

TEXAS PARTNERSHIP FOR FAMILY RECOVERY

INTEGRATING CHILD WELFARE, SUBSTANCE ABUSE, JUDICIAL
AND LEGAL SERVICES TO SUPPORT FAMILIES

A GUIDE

Updated November, 2007

FORWARD

Research and practical experience repeatedly show a high correlation between parental substance use disorders and child maltreatment and that many, if not most, children under the jurisdiction of child welfare agencies and the courts come from families with substance use disorders. National and local data reveals that up to 80% of adults associated with a child welfare case have a substance abuse problem that contributes to the abuse or neglect of the children.¹

While substance use disorders are not the sole determinants of risk to children, many Texas families involved with the child welfare agency have a substance abuse and related mental health problem. This correlation has implications for families, child welfare professionals, substance abuse treatment providers, and judicial actors. Child welfare agency policies should require initial and ongoing screening and assessment to help identify possible substance use disorders. Indeed, best practice demands that all those involved with a CPS family work with the assumption that those disorders are likely to exist (i.e., the practice should be to “rule out” substance use disorders). Once identified, assessment of child safety and risk of child maltreatment within families receiving substance abuse services should occur at intake and on an ongoing basis.

Judicial decisions should be based on information from the child welfare and alcohol and drug treatment systems regarding the extent of parental substance use and related mental health disorders, their impact on the child(ren), and the potential for engaging the parents in treatment and recovery.

Recognizing the need for an integrated system, the Texas Partnership for Family Recovery developed this Guide based on three principles:

- The problems of child maltreatment, substance use and related mental health disorders demand an approach that requires use of evidence based practices of all those who work in systems charged with promoting child safety and family well being;
- Success is possible; and
- Family members are active partners and participants in addressing these urgent problems.

No single agency or court has the authority, capacity or skills to respond to the array of challenges faced by these families, but collectively, well-informed professionals can bring capabilities and skills together to help address the problem. When leaders have a common vision, create joint policies and engage in collaborative front line practices, it creates a positive work environment and the expectation that the professionals involved will coordinate with colleagues from other systems in decisions that affect family stability and recovery.

This Guide is designed to assist communities to collaboratively develop and integrate their local child welfare, substance abuse, legal and judicial systems, i.e., integrated services system, which may include a Family Drug Treatment Court (FDTTC)². Texas Partnership for Family Recovery anticipates that feedback from

¹ *Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Drug Services With Child Welfare*. Nancy K. Young, Ph.D., Sidney L. Gardner, M.P.A. Prepared by Children and Family Futures, Inc. For the Substance Abuse and Mental Health Administration, Center for Substance Abuse Treatment, Technical Assistance Publication Series 27.

² The state has provided legislative and fiscal support for the development of Criminal Drug Courts under HB530 (90th Legislature). HB 530 mandates drug courts in counties with populations over 200,000 if they receive state or federal

stakeholders and end-users will result in a final product that is useful and informative of the process.

Please take the time to share insights and experiences with any member of the Advisory Committee or Core Team (See Appendix O). Your input and experience will inform future additions to and revisions of the Guide and will be immediately helpful to other agencies, counties and jurisdictions across the state. Please email your comments to: judy.brow@dshs.state.tx.us.

The Guide is the product of in-depth Technical Assistance (TA) from the National Center on Substance Abuse & Child Welfare. The Texas Partnership for Family Recovery is an inter-agency initiative. A list of the Executive Committee, Advisory Committee and Core Team members is available at Appendix O.

Electronic Access and Copies of Publication

This publication may be accessed on the Internet at: <http://www.dshs.state.tx.us/sa/txpartnership/>

Hard copies can be ordered by contacting: judy.brow@dshs.state.tx.us

funds for drug courts. It also authorizes county commissioners and municipal governments to establish other types of drug courts including family drug treatment courts.

