appointment to see them. The mentor focuses on things they have in common with the client. Mentors meet with client weekly in-person at the client's home. They provide transportation to Alcoholic's Anonymous (AA), Narcotics Anonymous (NA), and faith-based and other treatment services. They work with clients to help them meet their service goals and report weekly on the client's process to their POWER supervisor and to CYF (the Confidentially Waiver allows this). If the client is not meeting her goals, the mentor explains why. Mentors also accompany clients to court hearings to provide support, but not to testify.

Mentors work with clients throughout the dependency process. A tribute to the success of the POWER program is that on average, children are returned to their parents within 12.5 months, compared with 22 months for clients not in the POWER program.

Listen to these comments from POWER clients who had mentors:

- “She (the mentor) is my friend. I can call her anytime of the day and she is always there for me. She goes to my (AA) meetings with me.”
- “When I got to her (my mentor), I was finally able to talk about things that had been so deep inside and get them out. I saw others like me, and that helped.”
- “She understands me because she went through what I am going through. Seeing how well she has done gives me hope.”
- “She even goes with my son to his doctor's appointment. She is part of our family.”

Family to Family

Family to Family is an intensive program within CYF to provide in-home services to parents. It began five years ago with a grant from Fannie Mae. A single senior caseworker with special training works to assess strengths and conduct a risk assessment.

Unlike typical CYF activities, the Family to Family caseworker provides intensive service in the family's home. A wide variety of services are available to help the family with whatever they need to recover their children, including housing, transportation, parenting classes, medical intervention, crisis intervention, visits between parents and children, sibling visits, empowerment training, and access to community resources. In order to provide these intensive services, the CYF caseworker's client load is reduced from 30 families, as in the regular unit, to 15 families in the Family to Family Unit.

An example of a Family to Family case involved a mom and dad who were both drug addicts. They had six children; the six and nine year olds were removed by CYF for abuse and neglect and placed with their older sister. The caseworker from Family to Family went to the mother's home and to visit the dad in jail to see what services were needed. Substance abuse treatment, parenting classes, and a GED program were provided to the mom. The caseworker provided transportation to appointments as needed. A larger house was secured for all the children and furniture was bought. Sibling visits and visits between the parents and their children were set up on a regular schedule. The kitchen was stocked with food. Once things were going well (that took two months), the case was closed in the Family to Family unit and transferred to the regular CYF unit to monitor until the dependency matter was closed.

Family Group Decision Making

Family Group Decision Making (FGDM) invests in the strengths of families and helps families provide a safe environment for children. It began in Allegheny County in September 2001. It is an experimental program available in two of the five CYF regional offices. Within those offices, every family is eligible to participate with the exception of

families in which there is active domestic violence or if the child has been sexually abused.

Since its inception, 376 families have participated in FGDM meetings. It is the parents' decision as to whether they want to participate. The FGDM meeting empowers a family to participate in the decision making process rather than leaving the decision making to the legal authorities and service providers. It identifies and taps resources within the family and allows services to be customized to meet the needs of families. It is a real paradigm shift in how CYF handles cases, because rather than imposing a plan on families as CYF agencies typically do, the parent and supporters draw upon their resources to develop a safety plan. Engaging families in the process is seen as a better way to help families keep children safe and structure functioning families rather than imposing the state's plan on the family. It is an early intervention program that is designed to keep parents and children out of dependency court. The guiding philosophy of FGDM is:

- Families have strengths and are capable of making decisions and plans which keep their children safe.
- Families have the most information about themselves to make well-informed decisions.
- Individuals find security and a sense of belonging within their family; families provide a sense of identity for their children.
- Families have the ability, if given the chance, to activate helping networks with communities to keep children safe.
- Plans to protect children are most effective when they develop out of the strengths of the community and the culture in which the family lives.

Guiding principles of FGDM are:

- Children must be protected from harm, their rights upheld, and their welfare promoted.
- The family has the primary responsibility in caring for and protecting children.
- Families should be supported in their efforts to keep their children safe.

- It is desirable for children to live with their families. Children should be kept out of institutional and stranger care if at all possible.
- Government agencies and communities must partner with families to ensure child safety and well being.

With the help of their CYF caseworker, parents identify who among their friends, family, community members, teachers, pastors, faith-based providers, treatment providers, and others can help develop a safety plan for their children and return the family to a healthy, functioning unit. Up to 40 people may be invited to the FGDM meeting (if friends or family members who can be supportive live out of town, CYF will pay for them to come in for the meeting). The FGDM meeting is held at a location where the family feels comfortable, such as at a restaurant, or a faith-based community-owned facility.

The FGDM meetings last three-four hours and are run by a facilitator selected by the parent (a family member or friend). The CYF caseworker and treatment service providers who may be of assistance attend and help the family sort through the issues the family needs to deal with. The FGDM meeting agenda is:

- Welcomes
- Introductions of those present at the meeting
- An overview of the FGDM process
- Opening in the ways of the family tradition
- Oral history of the family
- FGDM rules
- Identification of family strengths
- A family meal
- Discussion of issues/concern for the family
- Identification of bottom lines/nonnegotiable issues
- Statements of the family
- Questions/answers
- Parental statement
- Family Planning Time
- Review of the Plan by CYF and family advocates
- Identification of family contact person
- Evaluations of the FGDM process

- Schedule Review Date three months after the FGDM meeting; if everything is going okay, CYF closes the case: 80% of the 376 FGDM cases in two out of the five regional offices where it is available have been closed successfully within the three-month period

Observation of a Family Group Decision Making Meeting

One of our ABA researchers observed a portion of an FGDM meeting. The family chose to have the meeting in a house owned by a Lutheran church that is used for meetings. Participants sat around a conference table.

Welcomes. The family chose a family friend as their facilitator. He received training from the FGDM director on how to be a facilitator and watched a film about this role. He seemed quite at ease, organized, and competent. He welcomed everyone to the meeting.

Introductions of those present at the meeting. Everyone took a turn at introducing themselves. Present were the mother under CYF investigation, her 14-year-old son, a friend of her son's, the mother's mother and step-father, the CYF caseworker, a CYF supervisor, the FGDM director, a representative from a service agency that provides services that might be helpful to the family, and one of our ABA researchers.

An overview of the FGDM process. The facilitator and the CYF caseworker explained the process. The purpose is to help the family identify their strengths to work with their support group of family and friends to address the issues that brought them to the attention of CYF.

Opening in the ways of the family tradition. The facilitator asked the family if there was a way they generally began their family gatherings. They said they usually began with prayer and the facilitator asked who would like to lead the prayer. The mother's mother offered a prayer.

Oral history of the family. The facilitator asked about family members who were not present that day. The mother said she had a brother who wanted to come but could not take time off from work. A brief discussion of other relatives was given.

FGDM rules. The facilitator went over the rules and listed them on news print so everyone could see and refer to them.

Identification of family strengths. Everyone in the room was asked to identify family strengths and they were listed on the news print, including:

- a loving family that cares about each other,
- a strong belief in God and importance of prayer and their church,
- a sense of humor,
- willingness to seek help and work on their problems,
- enjoyment of food and good cooks, and
- open to getting services to help them.

A family meal. The FGDM program administrators believe sharing a favorite meal during the meeting creates a good atmosphere and helps break tension while giving the family a time to have fun and share before talking about the tough issues. The family may choose whatever type of food they like and everyone in the room shares in the meal. This family chose Kentucky Fried Chicken with all the fixings and everyone seemed to enjoy the fellowship and food. There was lots of laughter and loving rapport among those in the room. Before the meal, the grandmother offered a prayer of thanksgiving.

Discussion of issues/concerns for the family. The family and CYF representatives identified several issues that needed to be addressed for this family (again, the facilitator listed them on news print). Major challenges are:

- The mother has cancer and is undergoing chemotherapy. She lost her job as a result and is homeless, as she does not qualify for SSI (she has already used her yearly allotment). She and her son shuttle among family members' houses. They are working on getting her Section 8 housing.

- The son has been suspended from school twice in the last month for minor brawling issues. The grandmother said she is very worried about the boy as he is dealing with so much and is understandably upset. He is worried his mother will die from cancer; he has no father; he has no permanent home; his cousin is dying from cancer; and his step-grandfather just got out of rehabilitation for substance abuse. A representative from a program that teams men with boys in a mentoring program described their services that could help the boy cope with all that he is going through. Family members seemed to like the program and said they would follow up to obtain services.

The family met privately to discuss their plans.

Permanency Planning Conference (PPC)

A member of the ABA research team observed a PPC. At the PPC were three representatives of CYF (including the caseworker), the mother whose two children are in dependency court, the father, the child's aunt (who is caring for the two children), and an attorney from Kid's Voice (the children's attorney). The mother's attorney was not present at the PPC although he was invited to attend (the father just got out of prison and does not yet have an attorney—he was given a number to call to get an attorney). The CYF caseworker ran the conference.

There was lengthy discussion about the welfare of the children, who have been in the aunt's care for nearly one year. Both children are behind in their education and the CYF caseworker asked if it would be okay for the educational specialist in her office to call the mother and aunt. They agreed. The mother visits with her children in a supervised environment several times a week (the aunt has to be there). The father just got out of prison and has seen his children twice.

A cousin of the mother has her three other children. The brothers and sisters do not see each other because the cousin and aunt do not get along. CYF stressed the importance of the children seeing each other and offered to call the cousin to arrange a

neutral setting where the children could visit. The aunt and mother indicated they would like CYF's help with the visiting as they want the children to see each other.

The aunt is willing to keep the two children as a long-term guardianship. She does not want to adopt the children as she does not want to take her sister's parental rights away. The cousin is adopting the three other children, which is okay with the mother.

They went over the mother's goals, which had been articulated at the last court hearing. The mother was not at the hearing, because she claimed she did not receive notice. The CYF caseworker confirmed they had the right address and the mother said maybe someone stole her mail. The caseworker said she could also send notice to her sister to make sure the mother received her mail. It was also emphasized that the mother and father have the responsibility to stay in touch with the caseworker, and neither have been doing so. It was also pointed out that the mother has not done any of the things she needs to do to comply with court orders, including:

- obtain a permanent residence,
- obtain drug and alcohol treatment, despite a history of abuse going back to 2001,
- undergo weekly urine screens; this was ordered five months ago and she is not in compliance, and
- enter a parenting class; the mother said that she has done that and CYF asked her to sign a release form to verify that she is attending.

The PPC lasted about one hour. The atmosphere was casual and cordial but the CYF representatives firmly stated that the mother is not in compliance with court orders; that the children need help with their education; that the siblings need to visit with each other; and that the father has not had any contact with CYF since getting out of prison, until the conference today. It was clear they were frustrated with the lack of compliance with both the mother and the father and grateful for the care provided by the aunt.

Gaps in the Allegheny County Approach

We interviewed children's attorneys; parent's attorneys; CYF administrators and caseworkers; POWER administrators, counselors, mentors and clients; and judges.

During those interviews, a number of gaps emerged, including:

- more treatment facilities that accept women and their children as there are only two in the county;
- outpatient treatment centers that provide childcare, as they only have one;
- more in-patient care centers, because sometimes parents have to wait up to three weeks for a bed;
- more programs for children of all ages, as they have only two places in the county for children;
- more training for judges on recovery and relapse, as some judges are very educated on these issues but others are not; and
- treatment services for men and in-patient treatment centers where fathers can reside with their children.

