

Exploring the Links Between Parental Substance Abuse and Child Welfare

Increasing Understanding of
the Research and Program
Issues in Alaska



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TABLE OF CONTENTS

Executive Summary	1
Introduction	2
Defining the National Problem	2
Addressing Issues of Substance Abuse and Child Welfare Together	2
Values, priorities, and policies	3
Operations	4
Training	4
Assessment	4
Filling Information Gaps	5
Support for On-Going Recovery.	5
Broadening and Sustaining the Collaboration	6
Programs that Successfully Link AOD and Child Welfare Services	6
Project SAFE—Connecticut	7
Alcohol and Other Drug Treatment Initiative (AODTI)— Sacramento County	7
Child Protection Substance Abuse Initiative (CPSAI)— New Jersey	8
Family to Family—Cuyahoga County, Ohio	8
San Diego County Dependency Court Recovery Project (DCRP)	9
Miami-Dade County (Florida) Drug Dependency Court	9
Jacksonville (Florida) Community Partnership	9
Table 1: Promising Practices in Family Support and Substance Abuse Treatment	11
Programs Which Target Native American Issues	15
Issues Regarding Substance Abuse and Child Welfare in Alaska	15
Vulnerable Groups	16
Women with Children	16
People with Co-occurring Disorders	16
Alaska Natives	16
Gaps in Information	17
Gaps in Treatment	18
General Knowledge of Best Practices in Alaska	18
Elements of Healing Practices for Alaska Natives	18
Measuring Effectiveness in Alaska	20
Chemical Misuse Treatment and Recovery Services (CMTRS) Program	20
Table 2: Comparison of CMTRS and VAEC Communities	21
Hudson Lake Recovery Camp	22



Deilee Hit Safe Harbor House	23
Cook Inlet Tribal Council's Substance Abuse Programs	23
Mobile Treatment Unit	23
Other programs in the CITC System of Care	24
Dena A Coy	24
Anchorage Family CARE Court	24
Table 3: Family CARE Court: Preliminary information for 2004	26
Alaskan Agency Interviews	26
Responses to the Questions	27
Discussion of Agency Surveys	28
Conclusions and Recommendations	29
References	32
Other Resources	36
Appendix A: Matrix of progress	38

Exploring the Links Between Parental Substance Abuse and Child Welfare

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Conducted by

THE UNIVERSITY OF ALASKA ANCHORAGE
School of Social Work &
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Executive Summary

A partnership of child welfare stakeholders in the state of Alaska sought to examine what current research reveals about the effectiveness of programs which address the co-occurring problems of parental substance abuse and child abuse and neglect. They also wished to explore what models, practices, and means of evaluation are being used by programs in Alaska which serve this population. Stakeholders intend to use the findings from this report to inform both policy and practice. Particular emphasis was placed on investigating culturally relevant programs that have been shown to be effective within and outside of Alaska.

Although the link between substance abuse and child maltreatment has been well-established, it has been only recently that governments and non-profit agencies have turned their attention to the necessity of addressing these problems together. Evaluations of these efforts are sparse, and no one set of treatment “best practices” to address the intersection of these problems has been established. However, recent research into promising programs has revealed that success in treating these families requires concerted collaboration across alcohol and drug treatment agencies, child welfare entities, and dependency courts in four key areas: staff training, client screening and assessment, filling information gaps, and providing long-term support for recovery. (A matrix by which to measure progress toward building such collaborations is contained in Appendix A.) Descriptions of seven sites which have established successful links across all of these areas are provided, as well as a matrix of several other sites identified as achieving outcomes with “promising practices” in assisting the families they serve.

A literature search for evaluations of relevant tribal programs outside Alaska which combine substance abuse treatment and child welfare found no *demonstrated* effective or exemplary programs. Programs reporting positive outcomes were discovered and one multi-site program was described. Inside Alaska, several programs serving Alaska Native families reported positive results, although, as with the rest of the literature review, rigorous program evaluation was sparse. One study found some key elements contributing to successful treatment for Alaska Natives: ensuring that staff members are Alaska Natives, are familiar with Native culture, and/or have village experience, that programs include cultural components (such as spirituality, foods, etc.), and that Alaska Natives have adequate access to treatment. Several examples of programs serving Alaska Native people were provided.

Suggestions to improve collaboration between substance abuse treatment and child welfare services in Alaska included: increased collaboration between the Office of Children’s Services and the Division of Behavioral Health, including compatibility of their respective information systems; creating common definitions of success across programs; improved outcome evaluations and sharing of findings; developing common screening and assessment tools for child welfare and substance abuse treatment and prevention agencies; and ensuring that demand for treatment needs meets availability of services. Further investigation of current programs which provide anecdotal evidence of success is necessary to establish them as potential models of success.

Introduction

This paper will examine national as well as Alaska-specific data and information on the treatment issues related to child welfare and parental substance abuse. The goal of this paper is to address the following questions:

- What is happening outside Alaska in the area of substance abuse treatment with families identified as abusive/neglectful?
- What programs currently exist in Alaska for families with substance abuse and child abuse and neglect issues?
- What are tribal programs out of state doing in this area?
- What do we know about “best practices” in this area?

Defining the National Problem

One of the most significant problems affecting the integrity of families today is substance abuse. Over eight million children live with substance abusing parents (Huang et al., 1998, as cited in Department of Health and Human Services [DHHS], 1999a). National estimates of families involved with the child welfare system that include substance abusers range from 20% to 80% (Besinger, Garland, Litrownik, & Landsverk, 1999; Young, Gardner, & Dennis, 1998). Children with substance abusing parents are three times more likely to be abused and four times more likely to be neglected than those children with parents who do not abuse alcohol or drugs (Kelleher, Chaffin, Hollenberg, & Fischer, 1994). Kelleher et al. also noted that children who are prenatally exposed to alcohol are two to three times more likely to be abused than those children who are not exposed. The National Center on Addiction and Substance Abuse (CASA, 1999) cited as a conservative estimate that 70% of child welfare system expenditures, or about \$10 billion in 1998, are a result of parental substance abuse.

The Child Welfare League of America (CWLA, 2001) has estimated that sixty-seven percent of parents in the child welfare system required substance abuse treatment services but child welfare agencies were only able to provide treatment for less than one-third of these families. Furthermore, in most states, the wait for treatment services was up to 12 months (p. 8).

CWLA noted that many states faced procedural issues that hinder their ability to address substance abuse issues in child welfare cases. In their survey, 27 state child welfare agencies did not know whether families requiring alcohol and other drug (AOD) services could receive these in a timely manner; 13 states reported that 50% or more of families requiring AOD services could not be treated in a timely manner; and only one state reported that families requiring AOD services could obtain these within one month (CWLA, 2001). From the other direction, the National Institute on Drug Abuse’s Drug Abuse Treatment Outcome Study has found that fewer than half of AOD treatment programs provide such parent/child welfare assistance as parenting services, women’s support groups, childcare, domestic violence intervention, or pregnancy support (Grella, 2003).

Addressing Issues of Substance Abuse and Child Welfare Together

While the fields of AOD treatment and child welfare each have traditionally excluded the other, recent national attention has focused on finding ways to share information and create a body of research at the intersection of these frequently co-occurring problems (Walter R. McDonald & Associates, 2001). Five recent national reports discuss the challenges at the intersection of substance abuse and child welfare. These reports, listed below, provide recommendations and/or models to address the barriers and

challenges in linking substance abuse treatment and child welfare:

1. *Responding to Alcohol and Other Drug Problems in Child Welfare: Weaving Together Practice and Policy* by the Child Welfare League of America (Young, Gardner, & Dennis, 1998)
2. *Foster Care: Agencies Face Challenges Securing Stable Homes for Children of Substance Abusers* by the U.S. General Accounting Office (1998)
3. *No Safe Haven: Children of Substance-Abusing Parents* by the National Center on Addiction and Substance Abuse at Columbia University (1999)
4. *Healing the Whole Family: A Look at Family Care Programs* by the Children's Defense Fund (CDF, 1998)
5. *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection* by the U.S. Department of Health and Human Services (1999a).

In order to provide effective substance abuse treatment and/or prevention as well as services to address or reduce child maltreatment, substance abuse agencies and child welfare agencies need to overcome their differences. Although there is little in the way of program evaluation, the reports listed above provide insight into the issues that need to be addressed in creating a collaborative approach.

Values, priorities, and policies

The five major reports characterize current service provision as fragmented and often at odds. The differences in missions, professional perspectives, approaches to treatment, and constituencies between alcohol and drug treatment and child welfare organizations often inhibit communication and collaboration that could benefit their mutual clients. Child welfare (child protective services) programs may not be oriented toward the special needs of parents and children with AOD addictions, while AOD services may be built upon a program design that utilizes confrontational tactics which may not work for women with low self-esteem, may not incorporate parent education into its treatment programs, may be unaware of child development issues, and may not prioritize its limited treatment spaces for parents (Walter R. McDonald & Associates, 2001).

Substance abuse and child maltreatment issues “are pervasive, multiple, and chronic” (National Research Council, 1998, p. 102) and are often well out of the influence of a single social or health service agency. Involvement with multiple agencies compounds these difficulties. Funding streams tend to focus on individual needs and not address the complex and diverse needs of parents, children, and families (see, for example, the Pew Commission on Children and Foster Care [2004] report). Families find themselves pulled in different directions by the resulting policy differences and agency priorities. Timing differences, often related to the different funding streams, exist among welfare and child welfare mandates, treatment and recovery, and child development (Grella, 2003; NCSACW, 2003a). The National Center on Substance Abuse and Child Welfare (NCSACW) describes this as five “clocks” affecting families:

1. The Temporary Assistance for Needy Families (TANF) legislation, which requires parents to work after receiving 24 months of assistance, and caps lifetime benefits at 60 months;
2. The Adoption and Safe Families Act of 1997 (ASFA) which requires permanency decisions to be made on a 12-month timeline, and petitioning for Termination of Parental Rights (TPR) to be done if a child has spent 15 of 22 months in out-of-home-care;
3. The pace of recovery from addiction does not fit into a neat timeline, “relapse is common” (Department of Health and Human Services, 1999a, Chapter 6, p. 3), and the long-term need for recovery may conflict with the shorter timelines required by the ASFA;

4. Child development may occur at a faster rate than recovery and reunification, especially from birth to age 5, and;
5. The child welfare system, suffering from high caseloads, is pressured to accurately address the needs of the family in order to achieve permanency of the child quickly (NCSACW, 2003a).

The interactions of these “clocks” can have significant consequences on individual families. For example, CPS cases with caretaker substance abuse problems are more likely to have termination of parental rights proceedings initiated and do so sooner than cases without substance issues (Barth, 2003). Assuring timely access to services requires the substance abuse and child welfare fields as well as the courts to take comprehensive views of the family’s situation, and understand the contributions of various factors to child maltreatment. Even when high quality treatment designed for parents and children is readily available, access to that treatment may be limited by the family’s interactions with the surrounding systems. To help families deal with these conflicting clocks, the NCSACW (2003b) recommends a trilateral collaboration of substance abuse treatment, child welfare, and court systems, working together to address and overcome past differences in priority, scope, identified client, funding stream, and other factors.