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EXECUTIVE SUMMARY

The Texas Partnership for Family Recovery is an interagency initiative of the Office of Court Administration (OCA), Department of Family & Protective Services (DFPS), Department of State Health Services (DSHS), TX Court Appointed Special Advocates (CASA) and the Court Improvement Program (CIP). These agencies, working in conjunction with the National Center on Substance Abuse and Child Welfare, established an Advisory Committee composed of representatives from Child Protective Services, substance abuse treatment agencies, the judiciary, guardians and attorneys *ad litem* for children, and attorneys for parents.

The purpose of the Partnership is to provide assistance to communities who wish to find a better way to address the problem of child abuse and neglect due to substance abuse/addiction and related mental health disorders. If we are to improve outcomes for families in the foster care system that are dealing with substance abuse and addiction, comprehensive and integrated services are necessary to address this wide-spread and complex issue.

This Guide has been developed to assist communities in working together to collaboratively develop and integrate three systems: child welfare, substance abuse treatment, and the judiciary.

The Guide describes the initial steps of the Integrated Services Development Process, which involves forming a Core Team and an Advisory Committee, followed by an examination and identification of the community's common values and goals. Next, an Integrated Protocol sets forth the principles, standards, and behaviors of each involved discipline to guide daily practice. The Integrated Protocol first addresses guiding principles for policy makers and management to achieve integrated service delivery, then provides a list of recommended specialized trainings for each discipline. Finally, the protocol describes guiding principles and actions for each of three stages of a case as it progresses through the various systems: 1) Client identification and initial screening; 2) Service delivery; and 3) Case closure.

An evaluation plan has been included to assist with the collection of data and is designed to provide information on impact, outcomes, cost efficiencies and demographic information on families served to ensure that objectives are being achieved. The Guide also provides a detailed explanation of the principles involved in developing a useful marketing and sustainability plan.

Numerous appendices contain valuable information, forms and tools for use throughout the implementation process.

It is our hope that you will find the information provided in this Guide helpful as your community engages in a collaborative effort to provide a comprehensive and integrated approach to the problem of child welfare and substance abuse/ addiction and related mental health disorders.

Texas Partnership for Family Recovery Mission Statement:

To reduce the number of children in out of home placements due to parental substance abuse and related mental health disorders, shorten time in care, and increase the number of children successfully reunited with families by building and sustaining integrated and coordinated substance abuse and mental health services, policies, protocols, and practices.

The Partnership realizes that no single agency has the resources and expertise to respond comprehensively to the needs of the parent/caregiver, the children, or the family as a whole. Therefore, the Partnership promotes working with other agencies. The Partnership promotes systems integration and implementation of evidence based practices that will result in improved outcomes for families who have substance use/abuse and related mental health disorders.

General Information

Child abuse and neglect cases frequently involve parental/caregiver substance use/abuse and related mental health disorders. According to Greenfield, nearly 4 in 10 child victimizers reported that they had been drinking at the time of the crime.³ And among drinkers, about half reported that they had been drinking for 6 hours or more preceding the offense.⁴ A 1999 study by the National Center on Addiction and Substance Abuse found that children of substance-abusing parents were almost three times more likely to be abused and more than four times more likely to be neglected than children of parents who are not substance abusers.⁵ Both nationally, and locally, up to 80% of the adults associated with a child welfare case have substance abuse problems that contributed to the abuse or neglect of the children.⁶ Substance abuse and related mental health problems affect everyone in the family and are often intergenerational with domestic violence as a frequent co-occurring problem. If the intergenerational cycle is to be broken, all members of the family must receive services.

Substance abuse recovery and adjudication of child welfare cases in Texas often occur on two different “clocks.” Stable substance abuse recovery can take up to two years and recovery may be interrupted by one or more periods of relapse, lengthening the time period between initial treatment and stability of recovery. Relapse may occur even after years of sobriety. Texas Family Code Section 263.40I requires that a child’s legal case be resolved within 12 months, with two exceptions.⁷ A six month extension may be granted if a court finds extraordinary circumstances or places the child back in the home with the parent under Section 263.403 under a monitored return.⁸ Because judicial and child welfare workers are often reluctant to allow reunification in families with a history of substance abuse and behavioral health problems, the restrictive legal timeframes can and do result in permanent removal and termination of parental rights of parents with substance use/abuse and related mental health problems.