Strengths in the Allegheny County Approach

The interviews also yielded many strengths inherent in the Allegheny County approach to dependency cases. These include:

- CYF reversed a hostile image among the public that CYF was “out to get them and take their children away,” into a positive image that CYF was there to help parents and children. Parents used to hide from CYF. Now they trust CYF is there to help them. This change in attitude took years to accomplish and lots of training and a strong Department of Human Services Executive Director. In the mid-90s, the system was “out of control” and the community “hated them” and now they are seen positively by the community.
- There is a strong team approach among treatment providers, CYF, and attorneys. The expectation, not the exception, is that they will work together. Communication between CPS and treatment providers is good.
- They have a multitude of treatment choices in the county. There is a Bureau of Alcohol and Drug Services in Behavioral Health under CYF to coordinate services and make sure that there are adequate, quality services in the county.

Within CYF, there are drug and alcohol specialists that work with parents to encourage them to get services. The county contracts with 35 drug and alcohol providers. During interviews with judges, we were told they are “spoiled” by all of the services they have in the county.

- The POWER program has certified addiction counselors and mentors who are recovering addicts. The clients see them as on their side and the POWER mentors work well with CYF caseworkers to keep them informed about parents’ progress. They feel it would be advantageous if something like POWER were available for men and teen mothers (POWER only takes teen mothers if the teen’s mother is involved in a dependency matter).
- The Family Group Decision Making Project in Allegheny is the first in Pennsylvania and has been featured on CBS and CNN. It is based on the premise that family are in the best position to protect the child and have strengths to protect the child and secure a healthy living environment.
- The Permanency Planning Conference engages parents in the dependency process by providing an informal setting that encourages parents to participate in the plan to get their children back.
- The Family to Family intensive service unit within CYF works with families in their home to provide all the help they need to have their children returned to them.
- The county has a strong legal program for children and parents. Kid’s Voice provides legal representation for children. Every child has an attorney paid for by CYF. Every parent has an attorney paid for by CYF if they cannot afford one.
- There are effective psychological and psychiatric assessments of parents to determine if they have mental health problems and for assessing dual-diagnosed parents.
- They have providers in the county to work with dual-diagnosed parents who have both mental health and substance abuse problems.
- ASFA has had a positive effect in moving cases along. In Allegheny, cases are reviewed every three months, rather than the required six-month review under ASFA. This has resulted in services, including substance abuse services, being offered early in the process and has moved children into permanent placement in a timely fashion. That did not happen before ASFA. Years ago, paper reviews were common; now, reviews are given more time and hearings are held in every case.
- ASFA has had a positive effect in letting parents know up front what they need to do to get their children back.

- Juvenile court judges have visited treatment programs to learn more about them and how they work. Most of the judges are informed, but some need more training on recovery and relapse.

Conclusion

Allegheny County offers many interventions to help parents whose children are in dependency court within the timeframes of ASFA. The Executive Director of DHS has surrounded himself with excellent administrative staff who firmly believe in tapping family's strengths to protect their children and create a safe home for their children. Impressive programs have been developed to achieve that goal, including the POWER program, Family Group Decision Making, Family to Family, and the Permanency Planning Conference. There are many in-patient and out-patient substance abuse programs to provide services to parents in a timely fashion. Parents and children have strong legal representation. Courts review cases every three months, rather than the six months under ASFA, to ensure parents have time to make the changes needed to have their children returned to them.

CHAPTER 9

COOK COUNTY, ILLINOIS (IL)

Cook County (Chicago), Illinois was visited in April 2005. It was chosen as one of the five case studies for a number of reasons. The Treatment Alternatives for Safe Communities (TASC) program offers case management and referral services for substance-abusing parents whose children are in dependency court. The Juvenile Court Assessment Project (JCAP) enhances the services of TASC by early assessment of parents' needs for substance abuse treatment and other services. The Recovery Coach Demonstration project is an intensive case management program that goes beyond what TASC and JCAP offers. This five-year project, which incorporates control and demonstration groups, is being rigorously evaluated; therefore there are data to document the effects of the project. Finally, Cook County's use of Title IV-E Waiver funds provides the resources needed to secure a wide range of services very rapidly. Because there is money to pay service providers, Cook County does not suffer a lack of treatment options and long waiting lists for services to help parents.

Under Section 1130 of the Social Security Act, the U.S. Department of Health and Human Services (HHS) was given authority to approve child welfare demonstration projects between 1998 through 2002. These federal demonstration projects involve the waiver of certain requirements of Titles IV-B and IV-E of the Social Security Act that govern foster care, adoption assistance, child welfare services, and other programs and administrative expenses. The waiver authority provides an opportunity for states to design and test a wide range of approaches to improve and reform child welfare. This is the second of three waivers (Subsidized Guardianship, Alcohol and other Drugs-AODA,

and Training) granted to Illinois by the Children's Bureau of the Administration for Children and Families (ACF). The Department's application for the Title IV-E AODA waiver project was submitted in June 1999 and approval was granted by ACF for a five-year demonstration in September 1999.

IV-E AODA Eligibility and Service Components

Families are eligible for the project if their case meets the following criteria: 1) the case is located in the Cook County area; 2) the custodial parents are assessed to have involvement with alcohol and/or other drugs; and 3) DCFS has been granted custody of a minor and JCAP has assessed the parent within 90 days of the temporary custody hearing. Eligible cases are either add-ons to existing foster care placement cases or are new placement cases to DCFS. Cases are initially identified through the Child Protection Division of Cook County Juvenile Court. Cases are referred to JCAP for a determination of their need for alcohol and other drug (AOD) treatment.

The project seeks to serve 1,500 parents within the five-year period. Parents are randomly assigned to either a control or demonstration group and are assigned based on the child welfare agency serving the family. Families in the control group receive the JCAP assessment, a level of care determination, and an intake appointment at a treatment provider within 24 hours of the assessment. Existing child welfare and AOD services are also available. In addition to the above services offered to the control group, families in the demonstration group receive the enhanced services of a TASC Recovery Coach to coordinate their AOD services and to provide intensive home-based outreach and engagement opportunities throughout the life of their DCFS case.

The Children and Family Research Center in Champagne, Illinois is coordinating an independent evaluation to assess the impact of these enhanced services.

Overview of TASC

Treatment Alternatives for Safe Communities (TASC) began in 1972 with funding from the White House Special Action Office for Drug Abuse Prevention, the National Institute on Drug Abuse, and the Law Enforcement Assistance Administration. There are over 200 TASC programs nationwide. The largest, and only statewide, TASC program is in Illinois. TASC began in 1976 in Cook County as an independent, statewide, nonprofit agency providing support and community service coordination for clients who are referred or mandated to substance abuse treatment by various public systems. In 2004, statewide Illinois TASC offices served 27,776 clients. Two-thirds of TASC caseworkers in Illinois work in Cook County.

Most TASC clients have multiple health issues, including a combination of substance use disorders, mental health disorders, and HIV/AIDS issues, while facing barriers in housing, employment, child care, transportation, and community and family connections.

During the evaluation of the IV-E AODA Waiver Recovery Coach Program (discussed below), the evaluators found that, in addition to substance abuse problems, 78% of parents also had problems with housing; 57% reported problems with mental health; and 39% reported problems with domestic violence. Overall, 25% of the families reported problems in all four areas—substance abuse, housing, mental health and domestic violence.

There are 12 TASC offices in Illinois that provide a specialized model of clinical case management to deal with these multiple issues, including

- in-depth clinical assessment and verification process to assess the nature and extent of the client's substance use and other issues that inhibit the client's ability to become productive and self-sufficient;
- an individualized service plan to address the complexity and degree of the client's presenting issues, the services needed to promote recovery, and the resources needed to assist clients;
- coordination of all the activities needed to refer and place the client into appropriate treatment services and the provision of ongoing client support and intervention; and
- case management staff who continually monitor and reevaluate the client's progress and report to the agency or court that referred the individual.

TASC also helps public systems understand the interaction of sanctions, incentives, legal pressures, and the biopsychosocial issues associated with behavioral health problems. In addition, TASC advocates for local and national public policy helpful for its clients; conducts urinalysis; conducts and disseminates research about addiction and mental illness; and provides training nationwide. In 1989, Illinois TASC services were expanded from the criminal court system to the juvenile court system.

Recovery Coach Model - TASC

The Department has contracted with TASC to employ Recovery Coaches to provide intensive AOD outreach and case management services to families assigned to the demonstration group. The Recovery Coaches are employed by an independent agency to help ensure continuity of services when the client changes treatment providers, while also remaining an objective advocate for the client and entire family throughout the treatment process.

The primary goals for the Recovery Coach enhancement are to actively assist parents to address their AOD issues along with helping parents move towards reunification as safely and quickly as possible. These experts work in close partnership with the child welfare worker assigned to the case and remain engaged with the family even after the parent's treatment has been completed. Recovery Coaches work to ensure treatment engagement and consistent attendance, coordinate staffings and family meetings, conduct home visits to provide on-going support and education to the family, ensure random urinalysis testing, and submit monthly progress reports to the child welfare worker and courts as needed.

Summary of IDCFS AODA Waiver Project

Project implementation began in April 2000 and will run for five years. The project seeks to improve child welfare outcomes by providing enhanced alcohol and other drug abuse treatment services to substance-affected families in the Illinois child welfare system. Project goals include:

- Increase the number of substance-affected children in foster care that are safely returned home along with decreasing the length of time it takes for safe reunification.
- Increase the number of cases and the speed at which AOD-impacted cases are moved to a permanency decision.
- Increase the number of AOD-impacted individuals who remain in treatment for more than a 90-day time period.
- Reduce the number of subsequent oral reports of child abuse and neglect.

The TASC program offers case management and referral services for substance-abusing parents whose children are in dependency court. The JCAP program enhances the services of TASC by early assessment of parents' needs for substance abuse treatment

and other services. The Recovery Coach Demonstration project is an intensive case management program that goes beyond what TASC and JCAP offers. This five-year project, which incorporates control and demonstration groups, is being rigorously evaluated; therefore there are data to document the effects of the project. In addition, in 1995 the Illinois Department of Human Services, Department of Alcohol and Substance Abuse (DASA) and DCFS have jointly developed a statewide assessment, referral, treatment and case coordination system for substance-abusing parents in the child welfare system. DASA provides funding to treatment providers to serve referrals from the child welfare system.

As a condition of accepting the additional funding, treatment providers agree to provide assessments within 48 hours of the referral. DCFS provides funding for child care and transportation while the parents are in treatment. Because of this interagency agreement, there is money to pay service providers.

JCAP

The Juvenile Court Assessment Project (JCAP) began serving DCFS clients in 1999 and is located at Juvenile Court. JCAP is a program operated by Caritas, a nonprofit agency contracting with DCFS to provide on-site alcohol and other drug assessment and referrals to treatment providers. Any person 18 years or older who is involved in a dependency court matter may use the services of JCAP. More than 5,000 AOD assessments have been conducted at JCAP between 1999 and 2004. In order for the client to be eligible for the IV-E AODA Recovery Coach project, the assessment must be completed within 90 days of the temporary custody hearing. Typically, JCAP does its assessment at the Court Family Conference date held approximately 55 days after the

Temporary Custody Hearing date. However, the JCAP assessment may be done at any time during the case and will receive the same services but will not be eligible for the IV-E AODA Recovery Coach program.