Collaborative agencies need to dedicate themselves to providing comprehensive services that address the complex and diverse needs of families. Underlying values must be addressed because partners are likely to bring to the table different perspectives and assumptions about their agency’s mission. This may, for example, require the substance abuse agency to increase attention to children’s safety. Timelines and decision-making for children must be improved, and policies must allow for the increased availability, access, and appropriateness of substance abuse treatment for families. Enhancing children’s services will require an expansion of collaborative interventions for children and families in the child welfare system (the focus of this report) as well as preventive measures, increasing the capacity of CW agencies to address parents with substance abuse problems, and developing strategies to quickly achieve permanency outcomes for children when family reunification efforts fail.

Operations

Training

A comprehensive service delivery system requires committed, skillful, and flexible staff members who are able to address diverse and emerging needs. Appropriate training and staff development must be instituted, because without cross-training efforts conventional practice will deepen the division between agency staff groups who are oriented to think separately rather than collaboratively in serving shared clients. Training and identification skills of child protection workers in substance abuse issues and of substance abuse workers in child protection issues must be strengthened to more effectively identify and intervene with families.

Assessment

Daily practice in the areas of AOD screening and assessment of family functioning must be addressed to better determine problems, what treatment is best and what information needs to be communicated among workers. Child welfare clients are likely to need more help getting started than individuals who live without cohabiting family members (Grella, 2003). AOD programs traditionally may not address the special needs of families in which child maltreatment is present, and may not note whether a client is a parent for whom there might be a more appropriate treatment. Staff ability to appropriately identify risk to children, assess alcohol and drug use, accurately assess client needs, refer clients to appropriate services in their community, and evaluate the client’s progress must be enhanced in order for the client’s

treatment plans to be useful or relevant.

Filling Information Gaps

The child welfare and AOD systems need to be able to share more information. A survey of state child welfare agencies by CWLA (2001) found that few had information systems that track substance abuse-related information. Lack of information results not only in a lack of empirical knowledge about effective practices, but also a breakdown in cross-agency communication (DHHS, 1999a). A child welfare agency may refer parents to treatment programs without knowing if vacancies exist (or if the programs are useful) or if parents can obtain needed services, such as child care, to support their efforts to enter and remain in programs. Sharing information systems is a prerequisite for joint accountability, and helps overcome inadequate links among providers and inadequate monitoring of parents' progress in treatment.

Support for On-Going Recovery.

The ability to engage and retain clients in care and to support their ongoing recovery is critical. Daily practice in engaging and retaining parents must be addressed to keep clients on track in meeting parental goals. Ways to improve the engagement and retention of clients in care include:

- developing an integrated Child Welfare-Alcohol or Drug (CW-AOD) assessment approach
- using strategies that motivate parents to engage in treatment, and
- developing and using innovative court programs to reinforce the connection between treatment compliance and family preservation.

Optimal service delivery takes place in an accepting yet demanding treatment environment characterized by clear expectations and standards, as well as an understanding that setbacks are part of recovery (see, for example, Broome, Simpson, & Joe, 2002; National Research Council, 1998). Relapse is common, even among those who eventually remain substance-free, and predicting readiness for recovery and potential relapse is difficult. Providing comprehensive treatment to families affected by drugs and alcohol necessitates longer treatment timelines and aftercare that allow genuine change and healing to take place, as families uncover and address problems for the first time, practice new behaviors in a supportive setting, and ease back into the community. The various effects of interactions with other systems—justice, welfare, employment, etc.—must be taken into account.

Child welfare agencies typically do little to prevent or prepare for relapse. Steps must be taken to plan for relapse before the parent is discharged from treatment. These parents are likely to experience a multitude of stressors: the pull of different agencies and authorities (the “clocks”), single parenthood and younger children (Besinger et al., 1999), making up time at work or finding a new job, and so on. Having a plan in place will help minimize family disruption when the using parent is faced with those factors which previously triggered substance use. Programs should include active peer support among clients while in the program and as they make the transition out of treatment (Broome, Simpson, & Joe, 2002). There are programs, such as the Institute for Health and Recovery's Nurturing Program for Families in Substance Abuse Treatment and Recovery (see the joint project of Center for Substance Abuse Prevention and the Office of Juvenile Justice & Delinquency Prevention, *Strengthening America's Families*, www.strengtheningfamilies.org), that support parental recovery while also providing parent training and other family support services to further reduce stressors and the probability of child maltreatment.

Broadening and Sustaining the Collaboration

Innovation is necessary across fields both in approach to treatment and in use of funds to maximize treatment outcomes through grants and available federal funds (Medicaid, TANF, Social Security Title IV-E, Welfare to Work, etc.) (DHHS, 1999a). Budgeting and program sustainability must be addressed. Tapping the full range of available funding resources is the only way to develop multi-year stability for innovative, comprehensive, cross-agency approaches. In order to document expenditures and benefits, there should be a focus on evaluation and quality improvement, requiring the partnering agencies to emphasize joint accountability and shared outcomes.

As discussed, families often have diverse needs and come in contact with diverse systems. Collaborative efforts should extend beyond just the child welfare and AOD agencies to include the courts, mental health agencies, agencies that deal with family violence, the juvenile justice system, child development agencies, and schools. The role of courts is critical in enforcing time limits and making judgments about parental progress. Working relationships with other agencies and community members should be developed because many clients also require assistance from other agencies. Training should cover the services, benefits, and rules of each organization to which a client might be referred or required to interact. Children and Family Futures (www.cffutures.org; also available at ncsacw.samhsa.gov/products.asp) offers technical assistance and training, including self-assessments to aid collaboration, for organizations working at the intersection of substance abuse and child welfare.

Building these relationships provides many advantages. The links enable service providers to meet a broader range of family needs, where access to child care, employment services, methadone treatment, parent training, or another ingredient may make the difference between maintaining the children at home or placing them in foster care. These collaborations allow agencies to better coordinate efforts and ensure that they neither overwhelm families with competing requirements nor impose conflicting demands. They enable more efficient use of limited resources and prevent parallel program development. This may in turn allow for addressing the critical lack of appropriate multifaceted services in many communities (DHHS, 1999a). NCSACW (2003b) has developed a matrix of progress toward achieving these linkages across substance abuse, child welfare, and dependency courts. This matrix provides fundamentals for improving practice as well as best practices in collaboration (see Appendix A; also available at www.cffutures.com/Children_Family_Policy/CW/TAP/Matrix_of_Best_Practices.pdf). A comprehensive approach to address substance abuse among parents and its harmful effects on children is necessary.

Programs that Successfully Link AOD and Child Welfare Services

Evaluations of programs addressing this subject are scarce. The Children's Defense Fund (CDF, 1998) examined 22 family care programs providing integrated substance abuse treatment and child welfare intervention. The CDF study highlighted the need for outcome evaluation to determine program success and further direct efforts within family care programs. Only 2 of the 22 programs reported increases in the percentage of women (12% and 95%) reunited with their children while in the program. Two programs reported that all families in their programs had remained united after six months, and one program reported that mothers remained drug-free for a certain period of time (CDF, 1998). Such scarcity of evaluation of joint substance abuse-child welfare programs makes building a body of best practices impossible. What is left are promising practices, suggestions of potential efficacy that have not been fully evaluated.

Children and Family Futures (Young & Gardner, 2000), under contract with the Department of Health and Human Services, conducted site visits of programs across the country providing combined child welfare and substance abuse treatment services. The reviewers used a ten-part assessment tool to measure an agency's capacity to address the dual issues of child welfare and parental substance abuse. (This is one of the assessments available at CFF's website mentioned above.) CFF selected seven sites whose assessment results indicated the probability of being successful program models. They were Connecticut's Project SAFE, Sacramento's Alcohol and Other Drug Treatment Initiative, the Child Protection Substance Abuse Initiative in New Jersey, Family to Family in Ohio's Cuyahoga County, San Diego County's Dependency Court Recovery Project, the Drug Dependency Court of Miami-Dade County, and the Drug Dependency Court/Community Partnership program in Jacksonville, Florida.

Project SAFE—Connecticut

Project SAFE (Substance Abuse Family Evaluation), begun in Connecticut in 1995, is a program that provides evaluation and treatment of alcohol and other drug dependency among parents in the child welfare system (Young & Gardner, 2000). The program is a collaboration among the State Department of Children and Families (DCF), the Department of Mental Health and Addiction Services (DMHAS), and a network of nonprofit behavioral health providers (DHHS, 2001).

Most of the coordination and collaboration of casework occurs at the local level. At the state level, DCF and DMHAS base their partnership on 1) designated leadership and project responsibility; 2) joint program planning and evaluation; 3) regional service team meetings; 4) cross-training forums; 5) jointly contracting for behavioral health services; and 6) resource development and shared funding (Young & Gardner, 2000). This program seeks to improve services by the purchase of outside expertise to assist child welfare workers and strengthen their efforts with substance abusing families (DHHS, 2001).

In Phase I of Project SAFE, staff developed a specialized screening tool for child welfare and substance abuse issues, along with specific intake forms. Providers of substance abuse services were contracted to provide direct services to families. Phase II of Project SAFE focused on improving outcomes for women, children and families. Services for women and children included outreach and engagement, on-site childcare, on-site parenting support, trauma education and treatment, and comprehensive substance abuse evaluations (Young & Gardner, 2000). Program outcomes were not provided in any of the publications reviewed.

Alcohol and Other Drug Treatment Initiative (AODTI)—Sacramento County

Sacramento County in California sought to improve services to families affected by substance abuse by changing the daily practice of child welfare workers. They began with a vision of incorporating substance abuse treatment as an integral part of the health and human services delivery system, recognizing that health, social service, and criminal justice caseloads were driven by substances abuse, and that agency staff could be the first line of defense (Young & Gardner, 2000).

AOD was incorporated into every risk assessment, and child welfare clients were given priority for treatment. This required expansion of treatment services. Child welfare workers were trained as AOD group co-facilitators, not to provide treatment as much as to prepare clients for treatment, and provide information or support while they awaited treatment. Workers were provided three levels of AOD training, and were able to make referrals to certified counselors for an AOD treatment referral. This program was initially implemented poorly, and resistance among workers was encountered, attenuating its assessed effectiveness (CASA, 1999). Evaluation has shown a notable increase in service access by women (Young & Gardner, 2000), positive reports from mothers and fathers regarding abstinence and

satisfaction, and positive effects on child reunification (CASA, 1999).

Child Protection Substance Abuse Initiative (CPSAI)—New Jersey

The state of New Jersey initiated the Child Protection Substance Abuse Initiative in 1995 as a result of a high incidence of welfare cases that involved substance abuse (80%) and the involvement of substance abuse in several child deaths. The Division of Family and Youth Services (DFYS) collaborated with the state Division of Addiction Services to expand the capacity for treatment of mothers with substance abuse disorders. The CPSAI consists of an assessment, referral, and case management service that identifies the level of risk to the child posed by the parents' substance abuse.