³ Greenfield, L.A. *Child Victimization: Violent Offenders and Their Victims*. Washington, DC: U.S. Prevention, 1996.

⁴ *Id*

⁵ Reid, J.; Macchetto, P.; and Foster, S. *No Safe Haven: Children of Substance-Abusing Parents*. 1999.

⁶ *Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Drug Services With Child Welfare*. Nancy K. Young, Ph.D., Sidney L. Gardner, M.P.A.

II. Integrated Services Development Process

Integrated services must be developed to address the myriad problems facing families involved with the judicial and CPS systems due to substance abuse and mental health disorders. Substance abuse and mental health treatment alone will not, and cannot, ensure family reunification and self sufficiency. In particular, domestic violence, primary health care, housing, and employment-related services are central partners for successful family reunification. Collectively, community agencies and advocates concerned with child welfare reform and substance abuse can mobilize community members and community-based organizations. Along with on-going support, these community-based organizations and support systems can also assist with the prevention of both child abuse and substance use/abuse and related mental health problems

Best practices in setting up Integrated Services include:

- Cultural competence
- Community-based services
- Early identification and screening
- Strengthening parental capacity to protect and provide for their children
- Access to and availability of appropriate services
- Competent and trained providers
- Trauma informed treatment services (see Glossary, Part V).
- Family Group Decision Making (see Appendix H)
- Individualized services that respond to the unique needs of families
- Comprehensive Family Assessment
- Impact and outcome evaluation and data

It is important not to equate a FDTC with a adult or juvenile criminal drug court. While there are similarities, criminal drug courts are separate and different from the models discussed in this guide. It is possible that a parent or youth may be involved with both a Family and a Criminal Drug Court at the same time. In these situations, it is important to coordinate services but court actions remain **separate**.

“Simple” integrated service systems may simply involve substance abuse providers and CPS joining together to maximize case coordination and planning to improve family access, engagement, retention and reunification.

A more complex model may involve a basic FDTC in which the agencies participate in reporting and case coordination with one or more Family Court Judges, but also includes many of the aspects of a simpler model as described above.

The most complex FDTC model consists of a court coordinator, Family Drug Treatment Court judge and a Family Court judge. In this structure the FDTC judge takes on more of a problem-solving, social work role to encourage, direct and manage the families’ participation in treatment and related services. The Family Court Judge retains the judicial responsibility for legal actions including those related to termination of parental rights.

Other court structures involve a court coordinator who tracks and monitors the progress of families in treatment, reports to the Family Court Judge or FDTC judge, and attends hearings with the family. The court coordinator also would meet with the families and CPS and other entities to review progress, provide

feedback, gain insight, and, if authorized, advise the family of possible sanctions and court actions

A FDTC model may be used in either a Family Based Safety Services (FBSS) case or a Conservatorship case (CVS). An FBSS case is where child welfare, substance abuse, judicial, and others work to **prevent a court from** ordering removal of the child(ren) from the home. This model requires the same tight service integration and coordination as others but focuses upon intervening prior to, and in an effort to prevent, removal of children from their home. In this type of case, the legal timeline will not apply. A CVS case would be subject to the legal timelines in the Texas Family Code, which are triggered when a judge gives Temporary Managing Conservatorship of a child to CPS. Children are ordinarily placed outside the home in a CVS case, and the level of service integration and coordination may be more demanding than in an FBSS case. It is important to be flexible and realistic at each stage of planning, design and development.