Referrals are often ordered by the judge, or a referral is made by the DCFS caseworker, the parent's attorney, or is a self-referral by the client. The assessment takes 45-60 minutes and includes self-reported behavior by clients and the DSM-IV assessment instrument. The results are given to the judge. If substance abuse has been identified as an issue, the judge may order urine tests at the next court date (at the Adjudicatory Hearing) held 35- 65 days after the Court Family Conference date. In addition, the DCFS caseworker, or the service provider to whom the clients is referred, may order urine tests.

Based on the results of the assessment, the client is referred to appropriate services; but they are not left to navigate the service world alone. The JCAP assessor calls the treatment program while the client is still in the JCAP office and makes an appointment for the client. If possible, they attempt to make an immediate appointment to get the client into services (or in the very near future) while they are motivated to do so. The DCFS caseworker is encouraged to wait while the assessment is being done so they can transport the client to the service provider. Every attempt is made to facilitate and promote access to services. Immediate, or quick, access to treatment providers is usually not a problem in Cook County. There are a wide variety of different types of treatment available. Treatment services are paid for by the state's interagency agreement to those providers to serve those who may not be able to afford services. As a result, providers receiving funds through the state initiative give DCFS clients priority. Other TASC clients in need of services may experience waiting lists, but JCAP referrals receive

top priority. Obtaining a treatment bed or out-patient services within 24 hours is commonplace in Cook County.

One glitch to receiving immediate services is when the client is on medication for some physical or mental, illness but they do not have their medications with them, or they are not using their prescribed medications. If the JCAP assessor suspects that the client needs medication, they are sent to the Cook County Hospital for assessment before they are sent to treatment providers. If the client has their medications with them, they can go directly to the treatment program. For clients who are identified as dually diagnosed with mental health and substance abuse problems, there are two programs in Cook County to serve them. These programs believe that it is necessary to stabilize the mental health problems before they can treat the substance abuse problems; some programs across the country do it differently, such as choosing to work on the problem--substance abuse or mental health--which precipitated the immediate crisis.

Another glitch to receiving services is clients who have outstanding warrants. Programs will not take these clients unless the judge removes the warrant.

Reassessments may be done at any time during the process and clients have the option of using JCAP services multiple times. The reasoning is that clients' willingness to admit substance abuse problems, and seek services, may change from denial to acceptance over time. Therefore, they keep substance-abuse referral options open to help as many people as possible.

JCAP staff follow up with treatment providers to learn whether referred clients went to treatment and to learn how they are doing in treatment. This follow-up is

typically for 30-45 days after the referral is made, but may continue longer depending on the situation.

Following the JCAP assessment, clients who are randomly assigned to the Recovery Coach Program (see Evaluation Section below) meet with a representative of the Program who is stationed in the JCAP offices. Having the Recovery Coach staff person right there means that clients do not have to find their way to yet another agency to access services. The Intake Supervisor for the Recovery Coach Program explains they are there to help them get their children back. She also has them sign a consent form to participate in the Program along with a Confidentiality Waiver so that information can be shared among treatment providers, the Recovery Coach Program, DCFS workers, the court, and attorneys in the cases.

The IV-E AODA Recovery Coach Program

A General Accounting Office (GAO) study in 1998 was critical of parents' lack of access to substance abuse treatment. The report cites that of all cases studied in Cook County, 78% of all parents needed AOD services and only 20% ever accessed services.

The IV-E AODA Recovery Coach Program is a direct response to the challenge cited in the GAO study in which parents needing treatment services were not getting the treatment which was so desperately needed. Recovery Coaches help parents obtain a wide range of needed services in addition to AOD services, e.g., housing, food, job training, employment, transportation, mental health services, medical services, etc. Recovery Coaches have reduced caseloads compared with other TASC caseworkers. Recovery Coaches have a caseload of 20-30 clients whereas TASC caseworkers work

with twice that many clients. In Cook County, there are 22 Recovery Coaches, two outreach workers, four supervisors, and the Director of the Program.

In order to gain acceptance of the role of Recovery Coaches, extensive outreach, training and education took place. Some caseworkers were initially skeptical of the IV-E AODA Recovery Coach Program. Some treatment providers also had to be convinced of the benefits of Recovery Coaches and how they could be instrumental in communicating with workers, clients, family members, and clients. Some case workers were “very reluctant” because they thought Recovery Coaches were intruding on their job responsibilities. Public defenders were also initially against the Program. They feared that the Recovery Coach Program would increase the state’s involvement in their clients’ lives and result in their clients giving up legal rights, such as agreeing to random drug testing and waiving their rights to confidentiality. Through training, and over time, DCFS workers, as well as treatment providers and defense attorneys, came to see how Recovery Coaches could partner with them to help parents. For example, Recovery Coaches can drive clients to appointments and court (something that DCFS workers seldom have the time to do). Recovery Coaches can find parents who drop out of the system; again, something DCFS, and treatment providers, do not have the time to do. Also, Recovery Coaches conduct of family interventions and facilitate family “healing.” Substance-abusing parents have often destroyed trust and loving relationships with family members and friends by lying to them, asking them to care for their children when they were unable to do so, and by manipulating them.

It took one-and-a-half years to achieve the buy-in of some case workers, defense attorneys, and treatment providers. After a year and one-half, and much hard educational

and outreach work, the attitude changed. The relationship became one of mutual respect and appreciation for what can be accomplished together. Recovery Coaches are knowledgeable about substance abuse issues. Also cited in the GAO report, DCFS caseworkers received very little training regarding substance abuse issues and would often delay court decisions due to lack of diligent efforts. Therefore, Recovery Coaches can come to court and answer question from the judges, and other participants, about how well the parent is progressing in treatment and what other services may be needed to accomplish the changes needed to reunify the children and their parents.

Once a client agrees to enter the Recovery Coach Program, they are contacted by phone, or in person, by the assigned Recovery Coach within 24-48 hours. The Coach reiterates what they were told by the Intake Recovery Coach supervisor. The Recovery Coach is there to help parents make the behavioral changes necessary for them to get their children back.

For parents with substance abuse issues, the Recovery Coach Program works to get them into treatment and provide transportation when necessary. Available treatment services in Cook County are detoxification, residential treatment, recovery or halfway houses, intensive outpatient, and basic outpatient treatment. Services are provided at no cost to the patient, or on a sliding fee basis for parents who can pay something for services.

Some Recovery Coaches have personal histories of substance abuse and use and are a part of the recovery community. The Program believes these Coaches can be especially helpful, and can serve as positive role models for clients with substance abuse problems. The amount of training Recovery Coaches receive depends on their

background. All Coaches have an Associate's, or Bachelor's Degree, and some are already certified as an alcohol and drug counselor. All must receive their Certification within two years of their employment with the Recovery Coach Program. Clinical Supervisors all have a Master's Degree. Senior Recovery Coaches are certified to work with dually diagnosed clients who have substance abuse and mental health issues. Coaches are encouraged to attend monthly TASC meetings to remain current on substance abuse issues. As important as training and education is, their primary criteria for hiring is that the person has true compassion, and a passion, for helping people. The Program has a good retention rate for their Coaches. Most of the turnover is due to promoting within the Program rather than people leaving the Program. In the past few years, only four or five of the 22 Coaches have left the program.

Recovery Coaches are advocates for parents just as DCFS are advocates for children. The Coaches empower parents, motivate them, and work with them to make life changes that will result in their getting their children back. The Recovery Coaches: are available 24 hours a day, seven days a week for emergencies through a rotating emergency pager system; conduct visits to the client's home and community; and provide personal motivation to keep clients involved in their treatment.

If Recovery Coaches lose contact with clients, or clients are not willing to get services to help make the behavior changes necessary for the return of their children, the case is referred to the Recovery Coach's Outreach component. The Outreach Recovery Coach tries to contact the person. This often requires field visits to high-crime, high-drug areas. They are able to locate clients in about 25% of the cases.

Coaches interviewed said they think ASFA timelines are unrealistic, because parents cannot recover within these timelines. However, they also reported that most judges will extend timelines as long as the parent is showing progress in treatment. It is part of the Coach's job to educate judges, attorneys, and DCFS caseworkers about the recovery process, including that relapses are expected. During our interview, Coaches reported that judges and others listen to them and show them respect as long as they go into court prepared and knowledgeable about how the parents are doing. They also have to be honest and report when a parent is not making progress in order to maintain their integrity.

They recognize how difficult it is for a client with a long history of substance abuse to enter, and remain in, treatment. Therefore, Coaches are required to reach out to clients by visits, phone calls, letters and collateral contacts at least 60 times in six months, even if the client refuses services.

To be informed about the client's progress, Coaches stay in close contact with their clients by making home visits, having collateral contact with their family and friends, and staying informed about their progress in treatment by talking with service providers. The aim is to "engage and re-engage" their clients. Every chance is given for those reluctant to seek help to change their minds with the encouragement of their Coaches. All parents in the Recovery Coach Program sign a release that allows the sharing of information among Recovery Coaches, DCFS, treatment providers, and the court. Recovery Coaches complete intensive five-page monthly reports called TRACCS forms. These reports are given to caseworkers and to the TRACCS coordinators responsible for collecting the data for the project.

Coaches typically work with parents for 18-24 months and usually close their case when DCFS closes their case. However, Coaches cannot close the case without the approval of their supervisor and the program director. Even after a case is closed, clients may always come back to the program if a new problem arises or they want further help.

We solicited comments about Recovery Coaches during interviews with JCAP workers, treatment providers, TASC staff, and others. Consider these:

- “The Recovery Coach is another person working to monitor if the client goes to treatment. The Recovery Coach is an encouragement to the client.”
- “The client is already labeled as a bad parent when their child is taken away. The Recovery Coach is their advocate. The DCFS caseworker leaves but the Recovery Coach stays with them.”
- “The Recovery Coach explains the goal is to remove the red tape by reiterating that the goal is get their kids back. Someone is finally listening to their side of the story.”
- “The Recovery Coach Intake Supervisor spends 35-40 minutes with the parents and calms them down. Parents are exhausted by the time they get here. Some have sat on a hard bench in court all day; some of these women had a drug-addicted baby just 48 hours ago.”
- “Even after the children are returned home, Recovery Coaches stay involved.”
- The Recovery Coach Program is “excellent. The treatment counselor and the DCFS caseworker can only do so much. The Recovery Coach goes into the field to find out what’s going on. The Recovery Coach will bring the client in and sit in the staffing.” We (a treatment provider) “welcome the Recovery Coaches as they address all of the needs of their clients. Our clients are poverty stricken and need a lot of help. Some people don’t want to go into certain high-crime, high-drug neighborhoods, because they are afraid of the dealers, but the Recovery Coaches go into these places.”
- “Recovery Coaches develop close bonds with their clients who just want to know someone cares.”
- “Clients know when someone is genuine and when they are not. Our treatment program was doing the best we could before we had Recovery Coaches, but they get clients reengaged. Before the Recovery Coaches, more people left treatment and never came back or ended up in prison. It is better now.”

- Recovery Coaches are like “an extra arm or an extra leg and they care.”
- “Recidivism rates are going down since we have the Recovery Coaches. People who leave treatment come back sooner than before we had Recovery Coaches.”