The CPSAI began in four pilot cities with services contracted from Certified Alcohol and Drug Counselors (CADC) and paraprofessional home visitors from the client parents' community who have themselves overcome addiction. The CADCs provide assessment and case planning and help with client engagement and retention (CASA, 1999). In 2000, there were 31 CADCs and 37 home visitors working with DFYS (Young & Gardner, 2000).

Family to Family—Cuyahoga County, Ohio

Family to Family, funded by the Annie E. Casey Foundation, is a community-based approach to improving the child welfare system. Begun in 1992, the goals of Family to Family include keeping families intact in their home and communities, and when out of home placement is necessary, providing culturally relevant, time-limited, foster home care in the child's community. Foster families are included in case planning and family reunification efforts. Family to Family was initially field-tested in communities in several states and has expanded into several more sites in other states. The four core strategies of Family to Family are the recruitment, training, and support of resource families (foster and relative), building community partnerships, team decision making, and self-evaluation to drive decision making (Annie E. Casey Foundation, 2002).

One of the original Family to Family implementation sites was implemented by the Cuyahoga County (Ohio) Department of Children and Family Services (CCDCFS) in collaboration with substance abuse treatment agencies, mental health providers, and the Annie E. Casey Foundation "to blend best practices from addiction treatment, child welfare, and family preservation" (Usher & Wildfire, 2003, p. 601). The CCDCFS program targeted mothers of newborn infants with positive toxicology tests at birth. The department initiated Sobriety Treatment and Recovery Teams (START) consisting of a social worker and a paraprofessional family advocate (Young & Gardner, 2000). The family advocates are women with at least two years in recovery, often with closed child welfare cases of their own, whose role is to help the team engage with the client (Annie E. Casey Foundation, 2002; Usher & Wildfire, 2003). Teams are limited to fifteen cases. In the early phase of the case, the team may visit the client before she leaves the hospital. Home visits occur weekly, and the START team takes the client to treatment for the first few sessions (Annie E. Casey Foundation, 2002).

The family advocates work closely with the family, and are sometimes more adept than the social worker at detecting the client's potential for relapse. Weekly contact is made between the team and treatment provider to keep each other apprised of the client's status. Outcome measurements are obtained to gauge goal attainment (Annie E. Casey Foundation, 2002). The pilot study of START, implemented with 10 teams before expanding it throughout Cuyahoga County, showed some positive results, particularly long-term results (NCSACW, 2003b; Usher & Wildfire, 2003).

San Diego County Dependency Court Recovery Project (DCRP)

In 1996, San Diego County received 3000 new dependency cases which were the result of 90,000 reports of suspected child abuse and neglect (NCSACW, 2003b). Drug and alcohol use were the most prevalent triggers of reports of harm, yet AOD treatment programs had long waiting lists. In order to find ways to increase access to treatment for parents and reduce time for children to achieve permanent placement, the court system initiated a county-wide collaborative system that provided parents involved in dependency court with top priority access to AOD treatment. Besides greater access to treatment, the Dependency Court Recovery Project (DCRP) incorporates several other components, including implementation of a new Substance Abuse Management System (SARMS), greater participation of Court-Appointed Special Advocates (CASAs), use of settlement conferences and family group conferencing, and an improved automated tracking system. SARMS, contracted to a private mental health agency, serves as the guiding case management system. The agency provides assessments, monitors parents' progress through treatment, coordinates random drug testing and reports to the court for the usual nine-month participation (Young & Gardner, 2000). According to Judge James Milliken, (NCSACW, 2003b), who structured the program, the critical elements which make DCRP successful are case management, clear orders from the court, timely feedback to the court regarding client treatment, immediate access of the parents to treatment, and support for recovery.

Miami-Dade County (Florida) Drug Dependency Court

The Miami-Dade County Drug Dependency Court (DDC) is one of three national demonstration sites funded by the Center for Substance Abuse Treatment (CSAT) (Young & Gardner, 2000). Judge Jeri Beth Cohen created the DDC in 1999 after watching numerous addicted parents fail to meet requirements to regain or retain custody of their children. She noted that the parents who came through her court needed both intensive monitoring and a whole array of services if they were to successfully reunite with their children. Initially, she persuaded the Florida state legislature to fund three addiction specialist positions to provide mental health and addiction screening and assessment and referral to appropriate treatment services. Gradually, Cohen expanded the program and enlisted 30 mental health and substance abuse treatment providers in the area to work with the court to provide treatment and the necessary reporting to ensure compliance with case plans. Four of those programs, specializing in serving women and children, receive the bulk of the court's treatment referrals. Detailed Memoranda of Understanding were developed between the agencies and the court spelling out services and reporting requirements (NCSACW, 2003b).

Jacksonville (Florida) Community Partnership

The city of Jacksonville, Florida, has built a collaboration among alcohol and drug counselors and child protection workers through a community partnership supported by the Edna McConnell Clark Foundation. AOD counselors from Gateway Community Services serve on CPS teams to assist in assessing parents for substance abuse problems, making referrals for treatment, and engaging them in treatment (NCSACW, 2003b; Young and Gardner, 2000). At the heart of the collaboration is an Individualized Course of Action (ICA), which is a family-focused treatment plan built upon the strengths of the family with input from agency staff. Assessment early in CPS involvement as well as fast and easy access to treatment provides parents with a "smooth entry into the system" (NCSACW, 2003b, p. 19). The co-location of CPS and AOD staff "is seen as a tool for bringing all of the agencies and resources together with the family" (p. 19). Drug testing is an essential piece of treatment and continues after the clients have been discharged from treatment.

Other programs which have displayed promise but were not identified in the Children and Family Futures analysis are described in Table 1. The programs in Table 1 have at least some minimal reported

outcomes, but the table illustrates the relative lack of strong evaluation in this area.

Table 1: Promising Practices in Family Support and Substance Abuse Treatment

Program	Target population: Who	CPS involved	Urban/rural	Ethnic group? (cultural competence)	Setting/service medium	Format/essential components	Primary intended outcome of program	Reported Outcomes
Gateway Community Services/ Community Partnership, Jacksonville FL	Mothers who abuse alcohol or drugs (AOD)	Some clients	Urban		Residential & outpatient treatment centers	Residential and intensive outpatient substance abuse (SA) treatment, case management	Treat mothers for SA & reunify with children, keep children safe	One year after discharge, 72% not using AOD, 64% attained vocational skills or education needed for employment, 92% reported no further involvement with police, courts, or probation
Starting Early Starting Smart (SESS), SAMHSA & Casey Family Programs: 12 sites, including Tulalip Tribe in WA	Families with young children at-risk of or experiencing SA, at-risk of child maltreatment	Some clients	Both	Majority are non-Caucasian families. Staff are trained in cultural differences	Integrated service teams based on family's needs: school- & community-based depending on collaboration, with some in home services	Family support, advocacy, and care coordination; site-based parenting classes, home-based parenting skills development, life skills sessions, etc. Coordinating center provides common outcome measures of caregiver behavior, family environment, & child socio-emotional development	Increase service access, positive caregiver-infant interactions; decrease drug use; enhance child guidance/ support by family, child development (& school success)	Statistically different positive outcomes are seen in the SESS parents compared to the comparison group (across all 12 sites). Longitudinal studies are ongoing
Alcohol & Other Drug Treatment Initiative (AODTI), Sacramento County, CA	Parents of children in CPS	Yes	Urban		Community	Train CPS workers to perform screening for AOD problems, provide further training for assessment/ intervention or referral skills	Identify SA issues as essential component of child risk assessment & case planning	Provided greater access for women to treatment: 52% in Sacramento County vs. 35% in all of CA. Child placement with parents who graduated from the program increased by 48%

Program	Target population: Who	CPS involved	Urban/rural	Ethnic group? (cultural competence)	Setting/service medium	Format/essential components	Primary intended outcome of program	Reported Outcomes
New York Administration for Children's Services (evaluation conducted with the National Development and Research Institutes)	Substance abusing mothers with children under the age of six and/or drug exposed infants	Yes			Home & community	Home-based case work, social services, and substance abuse treatment	Prevent foster care (FC) placement and provide adequately for family's needs	28% of 173 clients completed treatment, 49% dropped out, 13% transferred to other programs, 9% still in treatment. Completers less likely to have child in FC than those who left treatment or were transferred (16% vs. 30%), have children living elsewhere at follow-up (20% vs. 48%), & have child placed in FC between entry & follow-up (6% vs. 23%)
Options for Recovery (California's Perinatal Projects)	Pregnant, post-partum, parenting, chemically dependent women	Yes	Both	Diversity of clients served. Some sites adapted to cultural components of communities served	Varies with program – hospital-based, community, residential, outpatient	Intake and referral, case management, outpatient and residential SA treatment, parenting education, and life skills training (services varied by site)	Promote recovery of chemically dependent women and improve the health and well-being their children	Women most likely to achieve satisfactory completion of treatment were mandated to tx, younger, high school graduates, or had participated in tx for at least 150 days

Program	Target population: Who	CPS involved	Urban/rural	Ethnic group? (cultural competence)	Setting/service medium	Format/essential components	Primary intended outcome of program	Reported Outcomes
CASAWORKS for Families, National Center on Addiction and Substance Abuse at Columbia University; in 11 cities in 9 states	Mothers over 18 with custody of at least 1 child, receiving TANF or expecting to (not SSI), admit to substance use in the last 6 months, no current SA treatment	Possibly	Urban	May vary with program	Varies with program – hospital-based, community, residential, outpatient	10 core services provided for families, including comprehensive SA & mental health treatment, employment, housing & financial assistance, literacy & vocational services, childcare support, comprehensive health services, mentoring, family skills development	Reduce substance use, find and retain employment, inhibit and prevent family violence and foster quality parenting	After 12 months the proportion of enrolled women abstinent from alcohol increased by 60%, from marijuana by more than 20%, from cocaine by 34%. They have more than doubled their rate of employment. In August 03 the New York City site began a randomized, controlled trial for evaluation
Project SAFE, Cook County Illinois	Mothers with alcohol/drug use & history of child neglect/abuse	Yes			Community-based	Outreach, case management, treatment, child care, parenting training, support groups, aftercare, relapse prevention	Family reunification	105 women over 2 years: 81% completed, 51% had positive prognosis rating, 54% reunification rate vs. 40% for comparison group
Parent Drug Court, Pensacola, FL	Parents with chronic SA, child in FC, and non-violent criminal or child welfare history	Yes	Urban		Court, with case management, community-based services	Intensive outpatient treatment, group therapy, drug testing, with & varying intensity & frequency later	Reunite parents with children and keep kids safe	21 of 39 participants graduated. 52 children reunited with parents, 6 pending. 18 parents terminated from program, 38 children of those parents freed for adoption/guardianship