And the **key** to success lies in bringing the Culture of Recovery into the courtroom and into service planning and review meetings with recovering parent(s). A Culture of Recovery permeates treatment centers and provides a social network for participants in 12 Step programs. It demands that each person accept personal responsibility for past and future behaviors. However the individual is accepted without being judged or stigmatized. That is, it is a **safe**, non shaming culture where the individual can safely discuss his or her experiences of addiction and recovery. It can help to provide vital social and family support across systems. Moving this Culture into environments beyond the treatment center and 12 Step fellowships is central to successful engagement, retention, and drives successful outcomes.

A. Initial Steps:

The first step is to identify and convene a team of key local representatives from CPS, substance abuse treatment providers, the judiciary, attorneys and guardians ad litem/CASA. This Core Team will lead planning, design and implementation of the Integrated Services process. The Core Team is responsible for coordinating, planning, and developing the components of the integrated services system, whether it is a FDTC or another model, and should have executive management support and authority from their respective agencies in order to provide the link between the local provider or office and the funding state agency or central office. A committed Core Team ensures support for needed policy coordination, fiscal and evaluation support.

A core principle of the team must be a shared belief that an integrated services system will best meet the needs of the CPS children and families with substance use/abuse and related mental health problems. Some of the necessary components for integrated services include:

- Criteria for participation in the integrated services or a FDTC
- A referral procedure
- Frequent scheduled and planned multi-disciplinary case staffing
- Criteria to measure clients' progress
- Court sanctions
- Defined frequency or reasons for a FDTC hearing
- Accountability measures
- Marketing, sustainability and evaluation plans and data collection
- Judicial procedures to support and enhance impact and outcome

After the Core Team has been established, a larger team should be developed to serve as an Advisory

Committee. The Core Team members serve on the Advisory Committee along with representatives from other agencies and community partners. The role of the Advisory Committee is to assist with the design and development of the integrated services system or FDTC. Members serve a central role by participating in workgroups, sharing expertise and skills, providing feedback, ensuring services are in place to meet client and families' treatment, employment, and stability needs. Appendix A gives a listed of recommended Advisory Committee members, an outline of recommended meeting schedules, sample meeting agendas, etc.

B. Examination of Community Values and Goals

Once the Core and Advisory Teams are in place, the next step involves examining your local community's values and goals with regard to the project. Each member will bring a different set of values to the table, including ideas about poverty, race, addiction, dependence, parenting, and other factors that affect the way people live their lives and make decisions. Child protective services professionals, substance abuse treatment providers, the courts and other community participants each bring a different perspective on what is the "right" thing to do in a given situation.

A community may find that system change and development should take place in steps with service integration between CPS, substance abuse, TX CASA and other agencies as the first stage. Integrated services may be sufficient or they may serve as a stepping stone that lead to garnering additional resources such as a case manager/court coordinator and eventually, the establishment of a formal Family Drug Treatment Court .

Because these community values will influence decision making, planning and implementation of coordinated service delivery, it is important to begin by exploring and sharing similarities and differences of key values and beliefs. Two tools are offered to assist in exploring these differences.

The Collaborative Values Inventory (CVI) is a tool provided by the National Center on Substance Abuse and Child Welfare (NCSACW). The CVI is an anonymous, online questionnaire. It is designed for advocates, consumers and professionals who are seeking a better understanding of the values that guide different disciplines and systems. The NCSACW will tabulate and analyze the results of the CVI and provide the team with a summary report. Those results can form the basis for a values discussion. Arrangements must be made in advance with the NCSACW for communities to participate in the CVI. To utilize the CVI, please contact the NCSACW at sboles@cffutures.org. A copy of the CVI can be found in Appendix B and is also available online at: <http://www.aodsystems.com/cvi/CVI.html>.

A related, immediate resource is the Core Values Statements list provided in Appendix B. This is a list of sample statements from which the team can identify and discuss priorities. The list can assist the team members with identifying their own unique priorities.