Evaluation of the Recovery Coach Program

The goal is to serve 1,500 parents: 1,000 in the demonstration group and 500 in the control group, within the five-year demonstration project. Parents are randomly assigned to either a control or demonstration group. Families in the control group receive the JCAP assessment, a level of care determination, and an intake appointment at a treatment provider within 24 hours of the assessment. Families in the demonstration group receive these services plus the enhanced services of the Recovery Coach program that coordinates their treatment services and provides intensive home-based outreach services (as described above).

The evaluation is being done by the Child and Family Research Center at the University of Illinois, located in Cook County. Some of the evaluation questions are: (1) are parents in the demonstration group more likely to access treatment than parents in the control group?; (2) will parents in the demonstration group access treatment quicker than parents in the control group?; (3) will parents in the demonstration group stay in treatment and be more successful in treatment than parents in the control group?; (4) will more families in the demonstration group achieve reunification, or other permanencies, and will children spend fewer days in care than families in the control group?; (5) will there be fewer subsequent maltreatment reports in the demonstration group than of parents in the control group?; and (6) is the project cost neutral, i.e., will what it costs to run the program off-set the money saved by returning children to their homes sooner?

As of April 2005, statistically significant findings include:

- 73% of the demonstration group parents accessed AOD treatment as compared with 50% of the control group parents.
- 50% of the demonstration group parents accessed treatment within 40 days of the JCAP assessment, whereas it took 100 days for 50% of the control group parents to access treatment.
- 13% of the children in the demonstration group were returned home compared with 11% in the control group.
- Children in the demonstration group averaged 182 fewer days in foster care before returning home than children in the control group.
- Children in the demonstration groups averaged 43 fewer days before adoption.
- Twenty percent of parents in the demonstration group had a subsequent maltreatment report compared with 29% in the control group.
- The project remained cost neutral through September 2004; indeed, the project actually produced a cost savings of over \$3.9 million, primarily due to the savings generated by children spending fewer days in foster care.

Conclusion

Cook County has several impressive programs to help substance-abusing parents whose children are in dependency court. TASC, and its Recovery Coach Program, helps parents obtain a wide range of needed services, e.g., housing, food, job training, employment, transportation, mental health services, and medical services. A sophisticated evaluation component has documented the effectiveness of the Recovery Coach Program. JCAP provides immediate assessment and referrals to a wide variety of treatment providers. All of the above provides substance-abusing parents with a myriad of services to help them reclaim their children within the timeframe dictated by ASFA.

CHAPTER 10

SAN DIEGO COUNTY, CALIFORNIA (CA)

San Diego was visited in September 2005. It is the seventh largest county in the United States, covering 2,000 square miles, with a population of 2.9 million. The county is primarily Caucasian (66%), but it has a sizeable Hispanic population (27%). It is the southern most county in California, bordering on Mexico. The median household income is \$47,067 (U.S. Census, 1999).

Last year, 6,500 dependency cases were processed in San Diego County. Over the past few years, the number of dependency cases has increased by a couple of hundred per year. Within the county, there are six CPS regions, with a total of approximately 900 Child Protective Services (CPS) staff.

San Diego was selected to learn about its Substance Abuse Recovery Management System (SARMS), which includes their Dependency Drug Court. SARMS was the creation of Judge James R. Milliken, Presiding Juvenile Court Judge at the time. He recognized that 80% of the parents with children in dependency court have substance abuse issues that impair reunification or result in termination of parental rights. Traditional processing of these cases was not working. Lack of adequate access to, and follow-through with, drug and alcohol treatment services for parents was a major contributor to delays in dependency cases. Because parents did not receive effective and prompt treatment, cases were not resolved within ASFA timelines. These delays discouraged parents from making positive changes in their lives and reunifying with their children.

In 1997, Judge Milliken, at his own expense, traveled all over the world over a six-month period, to learn what other courts were doing to handle these types of cases. He returned with an idea for SARMS. The idea was presented to the Board of Supervisors and funding was secured.

Parents in dependency cases with alcohol or substance abuse issues are required to participate in SARMS. Those who fail the SARMS program will be given a chance to participate in the Dependency Drug Court part of SARMS as their last recourse to reunify with their children. It is unusual that the San Diego Dependency Drug Court accepts those who have failed all other treatment services. Many drug courts around the country are the first line of intervention, not the last one. Because the San Diego Dependency Drug Court deals with those who have failed in treatment in every other program, they have a difficult challenge.

Planning SARMS

Careful planning was critical to the development of SARMS. The Dependency Policy Group was formed to discuss and develop policies on how cases will be handled in the dependency system from beginning to end. Its objective was to create definitive policies that would result in uniformity in how cases are processed. The Dependency Policy Group was made up of three judges from Juvenile Court, including Presiding Judge Milliken, the Office of County Counsel, an attorney from the Public Defender's Office, an attorney from the Alternate Public Defender's Office (described below), the Deputy Director and a Program Specialist in Child Welfare Services within the Health and Human Services Agency (HHSA), the Director of Juvenile Court Operations, a Juvenile Court Research attorney, and the Court's Special Projects Manager. There was

also a formal subcommittee in place which included two members of the Board of Supervisors, the Director of the Health and Human Services Agency and the Presiding Judge of Juvenile Court. The Policy Group initially met weekly while the program was being developed but later moved to monthly.

The current Policy Group is comprised of fairly high level managers and has expanded to include Voices for Children, HHSA's Mental Health and Residential Services, the Executive Director of the Commission on Children, Youth and Families, other court managers, and a Housing Coordinator from the Department of Housing and Community Development. Guest speakers are frequently brought in for their expertise.

The Dependency Policy Group met weekly to plan SARMS. The Group has responsibility for formulating policies for all aspects of dependency matters, not just for SARMS. With regard to SARMS, they discussed, and decided, what the SARMS model would consist of; which agencies would take responsibility for aspects of the program; what training was needed; and what service provider would provide substance abuse treatment. They issued a competitive Request for Proposals (RFP) for the drug treatment provider (Mental Health Systems, Inc., was selected).

The Dependency Policy Group set the primary goals of SARMS: to reduce the amount of time children spend in foster care and to achieve positive reunification for as many families as possible by promoting successful recovery for alcohol or drug dependency when these factors contribute to removal of their children. To achieve this goal, alcohol and drug treatment services are ordered for parents who agree to cooperate with prescribed treatment plans.

Currently, the Dependency Policy Group meets monthly (in the beginning, they met weekly) to address issues related to policies and to decide if new policies are needed, or established ones need to be changed, for SARMS as well as other dependency matters within San Diego County.

Implementing SARMS

SARMS began in the spring of 1998 (eight months after the Planning Group began its work). A SARMS Implementation Team Group was formed to provide a formal mechanism for resolving operation issues that occurred in the implementation. Mid-level managers (approximately 30 people) from CPS, the Judiciary, the Public Defender's office, the State Attorney's Office, Mental Health systems, and Alcohol and Drug Service meet weekly to make sure the programs run effectively, to address any operational problems, and to make any needed operational changes (policy matters remain under the purview of the Dependency Policy Group). In addition, a Special Project Manager was hired to implement SARMS.

SARMS

SARMS is an extensive case management system. Mental Health Systems, Inc., received the contract (it is a five-year contract with the option of applying for a five-year renewal) to provide immediate alcohol and drug assessments for parents with a substance abuse problem. Since June 2004, SARMS has served 1,100 clients. Mental Health Services is responsible for developing a treatment plan and monitoring the parent's progress. SARMS serves the entire Dependency Court System: all seven dependency departments at the four Superior Court locations in the county. To make it easy for

parents to report to SARMS, all of the SARMS offices are located within walking distance of the courts.

When SARMS began in 1998, they accepted any court, CPS, or parent's attorney referrals in cases in which parents have a substance abuse problem. Budget cuts could not support this broad eligibility standard. Within the last two years, SARMS only accepts parents if alcohol or drug abuse is *the* reason the child was removed from the parent's custody or if parents have had a substance abuse problem within the last two years.

Mental Health Services generally work with clients for one year, but that time may be extended, if needed.

Before SARMS, CPS workers had the responsibility for assessing the need for substance abuse treatment and monitoring parents' progress in treatment. The Dependency Policy Group determined that CPS workers did not have the expertise (or time) to evaluate what treatment parents needed, or to assess their progress in substance abuse treatment. There was some resentment among CPS workers at first with this shift in responsibility, but CPS workers came to welcome the partnership with the treatment experts at SARMS. It allows CPS workers to concentrate on other parts of the case, and many workers acknowledged they did not have the expertise to oversee substance abuse treatment. Listen to some of the comments we heard from CPS staff:

- SARMS helps parents receive services more rapidly and SARMS does close monitoring. SARMS is a "great addition" that helps our clients.
- Before SARMS, CPS workers had to set up the urine analysis, which was "difficult;" now SARMS does that.
- SARMS really knows the treatment facilities and what they provide; new social workers do not have this knowledge.

- Unfortunately, SARMS does not take minors who are parents. CPS workers said they wish SARMS did as the program has so much to offer.

The judge, CPS worker, or the parent's attorney may refer a case to Mental Health Systems. The parent meets with the SARMS Recovery Specialist, usually the same day the referral is made, or at least within a week of the referral. The Recovery Specialist conducts an assessment using the Addiction Severity Index and interviews the parent. The assessment takes about two-to-three hours. Brochures and a video that describe SARMS are available for parents to read and watch. If substance abuse treatment is indicated, a Recovery Services Plan is prepared and the parent signs the Plan. The Plan specifies all of the requirements for substance abuse treatment and it becomes a part of the court-ordered reunification case plan. Parents attend counseling, therapy, education sessions, and recovery support groups through community-based treatment programs. The Plan may include attendance at AA meetings, nonresidential treatment, or residential treatment. The Recovery Specialist makes any appointments for the client with treatment providers. Usually, out-patient services can be scheduled within two days. Residential treatment may take up to two weeks to secure. Parents are also required to submit to frequent alcohol and drug tests.

San Diego County has a wide array of substance abuse treatment programs available and waiting lists are generally short. The county spends over \$4 million per year on SARMS and substance abuse treatment programs. There are residential programs for women who can live with their children under the age of five. There are intensive out-patient services; some are all-day programs while others are three-hour programs. Culturally relevant programs are available, including programs for Hispanic,

African American, and gay and lesbian clients. Recovery Specialists are very familiar with treatment programs and providers and spend substantial time at the programs. As a result, they are in a good position to match the needs of a substance-abusing parent with the best treatment program for each individual.

Most (about 90%) of the SARMS Recovery Specialists are recovering addicts who have to be sober for at least three years before they can serve in that position. They have to be Board Certified AOD counselors, or have completed two years of college and have some work experience in substance abuse. In addition, Mental Health Services provides a 2-2.5 day training for Recovery Specialists. A supervisor oversees five-eight Recovery Specialists and reviews all court reports for accuracy and to ensure timely reports to the court. It is hard to recruit and maintain Recovery Specialists, because they are not highly paid. SARMS Recovery Specialists once had a client caseload of 30, but budget cuts have increased that to 60; all of those interviewed thought that was much too high. This decreases the Recovery Specialists' job satisfaction and further exacerbates the turnover problem among specialists.

SARMS Recovery Specialists are required to meet face-to-face with parents twice a month (or once a month if the client is in the Dependency Drug Court, because they also accompany the client to the Drug Court). The meet either at the SARMS office, or the Recovery Specialists may meet the client at a treatment program that the parent attends. If the Recovery Specialist has not heard from a client, and the client has dropped out of services, the Recovery Specialist closes the case. Recovery Specialists do not go to clients' houses, or into the field, to try and find clients who drop out of the process.