Program	Target population: Who	CPS involved	Urban/rural	Ethnic group? (cultural competence)	Setting/service medium	Format/essential components	Primary intended outcome of program	Reported Outcomes
Drug Free Families, Pinellas County, FL	Substance abusing pregnant & parenting women and their families				Home & community	Home visit within 72 hours of referral. Weekly visits, case management, crisis intervention provided. Referrals when there is evidence of SA in home by another family member. Pregnant women get on-going pre-natal care	Link family to SA services, strengthen parenting skills, help adopt a healthy lifestyle, reduce potential for child abuse	94% of families were not involved in a verified report of maltreatment during an 6-month review, and 91% of women participating in the program before their third trimester delivered drug-free infants
Safe Port, Monroe County, FL	The primary client is the substance using woman. The children & partner are included in treatment	Many clients	Urban		Residential. Clinical staff and on-campus childcare center collaborate to work with the family	Holistic family centered approach. Family is housed on treatment facility campus. Children in CPS are reunited while the family is on campus. Ongoing treatment and aftercare supports are provided	Treat the family as a whole for addictions. Provide skills to recover from addiction and reduce the potential for relapse	78% of women entering the program with their children completed the program vs. 50% of mothers entering without; 3 months after completion, 90% employed full-time, 93% not involved with criminal justice system; 6 months after, 83% of women who entered with children were abstinent vs. 15% of those who entered without
Women's Residential Addiction Program (WRAP), Dade County, FL	Substance abusing women requiring structured treatment		Urban		Residential: highly structured therapeutic environment	Provide care, supervision, & treatment; case management; individual, group, & family counseling; SA education; life skills development. Children visit but do not live with parents	Facilitate continuity of care throughout treatment and aftercare	93% of mothers showed increased communication with children; 88% improved parenting skills; 90% increased knowledge of domestic violence & related issues

Programs Which Target Native American Issues

Alcohol and substance abuse have long been recognized as “the most severe health and social problems facing Indian tribes and people today and nothing is more costly to Indian people than the consequences of alcohol and substance abuse measured in physical, mental, social and economic terms” (US Department of Justice, 2000, p. ix). The Department of Justice (2000) has noted that the current literature on prevention and treatment of alcohol and substance abuse is lacking in examples of successful prevention initiatives in Native communities. It suggests that evaluations of innovative programs using traditional Indian culture and religion would be valuable. A search for relevant programs combining substance abuse treatment and child welfare found no demonstrated effective/exemplary programs (defined by the presence of at least one random assignment experimental design). However, one substance abuse treatment and prevention program with strong family support (child maltreatment prevention) components has demonstrated positive program outcomes.

The Tulalip Tribe in Washington State is one of twelve sites participating in the Starting Early Starting Smart (SESS) Program. SESS provides an integrated system of child-centered, family-focused services targeted to children from birth to age seven at-risk of placement in out-of-home care. It is a four-year program, including an evaluative component, sponsored by a public/private collaboration between SAMHSA and Casey Family Programs. The program settings range from primary care to early childhood education facilities (Casey Family Programs & US Department of Health and Human Services, 2001a, 2001b, see ncadi.samhsa.gov/promos/sess/about.html for more information).

Program services use an integrated, multidisciplinary approach to provide strength-based behavioral health interventions in tribal and mainstream schools. The Tulalip program serves both tribal members and non-Native families at local preschool sites. Any family with a child between the ages of three and five who attends one of the SESS preschool sites may enroll in the SESS program. The SESS team consists of collaborators from the Child Advocacy Center, the Stop Violence Against Indian Women team, child therapists who work at the preschool sites, clinical and legal consultants, Indian Child Welfare case managers, and other community members. This multidisciplinary team meets regularly. Cross-trainings occur on a regular basis and as needs arise (Casey Family Programs & US Department of Health and Human Services, 2001a, 2001b).

The collective data from all twelve SESS sites, over multiple follow-up periods, showed positive program outcomes. There was increased access and use of needed services by participating families, families increased the positive guidance and support of the development of their young children, caregivers requiring substance abuse treatment decreased their substance use, interactions between caregivers and infants in the early months of life were strengthened, and the development of young children to guide future school success was strengthened (Casey Family Programs & US Department of Health and Human Services, 2001a).

Issues Regarding Substance Abuse and Child Welfare in Alaska

Alcohol is the most abused substance in Alaska, with a rate of abuse and subsequent disruption described as epidemic. The social cost of alcohol and drug abuse is evident in the rates of domestic violence and child maltreatment, injuries, chronic disease, and deaths (Alaska Department of Health and Social Services, 2001; Southcentral Foundation & Burgess, 2002). The McDowell Group Report (2001) estimated the total cost for alcohol and other drug dependency in Alaska in 1999 at \$453 million dollars. The report measured these cost in the categories of productivity losses, criminal justice and protective services, health care, traffic accidents, and public assistance.

Alaska ranks first of the fifty states in the rate of illicit drug use (US Department of Health and Human Services, as cited in Southcentral Foundation & Burgess, 2002), the rate of Fetal Alcohol Syndrome, number of deaths where alcohol is involved, and drinking by mothers of newborns. It ranks second in the nation for the percentage of chronic drinkers. A report commissioned by the Alaska Department of Health and Social Services, Alaska Division of Alcoholism and Drug Abuse, estimated that 14% of the adult population in Alaska abuses or is dependent on alcohol as compared to 7% of the US population (Division of Public Health, 2001).

Vulnerable Groups

The Alaska Department of Health and Social Services, in its 2001 Comprehensive Mental Health Plan (Alaska DHSS, 2001), identified six population sub-groups in its discussion of substance abuse in the state. Three of those groups are relevant to this discussion of substance abuse and child welfare in Alaska. They are 1) women with children, and 2) people with co-occurring disorders, and 3) Alaska Natives. Each group is discussed below.

Women with Children

One of the highest risk and lowest served populations in Alaska is alcohol-dependent women with children (Alaska DHSS, 2001). As in the rest of the country, appropriate and effective treatment for women with young children is often not available in many communities (DHHS, 1999a). Mothers tend to have the longest wait to enter treatment (C&S Management, 2001). Barriers to treatment faced by this population include fear of losing their children to state custody and a lack of childcare while in treatment. These women are more likely to have experienced trauma in their lives, such as sexual or physical abuse. Their children are likely to experience developmental problems and become substance abusers themselves (Alaska DHSS, 2001).

People with Co-occurring Disorders

During 1994-1996, an estimated 20% of Alaskans required both mental health and substance abuse treatment services (Bans & Pandiani, 1997). Nationally it is estimated that 51% of persons having a lifetime mental disorder also have a substance abuse disorder (DHHS, 1999b). Barriers to treatment for people with co-occurring disorders include separate billing systems for each disorder and different approaches to treatment by each system. Brems and Namyniuk (1999) estimated that “the social and medical cost of serving people with co-occurring disorders is estimated to be four times the cost to serve other clients” (p. 18).

Alaska Natives

Substance abuse and related issues affect Alaskan Natives more than non-Natives (Southcentral Foundation & Burgess, 2002). While the high prevalence of alcohol use is not restricted to Alaska Natives, its consequences are disproportionately higher (Segal, 2003). Alaska Natives have a higher death rate from cirrhosis, at 18.7 per 100,000, than both the state (9.1 per 100,000) or national rate (9.6 per 100,000). The rate for drug-induced deaths in all Alaskans is higher than the national rate, and the rate for Alaska natives is yet higher than the rate for all Alaskans (Division of Public Health, 2001). Hesselbrock and colleagues (Hesselbrock, Segal, & Hesselbrock, 2000) found high rates of co-morbid psychiatric disorders among Alaskan Natives. Thirty-six percent of cases admitted for alcohol treatment met diagnostic criteria for Antisocial Personality Disorder, and 14% reported a lifetime history of major depression. Over 8% of men and almost 18% of women met criteria for Post Traumatic Stress Disorder (PTSD). Twenty-two percent of male respondents indicated the stress was in the form of sexual abuse, while 73% of women experienced trauma associated with sexual abuse (Segal, 2003). These statistics

present a complex clinical picture of Alaska Natives that should be considered when determining appropriate treatment programs.

Gaps in Information

National reviews often cite information gaps, in regards to knowledge of the characteristics of those seeking care, need, client overlap among agencies, and outcomes (CWLA, 2001; DHHS, 1999a). Within the state of Alaska, there has been no systematic collection of data to identify the need for substance abuse treatment for parents involved with OCS, or information concerning the demographics (ethnicity, geographic location, gender, etc.) of parents with children in OCS who require substance abuse treatment. Finally, for parents who have entered treatment, there is no data collected by the state which tracks progress of treatment, nor their outcomes.

Since 1978, OCS has had a series of management information system (MIS) programs, but each has presented its own set of challenges and has not provided data required for in-depth analysis of families. In their current system OCS provides statistics on types of families (two-parent, single-parent, etc.) and the ethnicity of the children who are subject of a report of harm, but not the ethnicity of the parent. In order to provide culturally relevant treatment, knowing the mandated parent's ethnicity may be critical to success. It would also be helpful to know the gender of mandated parents since the best treatment programs for women may differ for best treatment programs for men. OCS is now in the process of converting to a system called ORCA (Online Resources for the Children of Alaska) which is programmed to capture substance abuse issues in child welfare cases. Full implementation with reports is not scheduled to be complete until Fall of 2005.

OCS statistics reveal that Alaska Native families are over-represented within the OCS caseload. Alaska Natives comprise 16.8% of the population of AK (State of Alaska, 2004), yet in the September of 2004 OCS figures on reports of harm, Alaska Native children accounted for 61% of the reports (Office of Children's Services, 2004).

Another potential source for data concerning substance abuse treatment outcomes is the Alaska Division of Behavioral Health (DBH). However, DBH collects only limited demographic information related to clients and statistical information regarding clients treated, e.g., number of clients admitted, treated, and discharged. Recognizing the inability to collect meaningful data, the division is currently working in collaboration with other states to develop a new information management system referred to as the Alaska Automated Integration Management System (AKAIMS) (Alaska Division of Legislative Audit, 2003).

AKAIMS is a web-based system, which will be accessed by providers through the Internet and is scheduled for full implementation in FY 2005. Providers will report outcome data and client characteristics into this system so that in the future statewide treatment data should be available. A few providers are now reporting data into the system, but no reports are available yet. Currently, DBH has only written provider reports and does not produce compiled provider reports. DBH envisions the new system providing the capability to assess and improve treatment services while complying with state and federal requirements (Alaska Division of Legislative Audit, 2003). However, at this point there are no linkages between the ORCA system and AKAIMS, although data sharing is planned for sometime in the future (Personal communication, B. Hogan, Department of Behavioral Health, September 28, 2004).