The Collaborative Capacity Instrument is another excellent planning tool also provided by the NCSACW. This is intended to be used as a self-assessment by substance abuse service and child welfare service (CWS) agencies and dependency courts who are preparing to work with each other or who may be seeking to move to a new level of cooperation after some initial efforts. The questions have been designed to elicit discussion among and within both sets of agencies and the court about their readiness for closer work with each other.

The CCI may help community members and professional staff in developing common goals for their work together. Responses from this assessment should be tabulated and distributed to the team members. The results provide a matrix of progress in linkages and aids in the prioritizing of needed action. The NCSACW has the ability to tabulate these responses via the internet for interested sites. After the questionnaires are

submitted it is helpful to have the items scored.

It is important to meet and discuss the data and what it shows about similarities and differences across systems. To utilize the CCI, please contact sboles@cffutures.org. A copy of the CCI can be found at Appendix B and is also available online at: http://www.aodsystems.com/CCI/CCI_Start.htm.

C. Policies and Procedures for Integrated Service

At the outset, it will be important to review existing policies and procedures to determine those that may need adjustments to facilitate the integrated services effort. Existing policies and procedures may not be readily supportive of an integrated system or FDTC. In addition, representatives from each system must agree upon shared criteria for integrated service eligibility and administration, including: markers for family reunification and/or case termination, reasons for termination of integrated services and/or parental rights, and relapse management and child safety planning. Steps that each system will need to consider and undertake both internally and collectively are included.

D. Training

In order to implement an integrated services process or a FDTC, each discipline must understand the other. Therefore, cross training is recommended and should be taught and attended by all the disciplines together. All participants, including substance abuse experts, need training as the language, relationships, and process of recovery is rarely expressed into a public forum such as a courtroom. Family and foster care training, along with a handbook for family members and foster care providers, is also central to success. Families cannot successfully participate without a clear understanding of the process, the goals and each of the steps. Foster parents also need to understand the process and be able to support recovery.

Training curricula should include, at a minimum:

- Screening, assessment and referral for substance use/abuse or related mental health disorders
- Substance abuse treatment
- Mental health services including Fetal Alcohol Syndrome Disorder (FASD) screening
- Domestic violence screening and services
- Substance abuse prevention services for children
- Educational and employment support
- Housing
- Parenting support and education

It is significant that children of substance abusers are themselves at particularly high risk of using, abusing or becoming dependent upon substances. It is important that integrated service systems and FDTCs consider this risk and ensure that the children of substance abusers are provided access to prevention services or plans if appropriate, and that these are included in the integrated services systems. Prevention services may provide one or more of the following: information dissemination, education, life skills training, problem identification and referral, crisis counseling, alternative activities, and environmental strategies. Many prevention agencies can identify early substance abuse risk as well as related opportunities for intervention. To locate prevention programs, go to <http://www.dshs.state.tx.us/sa/prevention>.

E. Evaluation, Marketing, and Sustainability

Evaluation, marketing and sustainability are closely linked and must be addressed at every step and level of planning and action.

Evaluation

Evaluation helps to ensure that you are achieving your objectives and to make mid-course corrections as needed. This information is meant to be used for quality improvement as well as marketing for policymaker and public support. Evaluation is the core component which informs and supports marketing and fiscal planning, providing the data and “selling points” for both. Policy and fiscal support will, in the long run, be heavily dependent upon the cost efficiencies and effectiveness that can be demonstrated for the integrated effort. The evaluation plan included in this Guide (at Appendix J) has been developed to provide data that will be useful for local and state level planning and policy development. It is designed to provide information on impact, outcomes and cost efficiencies, as well as extensive demographic information on families served from data already collected by DFPS. Local impact and outcomes can be compared with those of other initiatives across the state. At the state level, aggregate data on cost efficiencies and outcomes can be utilized for policy making and resource allocation.

Sustainability depends upon impact and outcome evaluation. If evaluation is coordinated with state agencies and offices it can provide the information required for long-term legislative and state level policy and fiscal support.