The Recovery Services Plan becomes part of the court order. Parents sign a Confidentiality Release allowing SARMS to report to the court twice monthly on the parent's progress in treatment and report the results of the alcohol and drug tests. If the parent tests positive for substances, the SARMS Recovery Specialist immediately notifies CPS so they can keep children safe during visitation with their parents. Violations of the Dependency Court Order, including a "dirty test," a "no-show," or failure to comply with SARMS or treatment program activities, may result in increasingly harsh sanctions. The first violation results in a reprimand by the judge. The second violation results in the judge imposing three-five days in jail and/or a monetary penalty. The third violation can result in the judge imposing three-five days in jail and/or an offer of voluntary Dependency Drug Court participation.

Opinions of SARMS

In addition to CPS workers, an Alternate Public Defender (handles all clients who appear in Dependency Drug Court), a Public Defender Attorney, a County Counsel, the SARMS director, a representative of Health and Human Services, and the director of Mental Health Services were interviewed about their opinions of SARMS. They said:

- Parents are ordered to SARMS during their first court appearance and the SARMS office is within walking distance. Prior to SARMS, parents were sent to various places to be assessed days after their appearance in court and they did not go to the assessment. Also treatment before SARMS often happened six months "down the line" and that was too late to meet ASFA timelines or engage parents to obtain treatment when they are most motivated, right after their children are removed. SARMS has enabled them to meet ASFA timelines.
- Parents do not have to locate and set up an appointment with the treatment program by themselves. The Recovery Specialist calls the program and sets the appointment.

- It is good that the Recovery Specialists are recovering addicts as you cannot fool them. “It is easy to ‘BS’ a new social worker, or even an experienced one, but because the Recovery Specialist has been there, they cannot be fooled by parents about their substance abuse.”
- The SARMS Recovery Specialist and CPS worker can be a team that “plays good cop, bad cop.”
- CPS workers can do social work while the Recovery Specialist monitors the substance abuse problem.
- Since SARMS, information about the parent’s progress in substance abuse treatment is “much more accurate.”
- Since SARMS, more parents are reunified with their children. There is more structure.
- SARMS “levels the playing field between new and seasoned CPS workers.”
- The Recovery Specialist relieves the burden from the social worker to talk parents into treatment.
- It is important that SARMS incorporates the sanctions, including jail time. The sanctions “get parents’ attention like nothing else can.” Not having sanctions would be a “deal breaker” for a program like SARMS. The sanctions, especially the jail sanctions, “motivate clients like nothing else can to seek treatment” and progress in treatment.
- The Alternate Public Defender and a Public Defender both noted that the defense bar originally fought SARMS “tooth and nail,” especially the jail sanction part of SARMS. Both said the attitude has changed. The defense benefits when negative urine tests prove parents are doing well (this is “double-edged sword” as clients doing poorly have urine tests to prove that). But the Alternate Public Defender said that prior to SARMS, drug testing was inconsistent and clients doing well did not have evidence to prove it. In addition, parents are obtaining residential or nonresidential treatment quickly (this was a real problem before SARMS). Since SARMS, parents are being reunited quickly with their children. Ultimately, the “benefits outweighed the harm.”

The Dependency Drug Court Component of SARMS

SARMS participants who are not meeting treatment goals may be eligible to participate in the Dependency Drug Court. Participation is voluntary and is subject to the approval of the Dependency Drug Court Judge. The Dependency Drug Court encourages

the substance-abusing parent to more fully cooperate with the program by heightening the supervision of the court and incorporating peer support among the court's participants. Parents receive praise for complying with the Dependency Drug Court rules and are given tokens for the number of days of sobriety.

The Dependency Drug Court includes a nine month three-phase program. Participants must commit to follow the Recovery Services Plan and appear in court at the following intervals. During Phase 1, the first 90 days, participants must appear once a week in court. If they are in compliance, they move to Phase 2 for the next 90 days, during which time they are required to appear in court once every two weeks. If they are in compliance, they graduate to Phase 3, during which time they appear in court once a month. If participants violate their order anytime during Phase 2 or Phase 3, they must return to Phase 1 and start the process all over again. In addition, the first or second violation can result in up to five days in jail. The third violation may result in the judge dismissing them from participating in the Dependency Drug Court.

There is one Alternate Public Defender who represents all parents who appear in Drug Court. If necessary, that attorney confers with the parent's attorney to discuss issues. As the Alternate Public Defender explained, clients in Drug Court have signed away most of their rights, so he is just there to make sure "nothing egregious" happens in court. The role of the Alternate Public Defender is very limited: "this is a court of last resort and participants have no rights in the Drug Dependency Court."

Visitation between parents and their children progresses in intensity as the parent proceeds through Dependency Drug Court. Supervised visits are scheduled at least once per month. If that goes well, unsupervised visits for several hours are scheduled. If there

are no problems, all-day visits are allowed, then an overnight visit, followed by a two-night visit. If the children are returned to the parent, all the children are not returned at once. This is done to minimize stress on the parent. For example, if there are five children, they return one or two at a time, spread out over several weeks, to give the parent a chance to acclimate to having the children back.

Opinions of the Dependency Drug Court

During our interviews with CPS staff, an Alternate Public Defender, a Public Defender, a County Counsel (a lawyer who represents HHSA), the SARMS Coordinator, a representative of Health and Human Services, the Dependency Drug Court Team, and the director of Mental Health Services, we asked their opinions of the Dependency Drug Court. We heard the following:

- The judge does a good job of supporting those who do well in the program while punishing those who do not. Participants understand that a violation results in jail time. It is good that the consequences of a violation are certain and that participants understand this when they volunteer for the program.
- “I would recommend it 100%.” Children are safely returned to their parents in a timely fashion.
- The Dependency Drug Court is for those who have failed at all other programs and is parents’ last chance to recover and reunite with their children. It is “not for everyone, but it is great for those who need it.”
- If a case goes to Drug Court, the parent is assigned to the SARMS Recovery Specialist assigned to the Drug Court. That Recovery Specialist has more time to spend with clients. There is “good communication” between the Recovery Specialist and the CPS worker.
- Judge Milliken, who started the Drug Court, left a couple of years ago. The Drug Court was “well-institutionalized” and was successfully transferred to another judge.

SARMS and the Dependency Drug Court are currently being evaluated in a multi-year longitudinal study.

Observation of the Dependency Drug Court

We observed a session of the Dependency Drug Court. Prior to the beginning of court, a representative from Mental Health Systems, Inc., distributed a list of cases for that day with a brief summary of the case including: number of children removed; where the child was placed; status of visitation between the parent and child; the participant's drug of choice; how many days the participant was clean; what Phase they were in, and when the participant entered the Dependency Drug Court.

The Dependency Drug Court is closed to the public. In the courtroom were the Judge, Alternate Public Defender, representatives from CPS, representatives from SARMS, the court reporter, and a few treatment providers. There were 12 participants who sat in the jury box in the courtroom. Each participant was called by name by the Judge, who asked them how long they had been clean and sober. Each participant answered. The Judge congratulated them on their success and everyone in the courtroom clapped for them. Two participants received Tokens from the Judge, (one for 60 days of sobriety and one for 90 days of sobriety) who stepped down from the bench to hug and congratulate them while everyone in the courtroom clapped for them. No one had a positive urine test and only one participant had an issue that was problematic. She had been mistakenly picked up on a probation violation that led to suspension of her visitation with her children. The Alternate Public Defender conferred with her lawyer in the hallway and explained the situation to the Judge. A letter was to be sent to CPS allowing visitation, because the probation violation was a mistake.

The Dependency Court was in session for about 30 minutes. Each participant (with the exception of the one with the probation problem) spent a couple of minutes

talking to the Judge. We were told this was a particularly light day and there were few issues to discuss. The Dependency Drug Court has been described as more similar to a Narcotics Anonymous (NA) or Alcoholics Anonymous (AA) “revival” meeting than a court, and that appeared consistent with what was observed.

Suggestions to Improve the Processing of Dependency Cases When Parents are Substance Abusers

Throughout our interviews, it became clear that San Diego County has a wide variety of substance abuse, and other, treatment programs that are easy to access and have minimal waiting lists. San Diego also has more adolescent treatment programs than any other county in California; \$3-4 million are spent on adolescent services each year.

Some gaps in substance abuse treatment programs were identified, including: substance abuse programs for parents with serious mental health problems; additional bi-lingual Spanish programs; additional residential programs where children can stay with their parents; more treatment options for dually diagnosed clients; and more substance abuse treatment programs for children.

Suggestions to improve how dependency cases are processed when parents are substance abusers included:

- Invest more in the SARMS Recovery Specialists. Pay higher salaries (currently, they pay between \$24,000-\$34,000 annually) to attract and retain staff with more formal training and greater expertise on dually diagnosed clients. Lower caseloads would also help retain staff by discouraging burn-out.
- Develop a good integrated data system linking the CPS, court, and SARMS databases.
- More support for parents after children are returned to them. Bonding between parents and babies may be difficult and bonding with older children may be problematic, because children may resent the parent and refuse to follow rules set by the parents.

Conclusion

During interviews, we learned that the success of SARMS was dependent on: (a) a charismatic judge who spent months researching alternatives to traditional case processing in dependency cases when parents are substance abusers, because he recognized that traditional case processing left children lingering in foster care and was not able to meet ASFA timelines; (b) careful planning and “buy-in” from all the agencies involved in dependency cases; (c) a team approach fostered through the Dependency Policy Group and the Implementation Team Group who meet regularly, make decisions as team, and have a true collaboration among all the agencies involved; (d) Recovery Specialists who are trusted, submit accurate reports on time, know which treatment providers are best suited for their clients, and who are sensitive to the different types of drug users (partly because most are recovering addicts themselves); (e) immediate assessments by SARMS Recovery Specialists and availability of treatment services when Recovery Specialists call to set appointments for clients; (f) judges in Dependency Court who understand the principles of SARMS, and Dependency Drug Court judges who are fair and even-handed in their use of rewards and sanctions for violating court orders; and (g) the use of the “hammer” of sanctions, including jail time, for those who violate orders as a means to motivate parents to stay in treatment and work towards reunification with their children.

CHAPTER 11

IMPLICATIONS AND RECOMMENDATIONS

The mail and telephone surveys, the legal analysis, and the five case studies yielded a great deal of information about how dependency cases are handled under the requirements of ASFA when children have parents who are substance abusers. Each of the research methods allowed us to draw implications and recommendations for policy and practice. During the brief mail survey of over 300 judges, we got a glimpse of how dependency cases when parents are substance abusers are handled, what the challenges are, and what strategies (if any) courts have implemented to overcome those problems. The telephone surveys with over 50 judges and service professionals allowed us to learn more about these issues and further develop suggestions and implications.