Gaps in Treatment

To examine the gaps in treatment needs, the Alaska Division of Alcoholism and Drug Abuse (now the Division of Behavioral Health) commissioned a study in 2001 of substance abuse treatment programs in seven Alaskan urban and rural communities. The study, entitled *Waiting in Line for Treatment*, found that on any given day in the communities surveyed an average of 199 people, statewide, were waiting in line for services. Of the people awaiting treatment, 55% were male and 45% female. Women were found to linger longer on the waiting list (46 days) as compared to men (40 days). Most of these people were, of course, in Anchorage, but the proportion of waiters in Anchorage, compared to other regions in the state, decreased through the study period (October 15 through December 1, 2001), while the proportion in the Southeast region increased (C&S Management, 2001).

The study also determined that 74% of the women on the waiting lists had children. This group had the longest wait for treatment services (107 day average). Almost half of all women had children in out-of-home placement (foster care or other living situations) and were waiting for specific programs that treat women, or women with children (C&S Management, 2001). Long waits for treatment make it difficult to meet the timeline required by the Adoption and Safe Families Act of 1997 (ASFA) for permanency decisions to be made within 12 months of the start of a case.

A 2003 legislative audit criticized the DBH for a lack of a comprehensive system for delivering prevention and treatment services:

ADA [now Behavioral Health] has operated without a comprehensive program for substance abuse treatment services. The division has not identified the state's overall need for prevention and treatment services by substance, region, or population nor has it identified the State's priority for addressing its needs. Further, ADA's grant funding methodology may not efficiently utilize limited resources. Without a statewide plan to guide the division's program development and funding allocation decisions, ADA may not maximized (sic) the effectiveness of substance abuse treatment and prevention services in Alaska (Alaska Division of Legislative Audit, 2003, p. 20).

General Knowledge of Best Practices in Alaska

What is known about best practices for treatment of substance abuse specific to child welfare within Alaska? In researching this question, there is little information concerning best practices for treatment of substance abuse in general within Alaska, or best practices for parents mandated into treatment by OCS. Few studies concerning practice in Alaska cited specific treatment programs or facilities noted for their effectiveness or successful strategies. Some studies provide recommendations for inclusion of program components. All of these will be explored below.

Elements of Healing Practices for Alaska Natives

A study entitled *Healing Practices* by the Alaska Federation of Natives (AFN) and Cook Inlet Tribal Council (CITC) examined the best practices in substance abuse treatment for Alaska Natives (Segal, 2003). The purpose of the research, funded by the Center for Substance Abuse Treatment (CSAT), was to identify, evaluate, and recommend cultural-based programs that can be utilized in serving Alaska Natives. It explains that Western substance abuse models are not helpful for Alaska Natives as they are based on a Eurocentric worldview that is not relevant to Alaska's indigenous people. The difference lies in the linear thinking of cause and effect of the Western world which conflicts with a circular perspective of Alaska Natives.

This study discussed the theory of historical trauma, a concept that is important to consider when developing and selecting culturally relevant treatment programs for Alaska Natives (Red Horse et al., 2000; Halverson, Puig, & Byers, 2002). Maria Yellow Horse Brave Heart (2003) and others developed the theory of historical trauma through years of clinical practice and observations. Historical trauma is defined as a “cumulative emotional and psychological wounding, over lifespan and across generations, emanating from massive group trauma experiences” occurring in previous generations (Brave Heart, 2003, p. 7). The historical trauma response is continuous and collective, affecting most if not all members of a community, and consists of a constellation of features in reaction to this trauma, which may include depression, self-destructive behavior, suicidal thoughts and gestures, anxiety, low self-esteem, anger, difficulty recognizing and expressing emotions, and substance abuse and self-medicating to avoid painful feelings (Brave Heart, 2003; Red Horse et al., 2000).

In addition to the traditional approach of an academic review of research and applied literature that could contribute to form a best practice strategy, the *Healing Practices* study used focus groups comprised of Alaska Natives to help determine culturally relevant approaches to treatment. A Governance Council, comprised of only Alaska Natives, oversaw the study and combined the findings from the academic review with their traditional knowledge to produce a “best practice policy/healing practice” for Alaska Natives (Segal, 2003, p. 4).

The focus groups included 42 Alaska Natives who had undergone substance abuse treatment. They were asked if the programs they attended were responsive to the needs of Alaska Natives, what would be helpful to them for healing from alcoholism or drug dependence, and what they would change about the current treatment system. Overarching themes derived from the focus groups are listed below.

- Substance abuse treatment staff members need to understand Native issues and ways.
- Substance abuse programs that treat Alaska Natives need Alaska Natives on their staff.
- The treatment staff members need to have lived in a village or at least visited a village.
- Alaska Natives need culturally based programs which include the wisdom of elders, native foods, spirituality, and Alaska Native values, which incorporate the benefits of living a subsistence lifestyle while in treatment, and which emphasize relationships with other Natives, their family and their children in the treatment process.
- Alaska Natives need improved access to treatment programs, which includes ability to pay, knowledge of available programs, and more programs in rural areas.

The report discussed differences in conceptualizing and treating substance issues in Native versus Eurocentric contexts, resulting in recommendations for practice with Native families. Treatment programs should include traditional Native practices (Segal, 2003) in order to alleviate culture loss or help resolve cultural dilemmas and conflicts that may contribute directly and indirectly to substance abuse. Values from the dominant white society may conflict with those of Alaska natives in terms of views of nature, spirituality, conceptualization of family, foods, and so on. Addressing these differences by incorporating native culture can itself provide healing while also aiding provision of other services, as in the highly regarded Wellbriety movement (White Bison, 2004).

The second recommendation was that treatment should be community-based. Substance abusing parents of children who have been abused or neglected come to the attention of the community, and treatment is imposed as an expectation of the community, not simply because the person recognizes that they have

an alcohol or drug problem. Native communities have their own standards by which they define problems associated with alcohol or drug abuse. The development of community-based “healing programs” would allow Alaska Natives self-determining powers. It would use village-based services, such as the current village-based counselors. Locally administered programs have used prevention, intervention, and aftercare treatment programs which have shown promise in reducing the incidence of substance abuse related problems, and have supported healing and recovery (Segal, 2003).

The Center for Alcohol and Addiction Studies at the University of Alaska Anchorage (UAA) conducted a study of the treatment needs of Alaska Native women (Segal, Foote, & Trojan, 1997). It was largely funded by CSAT, and took place at the Women and Children’s Residential Program in Fairbanks, involving both Native and non-native women. It was hoped the research would achieve a better understanding of what individuals bring to the treatment process, and how such individual factors are related to treatment completion and outcome.

The study found that “treatment outcome was best predicted by the extent of one’s drinking problem, social and family support, and cultural identity” (Segal, Foote, & Trojan, 1997, p. 16). The researchers concluded that improved admission screening procedures to identify high and low risk cases may reduce the probability of women terminating treatment during the tentative first weeks. Suggestions were given to improve treatment for women who have experienced physical and sexual abuse, including the education of both the providers and the clients in treatment.

Together, these studies underscore the need for culturally-competent treatment practice. They also provide an example of how Western science can be combined with Native knowledge, with cultural competence, an understanding of the history of Native trauma and substance abuse, and community support serving as a foundation for the application of evidence-based treatment programs. Addressing culture aids in the application of healing practices and in the retention of clients in treatment. This mix is being applied in different ways in Alaska, as the next section will illustrate.

Measuring Effectiveness in Alaska

While national programs that combine the efforts of substance abuse and child welfare agencies were the focus of the first half of this report, no program evaluations of such collaborations could be identified in Alaska. A variety of treatment programs have reported positive outcomes, some quantitative and some anecdotal, and deserve mention here. These programs could be utilized as treatment models for a future child welfare and AOD collaboration.

Chemical Misuse Treatment and Recovery Services (CMTRS) Program

The purpose of the Chemical Misuse Treatment and Recovery Services (CMTRS) Program was to investigate methods of strengthening substance abuse treatment services among indigenous people. Funding for the project was provided by the Center for Substance Abuse Prevention (CSAP) and the Center for Substance Abuse Treatment (CSAT), beginning in 1993. The CMTRS Program initially targeted Yup’ik and Cup’ik villages in the Yukon-Kuskokwim Delta area. The goal was for local village members, trained in substance abuse, to provide village-based interventions and treatment services, with some central oversight and services in Bethel, making maximum use of local Alaska Native cultural traditions and language (Institute for Circumpolar Health Studies, 2000).

The study compared the CMTRS to Village Alcohol Education Counselors (VAEC) operating in the same region. Basic differences between the two programs are seen in Table 2.

Table 2: Comparison of CMTRS and VAEC Communities

Area/issue	CMTR	VAEC
Clients	Individuals and family units	Mostly individuals
Services	A broad array of behavioral health services	Services limited to prevention, aftercare, and some outpatient counseling
Provider selection	Selected by Policy Steering Committees	Selected by Regional Substance Abuse System (RSAS) central office in consultation with traditional government
Coverage	2 counselors per village	1 counselor for 2-3 villages
Hours of operation per village	80 hours /wk	15 hours/wk
Treatment modalities	Western substance abuse treatment plus traditional treatment modalities	Focuses on Western prevention and Alcoholics Anonymous services
Referrals	Referrals from many referral agencies located in Bethel (mental health, family and youth services, courts, RSAS, and self referrals)	Most referrals from RSAS and court system and self referrals
Clinical supervision	1 clinical supervisor for 6 counselors	1 clinical supervisor for 9-18 counselors
Governance	Policy Steering Committees	Central mental health, alcohol, and drug advisory board, and Yukon-Kuskokwim Health Corporation governing board
Facility costs	Included CMTRS budgets	Donated by village government (variable by village)

(Institute for Circumpolar Health Studies, 2000, p.18, used with permission)

The main differences between the treatment provided by the CMTRS and the VAEC is that the CMTRS provided a more holistic treatment approach to include the family, community, traditional Western treatments, and culturally relevant treatments. The VAEC provided traditional Western treatment modalities, including the 12-step program, but no culturally relevant treatments (Institute for Circumpolar Health Studies, 2000).

Anecdotal information regarding the effects of the CMTRS program indicated decreased alcohol-related injuries, as reported by community health aides, and fewer people in jail during the holidays, which the public safety officers noted was a common time for arrests to increase (Capers, 2003; ICHS, 2000). Public safety databases documented the decline in alcohol-related arrests, which appeared to have been related to an increase in community opposition to alcohol and an increase in enforcement of liquor laws (ICHS, 2000). This is consistent with an anecdotal report that the villagers increasingly viewed public drunkenness not as an accepted amusement but as a serious issue (Capers, 2003).