Because judicial and other data systems do not ordinarily utilize a common database or information technology system, each community must work to identify local data sources and information resources. Communities should also identify evaluation questions to support their particular integrated services system in addition to those found in Appendix J. Utilization of the evaluation plan by local communities offers two major advantages:

1. Local implementation of universal basic evaluation plans and systems will provide court specific information for comparative analysis with other courts and quality improvement, as well as local marketing, policy development and planning. During planning and start up gather available background data that includes: number of families with substance abuse and related problems, outcomes of those families, demographics on all family members including age, gender, employment, education, presenting drug, race and ethnicity. This data describes who needs to be served and offers some information on service gaps.
2. Demographic data is the foundation for process evaluation, quality improvement, outcome evaluation, and impact evaluation. Demographics will identify who the program best impacts, procedural problems, and those points where families drop out, relapse or fail to move forward. Review the model data based evaluation plan provided in Appendix J and then determine your local evaluation plan and resources:
 - Identify data sources and persons responsible for recording and reporting the data
 - Establish guidelines and procedures to review data and process information
 - Establish guidelines and procedures for local data sharing
 - Identify the person(s) responsible for compiling data and providing reports to state and local level entities
 - Establish your cross system quality improvement team
 - Develop procedures for team to provide feedback and direction to each system and across systems

In conducting the evaluation, you should consider including a 30 or 60 day closed case review for problem identification and related quality issues:

- Are there service differences between reunified families and those who dropped out or were dropped? If so – what are those differences?
- Timing of drop-out: is there a point at which most drop--outs occur?
- Is there a greater loss related to any one service gap?
- What services do all families receive?

Long-term support and policy change mandate that each planning group coordinate with their state agency or contractor. The evaluation plan has been approved by the participating agencies and technical support can be provided. The aggregate data that state level coordination can provide can drive legislative and agency policies and changes.

Marketing and Sustainability

To maintain the integrated services system or FDTC, it will be important to develop a marketing and sustainability plan to garner policymaker and stakeholder support for the effort. You will need to identify the resources – existing and potential – to enable success. There are four basic principles to marketing and sustainability. Each is discussed in detail in Appendix K.

- Never come to the table empty handed
- Good data is essential
- Marketing is never-ending and all inclusive
- Be transparent

F. Summary:

In summary, there are several steps necessary to ensure a successful integrated services system. They include:

- Management support and coordination with central and state offices
- A team of key representatives from the core agencies (Core Team): local CPS office, all of the substance abuse treatment providers, the judiciary, attorneys and guardian ad litem/CASA
- An MOU signed by each agency represented on the Core Team
- An Advisory Committee comprised of social service agencies, advocates and consumers to assist with the design and development of the integrated services system or FDTC
- Exploration and sharing of the similarities and differences of the key values and beliefs that will influence decision making, planning and implementation of coordinated service delivery
- A Review of existing policies and procedures to determine those that may need adjustments to facilitate the integrated services effort
- A review and modification of these guidelines to meet local needs
- An Integrated Services plan that includes prevention services for the children of substance abusing parents involved with CPS
- Recognition of the importance of evaluation and of accurate data
- Marketing and sustainability plans and activities that incorporate evaluation data on impact, outcome and cost efficiencies.

Part III: Integrated Protocol

The Integrated Protocol should reflect the most important interactions across the systems and disciplines that will affect agency interaction for the benefit of the client population. The Integrated Protocol is designed to guide and support service integration and coordination so that families with substance abuse problems who are involved with CPS can achieve recovery and family stability. It also provides a set of principles, standards and behaviors to guide daily practice. An Integrated Protocol also incorporates the principles, standards, and behaviors of more than one discipline and requires the endorsement and support of all of the affected disciplines. The protocol summarizes the roles and responsibilities of the state or central offices of DFPS, DSHS, TX CASA, CIP and OCA, and “direct service” staff members who work with the families.