The five case studies allowed us to obtain details on the strategies dependency courts are using to respond to parents who are substance abusers within the timeframes of ASFA. We deliberately selected communities that varied in size, in different parts of the country, with varying resources, and with different approaches to these cases. Although their approaches differed, across the five sites we found some common themes. We derived four policy and practice implications and recommendations from the case studies, mail surveys, and community telephone surveys:

- 1. Dependency courts should recognize that most cases involve parents who are substance abusers. Instituting established “good practices” in all dependency cases can also improve the response to cases in which parents are substance abusers.**
- 2. Dependency courts faced with a sizable caseload of parents with substance abuse issues should consider, and plan for, special approaches to these cases.**

- 3. As dependency courts implement special approaches, they need to ensure that supports are in place, including training programs, substance abuse assessments, substance abuse treatment programs, other service programs, and initiatives to support parents throughout the dependency and treatment processes.**
- 4. Programs should plan for, and implement, evaluations to assess the effectiveness of special approaches to dependency cases when parents are substance abusers.**

IMPLICATIONS AND RECOMMENDATIONS

- 1. Dependency courts should recognize that most cases involve parents who are substance abusers. Instituting established “good practices” in all dependency cases can also improve the response to cases in which parents are substance abusers.**

Across the country, dependency courts are challenged by parents with substance abuse issues. Adopting “good practices” for all dependency cases will impact cases involving substance-abusing parents. Many of these practices are supported by the *Resource Guidelines: Improving Court Practice in Child Abuse and Neglect Cases*, which is the best practices guide for dependency courts. Published by the National Council of Juvenile and Family Court Judges in 1995, the *Resource Guidelines* have been endorsed by the American Bar Association House of Delegates and the Conference of Chief Justices. The *Guidelines* set forth the essential elements of properly conducted court hearings: timely and detailed hearings as governed by federal (ASFA) and state law; policies against continuances; reasonable efforts findings; calendaring for one-family-one judge; time-certain docketing; competent and diligent representation for parents, children and agencies; family-friendly courtrooms; key decisions and detailed findings of fact and court orders at each hearing; and appropriate use of mediation, among others.

1.1. The majority of cases in dependency court involve parents who are substance abusers.

The majority of cases in dependency court involve parents who are substance abusers. Previous research studies place the figure at a low of 40% to a high of 80%, with most studies finding that a majority of dependency cases involve substance-abusing parents. In the five study sites, professionals estimated that substance-abusing parents comprise 60-80% of their caseload. Substance abuse may be the primary reason for dependency court action, or it may be one of the factors that led to the action.

1.2. Many judges have developed strategies to meet ASFA requirements for *all* cases, not just for those with substance-abusing parents.

During the follow-up telephone surveys with 60 judges, we found a number of courts that have developed strategies for *all* dependency cases under ASFA, not just for those with substance-abusing parents. They recognize that parents with substance abuse problems comprise a very large part of their docket, but rather than develop a separate approach for them, they have taken steps to process all dependency cases with ASFA requirements by developing strategies that make sense in all cases. These strategies include expedited case handling, frequent reviews, strict monitoring of court orders, use of multi-disciplinary teams, mediation, and family conferencing. These strategies help in cases with substance-abusing parents by providing expedited assessment, early treatment, accountability for cooperating with treatment, and helping parents address their multiple challenges.

1.3. Communities with strong CASA and GAL programs, and experienced parents', children's, and states' attorneys, appear to be more effective in responding to dependency cases when parents are substance abusers.

Among the five study sites, several had robust CASA and GAL (Guardian Ad Litem) programs and attorneys. Dependency case processing benefited from these programs. For example, Tarrant County has a strong CASA program with 167 volunteers. Child Advocates of Tarrant County (CASA) is automatically involved in all cases several weeks before the judge hears the case. CASA has access to child protective services files and meets all parties, establishes a relationship with the caseworker, and sees the child twice a month. They also attend Permanency Planning Team meetings held by child protective services to determine the direction of the case. The judge asks for CASA's input and recommendations, and at the final hearing they provide a written report to the judge and all parties. Their involvement helps to ensure the case is resolved in the best interests of the child.

Halifax has a very strong GAL program. All children in dependency court receive a GAL, who has access to any and all information that can help them make recommendations on safe placement for the children. They are armed with a court order, allowing them to speak to and review anyone, or any materials, they decide are relevant to the case, including health/mental health records, school records, and fathers in prison and/or their parole officers. Their focus is to help clarify what is likely to happen to the child given a particular placement. GALs are given a lot of respect by the court, and the Chief District Court Judge said their input is invaluable in making decisions in the best interest of the child.

Halifax also has a very knowledgeable state's attorney who prepares detailed orders for the judge to sign. We were told that having detailed orders helps parents, child protective service workers, and treatment providers understand their responsibilities in complying with the case plan. This accelerates the resolution of the case, whether that resolution is reunification or termination of parental rights.

The Allegheny Executive Director of the Department of Human Services believes in the importance of strong representation for children and parents. His Department contracted with Kid's Voice to pay for representation for every child in dependency court, and provides an attorney to every parent if they cannot afford to hire one.

In San Diego, the Alternate Public Defender is automatically assigned to serve as the children's' attorneys. Every child has legal representation to protect their best interests and this is a valuable part of their collaborative team approach.

1.4. Courts need to consider conducting more frequent reviews than required by ASFA to monitor parents' progress in treatment, to intervene, and to offer support and impose sanctions when parents relapse.

ASFA requires a six-month permanency review. During telephone interviews with dependency judges and professionals, we found that many courts were meeting ASFA timelines in dependency cases in which parents are substance abusers by conducting more frequent reviews than required by ASFA.

In several of the five study sites, the required six-month review was moved up to three months. Professionals assert that waiting six months delayed assessment of progress and compliance with court orders. By moving the review to three months, they could make any mid-course adjustments necessary to achieve permanency within the timelines of ASFA. This is especially important when parents are substance abusers.

The studied courts decided they wanted to become more involved in cases than required by law. They did not want to wait for six months to review how things were going, because they could not afford to waste months if they are to meet ASFA timelines.

2. Dependency courts faced with a sizable caseload of parents with substance abuse issues should consider, and plan for, special approaches to these cases.

Improving the practice of dependency courts for all cases is commendable, but many courts will need to do more to address the specific needs of substance-abusing parents. Realizing that traditional processing in the age of ASFA is not effective is a first step. The next steps are a needs assessment, the selection of a strong leader, careful planning, development of a team approach, and the procurement of resources to help these parents.

2.1. Courts should consider whether the traditional way of handling dependency cases when parents are substance abusers is effective.

All five of the communities in our case studies recognized that “doing business as usual” was not working in meeting ASFA timelines. Parents were not being assessed quickly and accurately; were not assisted in obtaining early treatment; were not being supported through the treatment process; and were not given other services needed to overcome their substance addiction and other barriers inhibiting reunification with their children.

The five communities found that cases were often half-way through the dependency action before treatment was initiated (if then). As a result, cases lingered in the system and children lingered in foster care. By the time substance abuse and other services began, there was not enough time to meet ASFA timelines to achieve permanency for children.

Substance abuse recovery takes time and relapse is a part of the process; therefore, it is important to identify parents with substance abuse issues and initiate treatment early in the case. All of the five study sites realized that reunification was being thwarted because services started too late. They acknowledged that traditional processing was not working and took steps to implement strategies to change the way dependency cases were processed.

2.2. A community-wide assessment can be enormously helpful in meeting ASFA timelines and providing permanent, and safe, homes for children when parents are substance abusers. The assessment can uncover how effectively dependency cases are currently handled, determine what resources are available in these cases, and help formulate what is needed to improve the response to these cases.

Community-wide assessments may consist of written questionnaires, telephone surveys, informal feedback, meetings of stakeholders, and special task forces or interdisciplinary working groups. Assessments can be enormously helpful to determine: (a) the nature and extent of the problem; (b) available resources to address it; (c) what additional resources are needed; (d) what special approaches can be developed, if needed; (e) strategies for planning and implementing special approaches; and (f) what further assessments and evaluation should be done to document how well dependency cases with substance-abusing parents are handled within the requirements of ASFA. Assessments can help develop and sustain viable approaches.

2.3 A strong leader, or lead agency can effect changes in the way dependency cases are handled.

System change is hard. During the telephone surveys, we learned that implementing strategies to improve how dependency cases are handled is often initiated by a single individual. In each of the five communities, a strong, charismatic leader(s)

made it their mission to improve the response to dependency cases when parents are substance abusers. Leadership varied among the communities. In Halifax and San Diego, the Chief Dependency Judge was the driving force. In Allegheny County, it was the Director of HHS. In Cook County, it was TASC and the Department of Family Services. In Tarrant County, it was a combined effort of the Juvenile Court and Child Protective Services. In all five communities, bringing about change took considerable insight, time, and cooperation from key agencies, as discussed below.

2.4. Careful planning is important to achieve cooperation from key agencies.

While it often takes a special leader to spearhead a new approach to handling dependency cases when parents are substance abusers, it is wise to carefully plan the approach with a team that includes representatives of key agencies involved in these cases. All of the five communities had a planning phase and formed working groups to decide on the goals of their approach, discuss what was needed to implement it, and to resolve obstacles to implementing and maintaining the new approach.

San Diego had one of the most comprehensive plans for their new programs. Judge Milliken formed a Dependency Policy Group and a SARMS Implementation Team Group. They met weekly in the beginning to formulate definitive policies that would create uniformity in how dependency cases are resolved and to develop a plan for the SARMS program and the Dependency Drug Court. In just eight months these two new approaches were implemented. The two Groups continued to meet after implementation to resolve any problems in meeting the goals of SARMS or the Drug Dependency Court. These two Teams have fostered “buy-in” from all key agencies and have resulted in a true collaboration among agencies.

Each of the other study sites—Halifax, Cook County, Allegheny County, and Tarrant County—also developed a plan to change how dependency cases in which parents are substance abusers were handled. They all acknowledged that to bring about change requires a team approach. As discussed below, no one agency can address all of the complexities in these cases.

2.5. A team approach based on mutual trust, respect, and understanding of each others' roles is important in responding to parents with substance abuse problems. Information among agencies needs to be shared.

In each of the five study sites, a system was established to build mutual trust, respect, and understanding among agencies involved in the dependency process. It began during the planning phase with achieving cooperation from agencies and continued through implementation. Confidentiality releases signed by parents allowed agencies to share information about treatment progress. This permitted everyone to monitor that progress and intervene when necessary.

In some instances, joint training helped foster strong teams. In other instances, those opposed to a new approach had to be won over by seeing that the new approach worked and benefited their clients. In Cook County, it took over a year to convince child protective service workers and defense attorneys to accept the TASC Recovery Coach Program. Child protective service workers thought the new program was usurping their role and defense attorneys worried it would have a negative impact on their clients. Similar concerns were also expressed in San Diego and Allegheny Counties. Team meetings and considerable outreach and education helped to turn the situation around. But the primary reason that negative attitudes turned to positive ones was that the programs worked and benefited clients. It took time to earn respect and to trust the

information provided by team members, but it paid off. The five study counties were able to form true collaborations among agencies as they came together to improve how they responded to dependency cases in which parents are substance abusers.

2.6. Resources are needed.

A lack of resources often inhibits the response to substance-abusing parents. During the mail survey, 80% of the dependency court judges surveyed reported that insufficient treatment resources were an obstacle to meeting ASFA timeframes when the child's parents are substance abusers.

All of the five study sites needed an influx of additional resources, or had to redistribute resources, to develop new approaches to dependency cases when parents are substance abusers. Halifax received a small grant from the state to produce a video for parents that explains the dependency process and to implement a Family Drug Court. The county also received a federal grant to train court staff on substance abuse issues. But these resources were limited, and they were largely able to implement their Child Planning Conference and the Family Drug Court by stretching the resources they had. The judge and court personnel took on additional responsibilities without compensation, because they believed they needed to change how dependency cases are handled, especially when parents are substance abusers.