Like many evaluations, the CMTRS study has some weaknesses. There was a suggestion that a decrease in the rate of placement in child protective services in two of the three CMTRS villages might be related to the new treatment centers established for this study, rather than the program services. The CMTRS demonstrated a significantly higher proportion of female clients (31.2%) than the comparison group (14.8%). This was thought to be due to the requirement for CMTRS to have one female counselor on the two counselor staff. Further analysis demonstrated that historically the CMTRS communities worked to attract and retain female clients (Institute for Circumpolar Health Studies, 2000). It did not measure outcomes on a longitudinal basis, making it impossible to assess the maintenance of short-term effects. Additionally, the community data was derived from aggregate data and not specifically connected to the clients who received treatment from the CMTRS or VAEC during the study timeframe (Institute for Circumpolar Health Studies, 2000). Despite these weaknesses, some evidence of effectiveness was found. The authors concluded that:

- Solutions generated at the local level could have a greater impact on community substance abuse programs than those generated outside the community;
- Solutions that involved community involvement were more effective than those based on individual treatment alone in addressing substance abuse problems;
- Traditional treatment modalities provided an effective alternative for treating substance abuse problems among Yup'ik/Cup'ik people;
- The behavioral health model appeared to be appropriate for small rural Alaska communities (Institute for Circumpolar Health Studies, 2000).

Early qualitative findings of success of the CMTRS program helped the Yukon-Kuskokwim Health Corporation obtain funding to expand the program in 1998, creating the Village Sobriety Project. Now called the Village Services Program, it serves over 50 villages in the Y-K Delta, and through working with state officers to correlate traditional practices utilized in the program with Medicaid service categories, the program has been self-sustaining since 2000 (Capers, 2003).

Hudson Lake Recovery Camp

An example of a culturally relevant residential treatment program is the Hudson Lake Project sponsored by the Copper River Native Association (CRNA). The camp opened in 2000, funded by the Ahtna Corporation (the local native corporation), CRNA, and a grant from CSAT. It was designed to address gaps in existing treatment services for alcohol and drug abuse and supplement the outpatient programs in the Copper River Basin area of Alaska by providing local, culturally-relevant residential treatment in a traditional setting, relying on traditional activities (Burgess, Fair, & Saylor, 2002; Southcentral Foundation & Burgess, 2002). Extensive input from community members, tribal elders, behavioral health staff, other professional consultants, and existing materials produced by American Indian treatment programs in the lower 48 was relied upon in developing the treatment camp (Burgess et al., 2002).

The program treats residents in their home region, and includes families as soon as the detoxification phase (the first 10 days at the camp, when a regimen of vitamins and herbs is taken to begin cleaning out the body) is complete. The residents practice the traditional life skills of their Native cultures. The program uses established treatment practices, including cognitive-behavioral methods, combined with culturally appropriate treatment and rehabilitation models. Similar to other rural treatment camps, Hudson Lake emphasizes reconnection with traditional culture:

Finding...balance through traditional cultural activities is believed to be critical in developing self esteem and a sense of purpose that can replace feelings of hopeless and loss. Therefore, cultural activities such as building one's own home, trapping, hunting, dog mushing, beading, traditional singing and drumming, tanning skins, snowshoeing, [and] tending a fish wheel to catch salmon and then smoking the salmon, are used as part of the therapeutic process in this intervention (Burgess et al., 2002, p. 10).

Although centrally located in the Copper River Basin, the camp is situated at some distance from the local villages, at the end of an eight-mile trail. This remoteness helps limit distractions and maximize focus, reflection, and healing. It has also, however, contributed to difficulties with staff recruitment and retention and data collection (Burgess et al., 2002).

Documentation of the development, implementation, and initial outcomes of Hudson Lake was produced by the Institute for Circumpolar Health Studies (Burgess et al., 2002). Initial positive findings were reported. The services provided by Hudson Lake appear to be welcomed and deemed necessary by local residents. The large majority of those expressing an opinion were satisfied with the treatment services provided by Hudson Lake. By the time of the report, 73 clients had been admitted to the program, with 48 graduates, including all 25 clients in the first two years. The authors reported that 6 of the 48 graduates had relapsed, which was defined as being readmitted to the program.

Deilee Hit Safe Harbor House

The Southeast Alaska Regional Health Consortium (SEARHC) provides creative programs that draw on cultural strengths of Alaska Natives. One such program is the Deilee Hit Safe Harbor House. It is an eight-week intensive residential treatment program for women with alcohol and/or drug abuse or dependency problems. The program focuses on pregnant women or women with children who are unable to enter other forms of treatment due to child care responsibilities. Treatment consists of a holistic model, combining physical psychological, social, and spiritual elements, and addressing other major problems, such as depression, low self-esteem, victimization issues, and family problems. Additional programming is provided that includes developing strong parenting skills, and addressing specific women's issues and support for completing or continuing their education (US Department of Justice, 2000).

The program addresses cultural needs by including educational materials and traditional interpersonal techniques such as talking circles, ceremonial protocols, and Native art forms are used. Women with children reside in a separate non-smoking home that includes childcare, separate bedrooms and playrooms for the children and 24-hour staff coverage (US Department of Justice, 2000).

Cook Inlet Tribal Council's Substance Abuse Programs

The Cook Inlet Tribal Council (CITC) in Anchorage provides a continuum of care for substance abuse clients. This System of Care model of service delivery uses case management to expand services beyond traditional substance abuse treatment. It provides access to mental health, vocational, employment, housing and family and social services (Cook Inlet Tribal Council, 2003).

Mobile Treatment Unit

Approximately two years ago CITC began an innovative program called the Mobile Treatment Unit (MTU). MTU is a combined substance abuse and child welfare initiative which includes a home-based model of services. Staff members have mental health, child welfare, and child development expertise.

Services target adult women with children who are at risk of being or are currently under OCS supervision (J. Garrow, personal communication, June 1, 2004).

Other Programs in the CITC System of Care

CITC developed a second unit under a different granting source, but mirroring the services available in the MTU. This program is called the Clare Swan Center, and it also provides both office-based and home-based services. A third program, the Family Unit, is much like the first two, except that significant others are included in treatment as sobriety supports. This unit requires the support person to commit to the program as well as the participant, and may be a substance abuser or non-user.

The continuum of care for each program includes Intensive Outpatient (IOP) treatment, requiring an average of 11 hours of therapy a week, including home therapy. The participant is then transferred to Outpatient treatment, which consists of one to eight hours of therapy per week, and no home-based services. The same mental health clinicians work in all three units, and care coordinators are assigned to each case.

Clinicians maintain close contact with OCS to keep them apprised of the participant's progress. The American Society for Addiction Medicine's (ASAM) criteria are used to provide a thorough assessment of client needs. Additional support is given to address relapse prevention, parenting, and domestic violence. A client may enter the continuum at any point and move up or down in treatment level as required to address their needs (J. Garrow, personal communication, June 1, 2004).

Dena A Coy

The Southcentral Foundation conducts a program in Anchorage aimed at preventing Fetal Alcohol Effects (FAE). Dena A Coy offers substance abuse and mental health treatment for substance-abusing women. It is designed to allow women to remain in treatment throughout the duration of their pregnancy and ten weeks postpartum. It includes a transitional program to assist graduates on an outpatient basis for up to two years (Southcentral Foundation, 2004).

In the Athabascan language Dena A Coy means "the people's grandchildren." The eligibility requirements allow for inclusion of all women, pregnant or not, with substance abuse problems. Women may be dually diagnosed, and children under the age of three may be considered for admission with their mother (Southcentral Foundation, 2004).

Both residential and outpatient services are available, including aftercare. Traditional Alaska Native cultural activities are provided, such as talking circles. Other treatment services include mental health, life skills, medical wellness, parenting in recovery, and family and children supports. Prenatal care services are provided through the Anchorage Native Primary Care Center. The Infancy and Child Advocacy Project ensures the children of Dena A Coy receive optimal developmental and diagnostic services (Southcentral Foundation, 2004).

Anchorage Family CARE Court

The Anchorage Family Community Assisted Recovery Efforts (CARE) Court was implemented in September of 2002 with the mission to reunify "families by combining intensive judicial supervision and monitoring with a treatment program, working with participants to break the cycle of addiction and building a better life for themselves and their children" (Family CARE Court, 2004).

Participating parents must have a Child in Need of Aid (CINA) designation from the Office of Children's Services, have been identified as having an identified substance abuse problem, be motivated to achieve sobriety and provide a safe home for their child(ren), and be willing to participate in the court program. The program includes assessment, case management, regular visitation with children in out-of-home placement, a weekly support group, and weekly court appearances (Family CARE Court, 2004).

The Family CARE Court Coordinator, Muriel Kronowitz, provided an informal assessment of the program to date. One barrier she identified as directly impacting the court is the inability to access timely, relevant treatment services (mental health and substance abuse) for women and children. As discussed in the national literature, this prevents the court from moving participants quickly into treatment settings where their children can be returned to them. When parents have their children with them, under the supervision of the Family CARE Court (FCC), the state has the opportunity to intervene quickly if necessary. Extra parenting services can be provided as well, so participants have the full opportunity to achieve a successful reunification. Families participate for 12 to 18 months, allowing the court to monitor, supervise, sanction, and reward parents immediately.

The experience of FCC illustrates some of the difficulties in integrating different services systems and evaluating outcomes. According to Kronowitz, child welfare staff members are often unable to provide timely feedback about how parents are progressing in treatment, because of their workload; random drug testing occurs only from Monday through Friday, which is inadequate as clients can quickly figure out when they might be called if they are on a two- or three-day drug testing cycle. The primary drug of choice for participants in the FCC is alcohol, a drug that can evade detection with the current testing system because of how quickly it is processed by the body. It may very well be that some participants have had relapses that the FCC had no knowledge of if the participants did not disclose them. The current contractual relationship OCS has with the drug testing provider needs to be strengthened and money is an issue.

Finally, Kronowitz noted that FCC needs to have better access to comprehensive neuropsychological and cognitive functioning tests for many of the women in order for them to be successful. Frequently, the clients' own mothers drank and/or used substances during pregnancy, or they have suffered some subsequent trauma, mental and/or physical, that may affect their neurocognitive abilities. Without a comprehensive assessment of their capabilities, important details may be overlooked that can lead to treatment failure. Treatment programs as well as the court can be more responsive to them with this knowledge.

The FCC has not completed a formal evaluation, but has recorded some output information, presented in Table 3. Five clients graduated from the 12 month program the first year. All completed their treatment, and their children were returned to four of them. At the time of graduation all had verified sobriety of nine months or more. Two were employed, and one was awaiting entry into the Job Corps. Four experienced relapses, with two being brief. In addition, one woman withdrew from the program to return to the traditional court process, and five women were found to be non-compliant.

Table 3: Family CARE Court: Preliminary information for 2004

No. of Women Participating	11
Ethnicity:	
AK Native	4
Caucasian	4
Hispanic	1
Mixed	2
Average Age	31
Child(ren) placed with mother	8
Time of Sobriety:	
One to three months	3
Three months plus	1
Six months plus	4
One year plus	3

Since the first year, many changes have been made to the program. The most significant changes are the following: 1) extending the time in the program to up to 18 months for all participants, 2) verification of a sober support network during the final months of court before graduation, 3) requiring the client to obtain a job and/or be enrolled in a vocational program or school and 4) helping the client obtain mental health services early in the program. The referral process was also changed. OCS is now the gatekeeper for referrals and presents them to the FCC team as early in the case as possible.