In Tarrant County, the Children's Justice Act provided \$56,200 to fund the Family Group Conferencing Program as well as an additional grant to CASA. In Allegheny County, Health and Human Services changed their whole structure and philosophy to serve their clients and incorporated a Permanency Planning Conference and Family Group Decision Making Project into their case processing. The county also

invested \$1.2 million with POWER, a substance abuse treatment program, to provide services to substance-abusing parents in dependency court.

San Diego County spends approximately \$4 million a year on treatment services. Cook County used Title IV money to fund their Recovery Coach Program.

None of the five study sites were able to change how they respond to substance-abusing parents in dependency court without stretching limited resources or adding substantial funding for handling these cases and providing treatment to these parents. After acknowledging that the traditional case process was not working and a charismatic leader stepped forth, resources had to be allocated to change their approach to these cases.

2.7. Alternatives to traditional case processing need to be implemented.

Improving the response to all dependency cases will help process those cases with substance-abusing parents. However, given the enormous impact substance abuse has on these parents, specific approaches for them are often necessary. Each of the five counties established different approaches to improve their response to dependency cases when parents are substance abusers.

For example, in Halifax, the Juvenile Court implemented a Child Planning Conference to expedite cases. Under the old system, it took 30-60 days until the Adjudication Hearing before everyone became aware of the issues in the case and began to seek a resolution. At the Child Planning Conference, they attempt to obtain a Memorandum of Agreement that may lead to a Stipulated Adjudication among all the parties. Following the Child Planning Conference, they proceed to the courtroom. The judge reviews the agreement, or hears contested issues, and makes a determination. The

next court date is set for one week later. This is sooner than is required by ASFA rules and is intended to “fast track” the cases.

In Tarrant County, a methamphetamine specialist within child protective services was created to respond to the reality that methamphetamine was fast becoming the new drug of choice. The methamphetamine specialist is available to assist law enforcement when children are found in methamphetamine labs and helps CPS workers identify methamphetamine-making supplies in a home so that children can receive the medical treatment needed to de-contaminate them.

Tarrant County also implemented a Family Group Decision Making Program to “prevent, or shorten, the time children spend in foster care, by identifying family strengths and resources to shape and support the family and child plan and to form an alliance between the family, community and CPS.”

In Allegheny County, three programs illustrate how the county changed their approach to dependency cases. For substance-abusing parents, they initiated the POWER program. Mentors from POWER work with clients to help them meet their service goals and support parents throughout the dependency process. Mentors report weekly on their client’s process to their POWER supervisor and to child protective services (a Confidentially Waiver allows this). A tribute to the success of the POWER program is that children are returned to their parents within 12.5 months on average, compared with 22 months for clients not in the POWER program. Clients interviewed about their experiences with POWER mentors had high praise for their mentors.

Allegheny County also uses Family Group Decision Making (FGDM). The FGDM meeting empowers a family to participate in the decision making process rather

than leaving the decision making to the legal authorities and service providers. It is a real paradigm shift in how child protective services handles its cases. Rather than imposing a plan on families as child protective services typically do, the parents and her supporters draw upon their resources to develop a safety plan. Engaging families in the process is seen as a better way to help families keep children safe and structure functioning families rather than imposing the state's plan on the family.

A third strategy adopted in Allegheny County is the Permanency Planning Conference. The Permanency Planning Conference engages parents in the dependency process by providing an informal setting that encourages parents to participate in the child protective services plan to reunify them with their children.

In Cook County, Recovery Coaches provide intensive alcohol and other drug abuse treatment services, outreach, and case management services to families. The primary goals for the Recovery Coach program are to actively assist parents address their substance abuse issues and move towards reunification as safely and quickly as possible. Recovery Coaches work to ensure the parents attend and cooperate with treatment, coordinate staffing and family meetings, conduct home visits to provide on-going support and education to the family, ensure random urinalysis testing, and submit monthly progress reports to the child welfare worker and courts as needed. The Recovery Coaches work in close partnership with the child welfare worker assigned to the case and remain engaged with the family even after the parent's substance abuse treatment has been completed.

In San Diego County, the Substance Abuse Recovery Management System (SARMS) is an extensive case management system for substance-abusing parents in

dependency court. The program was a reaction to the realization that 80% of the parents with children in dependency court have substance abuse issues that impair reunification and may result in termination of parental rights. SARMS was formed and Mental Health Systems, Inc., was selected to provide immediate alcohol and drug assessments for parents with a substance abuse problem. Mental Health Services, Inc., is responsible for developing a treatment plan and monitoring the parent's progress. Prior to SARMS, parents were sent to various places to be assessed days after their appearance in court and they did not go to the assessment. Also treatment before SARMS often happened six months "down the line" and that was too late to meet ASFA, or engage parents to obtain treatment when they are most motivated, right after their children are removed. SARMS enabled them to meet ASFA timelines.

SARMS participants who are not meeting treatment goals may be eligible to participate in the Dependency Drug Court. The Dependency Drug Court encourages the substance-abusing parent to more fully cooperate with the program by heightening the supervision of the court and incorporating peer support among the court's participants. Parents receive praise for complying with the Dependency Drug Court rules and are given tokens for the number of days of sobriety. Parents who violate court orders, including testing positive for drugs, are sanctioned, including sentencing them to 3-5 days in jail. Professionals interviewed in San Diego had favorable opinions about the impact the Dependency Drug Court is having in achieving recovery for parents and reunification with their children.

3. As dependency courts implement special approaches, they need to ensure that supports are in place, including training programs, substance abuse assessments, substance abuse treatment programs, other service programs, and initiatives to support parents throughout the dependency and treatment processes.

3.1. Training is Needed.

During the mail survey, 84% of the dependency judges reported that they would benefit from additional training on substance abuse and 82% said they would benefit from additional training on ASFA. Due to limitations associated with the brief mail survey, we were not able to probe the judges about the type or content of training they would like to receive. But we were able to learn about training in the five counties.

Each of the five counties instituted internal training for staff in agencies involved in dependency cases. For example, the TASC Recovery Coaches in Cook County, the SARMS Recovery Specialists in San Diego, and the Allegheny POWER mentors all received internal training for their jobs.

Cross-agency trainings also were common in the five sites. For example, in Cook County there was considerable resistance to the TASC Recovery Coach Program. Some case workers were “very reluctant” because they thought Recovery Coaches were intruding on their job responsibilities. Public defenders were also initially against the Program. They feared that the Recovery Coach Program would increase the state’s involvement in their clients’ lives and result in their clients giving up legal rights, such as agreeing to random drug testing and waiving their rights to confidentiality. It took 1.5 years to achieve the buy-in of some case workers, defense attorneys, and treatment providers in Cook County. After a year-and-one-half, and intensive training, education and outreach work, the attitude changed. The relationship became one of mutual respect and appreciation for what can be accomplished together.

A few of the counties also participated in state-wide or national trainings. For example, Halifax County Family Court received a Bureau of Justice Assistance Grant to participate in implementation training for a Family Drug Treatment Court. Nearly a dozen professionals from Halifax attended the intensive training. The training fostered a team approach and helped Halifax Court participants understand the substantial amount of time needed to accomplish treatment and the expected relapses along the way. This changed how they processed cases with substance-abusing parents.

The San Diego Dependency Drug Court team participated with five other states in a national training on family drug courts. It was useful to hear what other courts were doing and it resulted in a stronger team approach within San Diego County and positively impacted their case processing.

3.2 Thorough and quick substance abuse assessments are important.

Among the five study sites, there was a common recognition that parents were not being thoroughly and quickly assessed for substance abuse issues. Parents are most motivated to accept substance abuse services shortly after their children are removed and they are confronted with court action. But the study sites found that assessments were haphazard, delayed until late in the case, and hindered by making parents responsible for arranging for the assessments.

In all of the sites, that was changed. Assessments by trained substance abuse specialists were incorporated into the process. Usually at the first hearing, parents were sent to an easily accessible assessment specialist (located either in the court building or within a short walking distance). Standardized substance abuse assessment instruments and interviews with parents determined the need for substance abuse treatment. In most

cases, the assessor made the appointment for the parent with the appropriate treatment provider for a day or two later. Parents, who are often in crisis after their children are removed, were not left to navigate their way through the assessment process or through initiating contact with the treatment provider. Rather, parents were supported by trained experts to ensure those who needed services are identified and supported during the initiation of services.

For example, in Cook County the Juvenile Court Assessment Project (JCAP) is located in the court building and parents are sent there after their first court hearing for an immediate assessment. The assessment takes 45-60 minutes and includes self-reported behavior by clients and the DSM-IV assessment instrument.

In Allegheny County, POWER assessors conduct the assessment in the client's home (this gives the chance to directly observe the home environment), usually within 24 hours of the referral. The assessment takes about 2.5 hours and consists of self-reports, standardized substance abuse screening instruments, and urine screens. Every client is also screened for mental health issues.

In Halifax, parents are sent to the assessment agency located within walking distance of the court immediately after their first hearing to be assessed for substance abuse. Standardized assessment tools and self-reports are used.

In San Diego, referred parents meet with the SARMS Recovery Specialist, usually the same day the referral is made, or at least within a week of the referral. The SARMS office is within walking distance of the court to make it easy for parents to be assessed. The Recovery Specialist conducts an assessment using the Addiction Severity Index and interviews the parent. The assessment takes about 2-3 hours.

3.3. A wide variety of substance abuse treatment options that can be accessed quickly is vital.

Once a parent is identified as having a substance abuse disorder, it is critical that they quickly receive appropriate services. During the mail survey of dependency judges, 80% reported that they had insufficient treatment resources in their jurisdiction for substance-abusing parents. Each of the five study sites made great strides to ensure a full range of services were available with minimum waiting lists.

For example, San Diego County has a wide array of substance abuse treatment programs available and waiting lists are generally short. There are residential programs for women who can live with their children under the age of five. There are intensive out-patient services; some are all-day programs while others are three-hour programs. Culturally relevant programs are available, including programs for Hispanic, African American, and gay and lesbian clients. Recovery Specialists from Mental Health Services, Inc., match the needs of a substance-abusing parent with the best treatment program for each individual.

In Tarrant County, there are numerous treatment options available for substance-abusing parents. Pine Street provides a detox center. Nexis in Dallas, which is close to Fort Worth, takes mothers and up to three of her children for three-to-four months of treatment. Lighthouse, Volunteers of America, Kirkpatrick, Homeward Bound, and Beaumont also provide treatment. Community Addiction Treatment Services offer an inpatient 30-day program (no children allowed) and an outpatient program that meets four times a week for as long as appropriate, depending on the client's needs. First Choice takes mothers and two-three children for 9-12 months.

Allegheny County has a multitude of treatment choices. There is a Bureau of Alcohol and Drug Services in Behavioral Health under CYF to coordinate services and make sure that there are adequate, quality services in the county. The county contracts with 35 drug and alcohol providers. During interviews with judges, we were told they are “spoiled” by all of the services they have.