When this court was established, the intention was to accept cases with little history of involvement with OCS and intervene early. Program staff, however, have found that women who have a history of treatment involvement and prior OCS cases appear to be more engaged in the program (M. Kronowitz, personal communication, April 7, 2004).

Alaskan Agency Interviews

The agencies described above do not provide a complete picture of all programs in Alaska that serve populations with substance abuse and child welfare problems. Instead, they represent the programs for which we were able to obtain some external reports of outcomes. To obtain a more complete picture of what services may be available in the state, a survey to identify successes of alcohol and other drug (AOD) treatment programs was conducted by the Child Welfare Evaluation Program at the University of Alaska Anchorage (UAA) with agencies which serve similar populations but have not been externally evaluated. The purpose of this survey was to obtain information about treatment outcomes of AOD programs in both urban and rural areas within the four regions of the state to begin to address the lack of substantive information from professional journals or government resources.

Twelve agency programs were surveyed, representing the four Office of Children's Services regions of the state (Southeastern, Southcentral, Anchorage, and Northern). Four programs provided residential services to women only. Four programs from the Anchorage Region and Northern Region were

surveyed, and two each from the Southcentral and Southeast Regions. All regions, with the exception of Anchorage, had at least one rural program included. There are no rural areas within the Anchorage Region.

All surveys were performed by phone. Three open-ended questions were used to elicit information from respondents. They were:

- What is success in your program?
- How do you measure it?
- What do you think contributes to this success?

Responses to these questions are listed and summarized below, as well as a state-wide summary. This survey was not exhaustive and was not intended to reach all substance abuse treatment programs which might serve parents and children, rather to represent the regions of the state.

Responses to the Questions

Question 1: What is success in your program?

The client successes could often be described as a continuum from seeking assistance to program attendance to program completion and aftercare. In addition, improved functioning of the client in life domains or reduction of substance abuse was considered success, even without abstinence or program completion. Total abstinence was not endorsed as the sole outcome by any of the participants.

It was recognized by some programs that relapse occurs, and one program thought success was achieved when clients develop intervention strategies in advance of relapse. Representatives from programs with segregated treatment for women stated that this sole focus on women (and their children) contributed to success for their clients. One program, which treats pregnant women, has a cohort group that goes from pregnancy to several years following birth in an effort to provide a stable support group. Another program emphasized the need to reintegrate clients into the community and provide stability in housing and job skills. Several programs recognized the need for treating the client holistically and including the family and community in the client's recovery

Question 2: How do you measure it?

Many of the interviewees reported data collection efforts that included data obtained from interviews and/or follow-up surveys. Several of the programs identified their data as the criteria required by the State of Alaska, while others obtained information from sources within the community. Several programs mentioned immediate feedback from clients in the program, or satisfaction surveys during program attendance as methods to measure success. One program has a formal grievance program for client complaints. The ability of programs to be responsive to clients' needs and concerns was seen as contributing to the success of the program.

Ten of the programs had regular intervals for surveying clients. Programs varied on how long after program completion they surveyed their clients. The remaining two programs obtained client feedback, but did not specifically state they had a formalized structure for data collection. The rural areas noted that some feedback is anecdotal from the family or others in the community who provided unsolicited reports about the client's welfare. Several programs reported the use of data to make changes in management and service provision.

Question 3: What do you think contributes to this success?

Many of the contributing factors to program success were attributed to program characteristics, such as

approach to client treatment, treatment modality, behavioral theory used in treatment, and services provided. Two programs noted the use of evidence-based practices in curricula. Several programs noted the need to provide the client with resources required for them to stay safe and sober, such as a job or housing, or a support group to encourage positive behaviors. Emphasis was placed on contributing factors other than remaining sober, such as healthy relationships and life skills. One program stated it was important to recognize incremental recovery.

The next major theme involved the staff in terms of qualifications, attitudes, collaboration, and skills. All persons interviewed were positive in discussing what they perceived made their program successful. A program representative in one urban area noted that having bilingual staff was important to success. Program resources played a smaller role, but one program with ancillary supportive services noted an advantage in engaging clients in areas other than AOD treatment alone.

Discussion of Agency Surveys

The scope of the survey was limited in size and unbalanced in the mix of rural versus urban programs. Additionally, each agency only discussed programs that included adults with children involved in child welfare, although many of these agencies have programs that are much broader in scope. Research from several sources (Beckman & Amaro, 1986, Stevens et al, 1994; Kumpfer, 1998, as cited in DHHS, 1999a) indicates that comprehensive services, (including health care, child care, child development, housing assistance, mental health) to families of drug and alcohol abusers enhances their retention and longevity in treatment as well as leading to more positive family functioning.

Descriptive data for either the agency or treatment program were not obtained, although they were sometimes offered by the respondent. Client demographics for programs was not requested, thus a comparison of programs is not possible. One agency gave their responses based on more than one program within the agency that treated adults with children involved in child welfare.

Few programs could readily cite program success based on the quantitative data they collect. One program has a data department, but did not provide any data to the researcher. Another program that provided data stated they produce monthly progress reports. However, when the researchers were provided with graphs, they could not be used to draw any conclusions about the program's outcomes other than completion of treatment. The new data collection program AKAIMS currently under development by the State of Alaska will allow treatment programs to collect data specific to their program in addition to the state-required data. It is hoped that this system will allow for reporting, comparison, and evaluation of outcomes.

All of the agencies surveyed focused on issues concerning substance abuse, and while most did recognize the connection between substance abuse and child welfare, few address both issues. Only 3 of the 12 agencies (two in Anchorage, one in Unalaska) report that they work with OCS in regard to child welfare issues including custody and reunification. Three agencies (two in Anchorage, one in Fairbanks) provide services to children through direct delivery or through contracting out those services. Two more agencies (one in Anchorage, one in Dillingham) either "involve" children or "involve issues with child welfare." Clearly there does not appear to be a well-integrated effort within the state to connect child welfare issues and interventions with substance abuse issues and interventions, particularly among women.

The agencies are similar in that they seem to have identified similar features that predict success in

client service provision. Agencies in all of the regions believed that being culturally competent and connected to the community, providing unconditional engagement with clients, and interacting with other agencies are important for success. In two of the regions, having a professional and satisfied staff was seen as important for success.

The purpose of this survey was to obtain some information on program success based on measurable outcomes that could also serve as a foundation or baseline for further research into program success. What is apparent is that there is a need for more focus on outcomes and more investigation into what truly works to help Alaskan families struggling with substance abuse issues.

Conclusions and Recommendations

There are several questions to be addressed if the success of treatment programs for parents is to be evaluated. These include:

1. What type of treatment programs are best suited to fit the needs of the parents who require treatment services?
2. How many parents who are mandated into treatment successfully complete the treatment, or have positive, life-altering outcomes?
3. How many children had subsequent reports of harm following their parent's treatment for substance abuse?
4. How many families were reunited after substance abuse treatment was completed?
5. Are treatment programs culturally relevant or gender specific, and should they be?

This list of questions is not exhaustive, but rather demonstrates the need for relevant data collection in order to guide decision makers when determining which treatment programs work best for substance abusing parents involved with OCS.

In exploring what is being done to develop service delivery models that address the issue of joint substance abuse and child maltreatment problems, a major theme that appears and reappears is the absolute necessity of building interagency collaborative relationships. Traditionally, child welfare agencies report difficulty obtaining timely substance abuse treatment for clients, particularly for women with children. They also report that other programs addressing parental needs are in particular shortage, including programs dealing with child care, parenting stress, economic issues, educational issues, reproductive health care services, psychiatric services, and domestic violence services. In order to better support children and families with multiple challenges, collaborations must be built to include not only substance abuse and child welfare agencies but also the courts, mental health agencies, agencies that deal with family violence, the juvenile justice system, child development agencies, schools, and agencies or even individuals with whom families come in contact or from whom families might receive needed services (Walter R. McDonald & Associates, 2001; Young & Gardner, 2000). The primary advantages of building these relationships are that they (1) enable service providers to meet a broader range of family needs, (2) allow agencies to better coordinate efforts and ensure that they neither overwhelm families with requirements nor impose conflicting demands, and (3) enable more efficient use of limited resources and prevent parallel program development. Thus, there is a need to develop a comprehensive approach to address substance abuse among parents and its harmful effects on children.

The research clearly indicates the need for early intervention services for children of parents with substance abuse and other related problems. The needs of children should be addressed in substance abuse treatment plans, to include issues of primary health care, mental health, and social services.

Traditionally, substance abuse prevention is not viewed as a function of CPS; this must change. As part of integrating substance abuse treatment into welfare programming, extensive joint parent-child activities need be included to improve parent's ability to avoid emotional or physical abuse and neglect. A therapeutic plan should be developed which includes family skills training and family therapy. There are several programs that specifically address prevention components as part of services for children of parents with substance abuse problems. The research also strongly recommends that agency workers be trained to look for and identify both substance abuse and child welfare problems in families, as neither child welfare nor substance abuse pre-service training typically includes information on the other field. It suggests that less attention has been devoted to assisting substance abuse treatment staff to recognize child safety issues, including how to recognize abuse and neglect, or how to intervene in family issues. Assessment training conducted jointly with child welfare as well as alcohol and drug treatment staff is one way to address this problem.

This report has focused on interventions that combine the services of substance abuse and child welfare agencies in serving families affected by AOD in which children have been or are at-risk of being maltreated. Efforts in this area could be greatly expanded by the development of collaborations applying evidence-based treatment programs to local families. Services in Native communities, for example, should incorporate cultural understanding and competence. This review has highlighted several Native programs addressing substance abuse in families. It may also be possible to develop a foundation of cultural competence upon which a treatment program is constructed, perhaps one of SAMHSA's Model Programs (modelprograms.samhsa.gov). SAMHSA also supports an Addiction Technology Transfer Center to disseminate current science, research, training materials, and other information (www.nattc.org). It might also be wise to incorporate some of the principles and practices of model programs in family preservation and support. Many such programs have a strong substance abuse prevention or treatment component.

This review of existing Alaska treatment programs discovered little in the way of outcomes. Further examination of these programs is needed, with particular regard to the:

- appropriate level of treatment services
- effectiveness of assessment
- effective discharge planning, including additional referrals and resources to sustain the recovery process
- demonstrated ability to connect clients with the appropriate level of "continuing care" (formerly known as "aftercare")
- ability to maintain clients within a fluid continuum of care with appropriate focus to maintain recovery
- willingness and ability of staff and caseworkers to collaborate regarding reunification efforts
- assurance that demand for treatment meets the availability of services in communities, particularly with regard to meeting the treatment needs of women with children

The CITC's Clare Swan Center would warrant further study, particularly since it utilizes the American Society for Addiction Medicine (ASAM) criteria to determine both severity of the addiction and appropriate level of care. This program may be a model to shape future recommendations; the State requires that agencies funded for substance abuse services utilize the ASAM criteria. However, there is wide variation among the treatment providers in how they interpret and utilize the ASAM criteria. Many providers may not effectively understand or utilize the criteria.

As the agency interviews demonstrated, each program defines success differently, but all share similar

goals of reducing substance abuse in families as well as ensuring safe and nurturing environments in which children can thrive. Without specifying, targeting, and evaluating outcomes, statewide evaluation is impossible. Without knowing what results clients have achieved, programs lose valuable insight that may improve practice. Learning from program successes and failures leads to improved practice across organizations and across disciplines. Here in Alaska, this means increased collaboration between the Division of Behavioral Health and the Office of Children's Services. Perhaps the new AKAIMS system will provide a platform for consistency of reporting across programs that will facilitate a better synthesis of program information in the substance abuse area. Without this, valuable learning across programs will be lost.

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Appendix A: Matrix of progress in linkages among alcohol and drug and child welfare agencies and the dependency court system

(Used with permission, National Center on Substance Abuse and Child Welfare, 2003b)

MATRIX OF PROGRESS IN LINKAGES AMONG ALCOHOL AND DRUG AND CHILD WELFARE SERVICES AND THE DEPENDENCY COURT SYSTEM			
May 17, 2003**	Fundamentals for Improved Practice	Good practice	Best practice*
<p>Underlying Values and Principles of Collaborative Relationships</p>	<p>Values clarification efforts have begun among the three systems</p> <p>There is an understanding and articulation of the value of family strengths and how family systems, issues of culture and gender are related to addiction, recovery, relapse and its effect on families</p> <p>Discussions have begun concerning the priority/political will to address the overlapping AOD/CWS population</p> <p>Different time limits and developmental needs of children have been identified as critical issues</p>	<p>A formal joint statement of principles has been negotiated and drafted among the three systems covering responses to CWS children and parents with substance abuse problems</p> <p>Cross-system discussions and problem solving among policy makers, administrators and practitioners are instituted</p>	<p>Formal values clarification efforts have included all staff of the three systems</p> <p>The systems have agreed upon individual and joint goals to serve the whole family as their primary client</p>
<p>Daily Practice: Client Screening and Assessment</p>	<p>The three systems have a joint policy on decision-making regarding screening and assessment and impact of results on removal/placement decisions</p> <p>There is a jointly developed and implemented risk assessment protocol that includes a formal review of parents= and children's AOD needs and is recorded for all clients</p> <p>Issues of culture and gender are included and appropriately addressed in the assessment process</p>	<p>Roles for screening and assessment have been clarified; AOD workers have been out-stationed at CWS offices and dependency courts for screening and assessment or contracted staff have been assigned screening and assessment roles for CWS parents.</p> <p>Culture and gender appropriate joint case assessments and plans have been developed with CWS parents with substance abuse problems</p>	<p>Screening and assessment roles have been negotiated with clarity among all three systems about which system will perform each, using tools that have been revised and refined based on interagency discussions of how best to detect and follow up on substance abuse problems</p> <p>Jointly developed quality assurance mechanisms have been implemented for interpretation of assessment information</p>

MATRIX OF PROGRESS IN LINKAGES AMONG ALCOHOL AND DRUG AND CHILD WELFARE SERVICES AND THE DEPENDENCY COURT SYSTEM

May 17, 2003**	Fundamentals for Improved Practice	Good practice	Best practice*
<p>Daily Practice: Client Engagement and Retention in Care</p>	<p>Systems have begun “drop-off mapping” of the points at which parents are not responding to referrals and not complying with treatment requirements</p> <p>Systems have agreed on procedures for cultural and gender specific approaches to outreach for parents who miss appointments</p> <p>The issue of relapse has been identified as a major area needing clarification between the two agencies and the courts, and discussions are under way to negotiate a consensus on shared outcomes that reflects both child safety and recovery goals</p> <p>Dependency courts understand that they have a role in monitoring compliance with court orders for treatment and case plans</p>	<p>Staff have been trained in motivational interviewing and/or other methods of engaging and retaining parents in treatment</p> <p>Programmatic responses have been put in place to improve family participation/completion rates</p> <p>Systems understand and are responding to how AOD issues and treatment requirements of families interplay with CWS and court requirements</p>	<p>Client relapse typically leads to a collaborative intervention to re-engage the parent in treatment and to re-assess child safety</p> <p>Systems are monitoring and responding to how compliance with case plans and requirements is resulting in changed behavior</p> <p>The three systems have agreed upon how aftercare will be monitored and what are the desired long-term outcomes of treatment as they affects children and families</p> <p>Efficient case management and outcomes monitoring tools that enable tracking progress of individual clients as well as the effectiveness of the whole system are in place</p>
<p>Daily Practice: Services to Children of Substance Abusers</p>	<p>Systems are taking a developmental perspective to addressing needs of children of substance abusers in their own system</p> <p>Each system has a focus on child safety as well as family recovery</p> <p>Each system is ensuring that children and youth are being assessed for the effects of parental substance use on children as well as youth’s own AOD use</p> <p>Issues of culture and gender are incorporated in service delivery and programs for all children</p>	<p>Each system is ensuring that children and families are linked to specific programming for family treatment and children of substance abusers prevention and intervention services</p> <p>Each system understands and implements its role in ensuring child safety</p> <p>Independent Living Programs include AOD prevention and intervention programs for youth</p>	<p>All children involved with CWS receive developmentally appropriate interventions to address their status as a child of a substance abuser</p>

MATRIX OF PROGRESS IN LINKAGES AMONG ALCOHOL AND DRUG AND CHILD WELFARE SERVICES AND THE DEPENDENCY COURT SYSTEM

May 17, 2003**	Fundamentals for Improved Practice	Good practice	Best practice*
<p>Joint Accountability and Shared Outcomes</p>	<p>Each system has their own outcome measures with beginning recognition of the overlapping issues in cross-system outcomes</p> <p>Some shared outcomes have been agreed upon but each systems feel primarily accountable for their own measures of success</p>	<p>Systems use outcome criteria in their contracts with community-based providers (who serve CWS-AOD parents) to measure their effectiveness in achieving shared outcomes</p>	<p>The child welfare agency has accepted shared accountability for recovery outcomes for its clients and the treatment agency has accepted shared accountability for child safety for the children of its clients and the court has accepted responsibility for monitoring the outcomes for children and families in the court system</p> <p>All three systems have accountability for safety, permanency and well-being outcomes for children and families</p> <p>Systems use summaries of outcome data from across the three systems to inform policy leaders and community on progress against consensus benchmarks</p>

MATRIX OF PROGRESS IN LINKAGES AMONG ALCOHOL AND DRUG AND CHILD WELFARE SERVICES AND THE DEPENDENCY COURT SYSTEM

May 17, 2003**	Fundamentals for Improved Practice	Good practice	Best practice*
<p>Information Sharing and Data Systems</p>	<p>The three systems have documented the gaps in their current client information systems and are addressing them</p> <p>AOD assessment at intake captures data about child needs among child welfare families</p> <p>CWS assessment at intake captures data about AOD issues</p> <p>Data on the overlap between child welfare families and the caseloads of other systems has begun to be available to AOD, CWS and court systems</p> <p>An interagency process has identified the confidentiality provisions that affect AOD-CWS and court connections and has devised means of sharing information while observing these regulations</p>	<p>The three systems have agreed upon information systems that track parents= referral, prior episodes in each system, progress in treatment, and family outcomes for those parents whom the agencies can regularly identify as shared clients</p> <p>Data on the overlap between child welfare families and the caseloads of other systems is consistently available to AOD, CWS and court systems</p> <p>Interagency communication protocols have been developed and are being utilized for information sharing between the three systems</p>	<p>The systems have developed and are fully utilizing information systems that can be linked to track parents through all three systems and monitor family and treatment outcomes, using data to re-allocate resources toward client and community needs and toward the most effective programs</p> <p>Overlap data is being used to redirect resources</p> <p>The systems are monitoring the outcomes of information sharing</p>
<p>Training and Staff Development</p>	<p>Commitment has been made to staff development in each system to address substance abuse and child welfare issues</p> <p>Training for all stakeholders has begun with regular updates and a set curriculum that devotes adequate time to substance abuse and child welfare issues</p> <p>Training for parents, guardians and foster parents has begun to address substance abuse issues</p>	<p>Training in each system has been institutionalized with regular updates and a set curriculum that devotes adequate time to substance abuse & child welfare issues</p> <p>Multi-disciplinary training has been implemented</p> <p>Training for parents and foster parents addresses substance abuse issues by drawing upon parents' experience and the lessons of services and prevention efforts with children of substance abusers</p>	<p>The three systems have engaged local colleges, universities and law schools to develop pre-service education that addresses the cross-system issues</p> <p>Systems are monitoring the outcomes of the training</p> <p>Training for parents and foster parents is treated as an equal priority to professional training</p>

MATRIX OF PROGRESS IN LINKAGES AMONG ALCOHOL AND DRUG AND CHILD WELFARE SERVICES AND THE DEPENDENCY COURT SYSTEM			
May 17, 2003**	Fundamentals for Improved Practice	Good practice	Best practice*
Budgeting and Program Sustainability	<p>Systems have begun to develop an inventory of all funds available for treatment and children=s services in the state/community</p> <p>Systems have begun to identify the outcomes of innovative practices that merit sustained funding</p>	TANF, Medicaid, and other major funding sources for treatment are used regularly for funding treatment for child welfare parents	A multi-year funding plan has been developed with input from all three systems, which includes negotiated commitments from multiple funding sources, including those beyond the direct control of substance abuse and child welfare agencies
Working with Related Agencies	<p>A partnership with law enforcement is in place to appropriately address the needs of children during any needed police action</p> <p>Recognition by all three systems that each member of a family may have a variety of co-occurring needs</p> <p><u>Core clinical issues</u>—mental health, family violence and trauma</p> <p><u>Concrete support services</u>—income support, employment training, transportation, housing and child care</p> <p><u>Other needed supports</u>—primary health care, HIV/AIDS, education, dental services</p> <p>Staff are aware of how to identify and link families with the other services that are frequently needed by AOD-CWS involved parents and make referrals to those agencies</p> <p>Parent education courses for substance-involved child welfare parents include significant content on alcohol and drug issues</p>	<p>Staff are assessing and addressing children and parents= needs as barriers to family recovery</p> <p>The three systems monitor receipt of services</p> <p>Parent education courses are formally evaluated for their impact on parenting practices</p> <p>The three systems have developed a case management role of mentoring and facilitating engagement in and delivery of services</p> <p>The three systems coordinate with law enforcement and corrections agencies and criminal courts to meet the needs of parents and their children affected by the criminal justice system (e.g., visitation and treatment while parents are incarcerated)</p>	<p>All three systems are evaluating outcomes of services provided to families and are routinely monitoring the effectiveness of services</p> <p>A fully collaborative process exists across systems with the resources needed by parents with substance abuse problems, including screening, assessment, follow-up, and joint advocacy for the added resources needed in each system to adequately serve families who have co-occurring problems affecting their parenting, family stability, and risks to children</p>