In Cook County, immediate or quick access to treatment providers is usually not a problem. There are a wide variety of different types of treatment available. Treatment services are paid for by the state’s interagency agreement for parents who cannot afford services. As a result, providers receiving funds through the state initiative give child protective services clients priority. Obtaining a treatment bed or out-patient services within 24 hours is commonplace in Cook County.

3.4. Besides substance abuse treatment, parents who are substance abusers often need access to other services.

Many substance abusers need other services to make the transformation into productive, functioning adults and parents. Years of substance abuse often co-mingle with low self-esteem, medical and mental health problems, poor social skills, anger control issues, lack of educational and job skills, poor parenting, ingrained guilt and shame about the substance use, alienation and lack of support from family and friends, financial problems, inadequate housing, and other challenges. Recovery from substance abuse is unlikely if these other issues are not dealt with. All of the five study communities realized that fact and provided a plethora of services to support parents in their substance abuse recovery.

3.5. The parent has to be supported throughout the process.

By the time children are removed from their parents and the case appears in dependency court, parents have usually been living very dysfunctional lives. It is unlikely they can navigate the dependency and treatment systems alone. Several of our counties had comprehensive support systems to help. For example, Allegheny County has the POWER Program, Cook County has the Recovery Coach Program, and San Diego County has Recovery Specialists within the Mental Health Services, Inc. Program to provide support throughout the process. All of these programs hire trained recovering addicts to provide mentoring services based on the belief that these mentors can serve as role models and understand what their clients face in becoming clean and sober.

4. Programs should plan for, and implement, evaluations to assess the effectiveness of special approaches to dependency cases when parents are substance abusers.

During our site visits, we interviewed many professionals, parents, and CASA volunteers about their approaches and strategies to respond to substance-abusing parents in dependency court. We obtained their opinions about how their approach was working. Overwhelmingly, we heard favorable comments, but there was little data to support their perspectives. Program evaluation can help determine the strengths and weaknesses of a program, guide programmatic changes, policies, and laws, and be used to apply for more resources to continue or expand the program. Two of the study sites had some evaluation data to document their successes.

Tarrant County is part of a state-wide initiative to establish Family Group Conferencing. The initiative is in place in 37 counties. Statewide evaluators have

prepared findings from the first two years of the statewide Texas initiative. Findings include:

- 993 families were offered Family Group Conferences (FGC). 594 conferences were held (60%), most (63%) within 30-45 days following a child removal.
- Most of the family's placement recommendations were to place the child with a relative; child protective services accepted the recommendation 95% of the time.
- Of the 373 families who participated in the FGC, prior to the FGC 54% of the children were in foster care, 24% in relative care, and 3% were returned home. Following the FGC, 45% were in foster care, 39% in relative care, and 10% returned home.
- On factors of satisfaction, family support, and caregiver and child well-being, parents and relatives give higher marks to FGCs than to Permanency Planning Team meetings (PPTs). They score higher on feeling empowered, on understanding expectations, and identifying key issues in the Family Plan, than they do at PPTs.

Cook County's Recovery Coach Program is being evaluated via a quasi-experimental design over a five-year period. The goal is to serve 1,500 parents: 1,000 in the demonstration group, and 500 in the control group, within the five-year demonstration project. Parents are randomly assigned to either a control or demonstration group. Families in the control group receive an initial substance abuse assessment, a level of care determination, and an intake appointment at a treatment provider within 24 hours of the assessment. Families in the demonstration group receive these services plus the enhanced services of the Recovery Coach program that coordinates their substance abuse services and provides intensive home-based outreach services.

The evaluation is being done by the Child and Family Research Center at the University of Illinois, located in Cook County. Some of the evaluation questions are:

(1) are parents in the demonstration group more likely to access treatment than parents in the control group?; (2) will parents in the demonstration group access treatment quicker than parents in the control group?; (3) will parents in the demonstration group stay in treatment and be more successful in treatment than parents in the control group?; (4) will more families in the demonstration group achieve reunification, or other permanencies, and will children spend fewer days in care than families in the control group?; (5) will there be fewer subsequent maltreatment reports in the demonstration group than of parents in the control group?; and (6) is the project cost neutral, i.e. will what it costs to run the program off-set the money saved by returning children to their homes sooner?

As of April 2005, statistically significant findings include:

- 73% of the demonstration group parents accessed substance abuse treatment as compared with 50% of the control group parents.
- 50% of the demonstration group parents accessed treatment within 40 days of the JCAP assessment whereas it took 100 days for 50% of the control group parents to access treatment.
- 13% of the children in the demonstration group were returned home compared with 11% in the control group.
- Children in the demonstration group averaged 182 fewer days in foster care before returning home than children in the control group.
- Children in the demonstration groups averaged 43 fewer days before adoption.
- 20% of parents in the demonstration group had a subsequent maltreatment report compared with 29% in the control group.
- The project remained cost neutral through September 2004; indeed, the project actually produced a cost savings of over \$3.9 million, primarily due to the savings generated by children spending fewer days in foster care.

San Diego County is currently the subject of an intensive, longitudinal study on the impact of SARMS and the Dependency Drug Court. The evaluation will examine the

short-and long-term impacts of SARMS and the Dependency Drug Court. It will provide much needed data to determine how well these programs are working.

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**APPENDIX A
MAIL SURVEY
JUDGES/MAGISTRATES/MASTERS**

This survey by the American Bar Association in collaboration with American University seeks to increase understanding of how courts are managing dependency cases within the requirements of ASFA (Adoption and Safe Families Act) when parents are serious substance abusers. Your answers will be treated confidentially but we are asking for identifying information in case we need clarification, or to follow up with you for more details. Responses will be reported only in the aggregate. This survey should take only approximately *5-10 minutes* to complete. We know how busy you are and appreciate your time.

State: _____ County: _____ Court: _____
Name: _____ Phone # _____
Title: _____ Judge _____ Magistrate _____ Master _____ Other title: _____
 _____ Full-time _____ Part-time

BACKGROUND, EXPERIENCE, AND TRAINING

1. Method of Judicial Assignment of Dependency Cases in your court: (please check all that apply)

- Judges assigned to hear dependency cases only and hear no other types of cases

- Judges hear dependency cases in addition to other types of cases:
If yes, please indicate other types of cases judges hear:
 - Juvenile delinquency
 - Domestic relations (custody, divorce, etc.)
 - Other Civil matters
 - Criminal matters
 - Any related family cases (one family, one judge)
 - Other (please explain) _____

2. Length of judicial assignment to hear dependency cases

- Indefinite
- Rotational: no more than two years
- Other (please explain) _____

3. How long have you been hearing dependency cases?

- Less than one year
- 1 to 3 years
- 4 to 6 years
- 7 to 11 years

- 12 to 15 years
- more than 15 years

4. Have you, prior to and/or since your appointment, received any training on ASFA issues?

- No
- Yes: did it change how you handle cases? ____yes ____no
do you think you would benefit from additional training? ____yes ____no

5. Have you, prior to and/or since your appointment, received any training about substance-abusing parents?

- No
- Yes: did it change how you handle cases? ____yes ____no
do you think you would benefit from additional training? ____yes ____no

DEPENDENCY CASES IN WHICH CHILDREN’S PARENT(S) ARE SUBSTANCE ABUSERS

6. What, if any, obstacles/challenges have you encountered in meeting the timeframe requirements of ASFA *when the child’s parent(s) are in substance abuse treatment?* (check all that apply)

- No obstacles or challenges
- Substance abuse recovery takes more time than ASFA timeframes allow
- Court intervention needs to be sooner in the process
- Court needs to provide more intensive/continuous supervision of these cases
- Statutory constraints resulting from ASFA
- Lack of effective programs for duo diagnosed parents (those with both mental health and substance abuse problems)
- Insufficient treatment resources available for parents: the problem(s) are:
 ____waiting lists for services ____not enough treatment programs
 ____poor quality of treatment programs ____costs of treatment programs
 ____not enough treatment programs to meet local needs
 ____not enough treatment programs that are culturally sensitive
 ____not enough treatment programs for nonEnglish speaking parents
 ____other—what?_____
- Difficulty in obtaining meaningful information on progress of parents to make appropriate decisions in the dependency case
- Other—please briefly describe_____

7. In general, how knowledgeable are professionals/volunteers in your court about (1) how substance abuse affects the ability to parent and (2) the process of recovering from substance abuse? Please answer using the following scale: (1) very knowledgeable, (2) knowledgeable, (3) somewhat knowledgeable, or (4) not knowledgeable? (please circle your response)

	How substance abuse affects....							
	Ability to Parent				Recovery Process			
Child protective workers	1	2	3	4	1	2	3	4
Agency attorneys	1	2	3	4	1	2	3	4
Parent's attorneys	1	2	3	4	1	2	3	4
Children's attorneys	1	2	3	4	1	2	3	4
CASA (circle only if you have CASA)	1	2	3	4	1	2	3	4
Attorney GALs (Guardian Ad Liems) (if you have them)	1	2	3	4	1	2	3	4
Nonattorney GALs (if you have them)	1	2	3	4	1	2	3	4

8. In your community, are there any targeted resources/mechanisms to respond to cases in which children in dependency court have parent(s) who have been identified as substance abusers?

- No
- Yes: If yes, what are they? (check all that apply)
- Special training targeted for judges on these type of cases
- Joint training among ___judges, ___substance abuse treatment providers, ___child protective workers, ___attorneys, and/or ___others
- Task forces/working groups to discuss general issues involved in these cases
- Multidisciplinary teams to discuss individual cases
- Case managers
- Family drug courts
- Prehearing meetings/conferences
- Targeted prevention program(s) to help the children avoid becoming a substance abuser
- Targeted intervention program(s) to treat children who are substance abusers
- Targeted service program(s) to help children cope with difficulties resulting from having a substance-abusing parent
- Targeted treatment program(s) for substance-abusing parents
- Other: what? _____

9. In cases of children in dependency court whose parents are in substance abuse treatment, do you receive feedback from the treatment provider on how parents are progressing in treatment?

- No—would feedback be helpful to you? _____ Yes _____ No
- Yes—is the feedback... (check all that apply)

- by phone
- in a written report
- in person—treatment provider attends court hearings

Yes—is the feedback...

- timely?: _____ usually _____ sometimes _____ not very often
- helpful?: _____ usually _____ sometimes _____ not very often

10. What barriers hinder the court from obtaining feedback by substance abuse providers on parent's progress? (check all that apply)

- No barriers
- Confidentiality concerns of the treatment providers
- Concerns by providers that the patient's trust will be compromised
- Concerns by providers that the information will be used punitively against their client
- Feelings by treatment providers that their feedback will not make a difference in how the case is handled
- Resource problems, e.g., lack of treatment staff time to give feedback
- Other: _____

11. Beyond specific Indian Child Welfare Act (ICWA) requirements for cases involving Native American children with substance-abusing parents, are there any additional challenges posed by these cases?

- No
- Yes: What are they? _____

- Have never had a case under ICWA

12. We would like to compile information on promising practices communities have developed to handle dependency cases involving substance-abusing parents within ASFA guidelines. Has your community developed any special approaches to these cases which you feel are noteworthy?

- No
- Yes: Briefly

describe _____

If you have any questions regarding this survey, please call Caroline Cooper at American University (AU) in Washington, DC, 202/885-2875

Thank you so such much for your valuable time. Please send the completed survey in the enclosed self-addressed envelope by date _____, or if you prefer, you may FAX it to AU, ATTN: Caroline Cooper, 202/885-2885.