Planning Group: Policies and Procedures

In order to establish a coordinated and integrated system, members of the Advisory Committee and Core Team must include the following key components in their planning:

- Develop a Memorandum of Understanding to be signed by a manager in each key system. A copy of the state level MOU signed by the participating lead agencies is attached (Appendix C). This can, if the group wishes, be used as a template or starting point in drafting one for the local initiative
- Review policies and procedures to identify required changes or additions for integrated service implementation
- Assign a manager or staff member to serve on the Core Team.
- Assess staffing needs and identify staff who will be assigned to the integrated service or FDTC program
- Identify internal and inter-system training needs and resources
- Review the Texas Partnership for Family Recovery evaluation plan (Appendix J) and identify local data sources; frame additional evaluation questions or demographic information sought for local use
- Develop guidelines, policies & procedures for the integrated services system or FDTC, including information sharing across systems, client referral, screening, assessment, engagement, retention and on-going recovery, response to client failure to enter treatment, dropping out of treatment, relapse planning and child safety planning.
- Identify and assign resources
- Map local service array including: type, intensity, environment, length of stay and modality
- Restructure services as necessary.
- Develop a system to inform and educate staff and clients on the integrated services system

A coordinated and integrated system must address the following areas:

- Management
- Training
- Client Identification and Initial Screening
- Service Delivery
- Case Closure
- Marketing, Evaluation, and Sustainability

Each is addressed in detail in the following sections.

A. Management

It is important to review existing policies and procedures to determine those that may need adjustments to facilitate the integrated services effort. Existing policies and procedures may actually discourage an integrated system. In addition, representatives from each system must agree upon shared criteria for integrated service eligibility and administration, including: markers for family reunification and/or case termination, reasons for termination of integrated services and/or parental rights, and relapse management and child safety planning.

Guiding Principles for Policy, Procedures & Services Review

1. The needs of children and families are of paramount importance
2. Agencies must be open to revising policies, procedures and services to facilitate integration of services
3. All participants and systems must be held accountable
4. Integration of services will result in better outcomes for children and families

Examples of Policies, Procedures and Services to Be Reviewed

Child Protective Services Agency:

- Identification of resources
- Information sharing across systems
- Marketing strategies
- Training
- Role of Substance Abuse Specialists (who will reach out to families that may be falling through the cracks?)
- Screening, assessment and referral process
- Family Group Decision Making process
- Coordinating congruent service planning between agencies
- Compliance/performance impact & outcome measures
- Criteria for continuation/termination of services

Substance Abuse Treatment Agencies:

- Inter-agency planning to develop service sequencing to ensure immediate access for families
- Map local service array including: type, intensity, environment, length of stay and modality
- Adopt trauma informed management and treatment modality
- Restructure services as necessary:
 - OSAR interim services
 - Utilization of outpatient care as a pre or interim service for persons on residential waiting list(s)
 - Prevention program resources for children and youth of families receiving integrated services
 - Develop plan to minimize number of steps or persons between client's first contact and admission to treatment
 - Develop plan and procedures to accompany and support client between and across services and agencies
 - Accompany client to new agency or level of care
 - Direct contact and outreach to maintain engagement and retention

- Develop service sequencing maps to leverage local resources, maximize impact and lengthen period of active family support
- Staff training to include:
 - Identification of child abuse & neglect of all clients
 - Trauma informed services
 - Child Welfare and Family Court procedures, timeframes and requirements
 - Role of Guardian Ad Litem, CASA Volunteer
 - Roles of judiciary and legal participants

Attorney Ad Litem and Guardian Ad Litem/CASA

Parents' Attorney

Judiciary

- Develop criteria for how the case will progress through the court system, including length of sobriety, relapse, parent participation and relapse planning.
- Develop sanctions, required legal steps and documents/forms and court procedures
- Assign courtroom, judge(s) and court schedule
- Develop criteria for the entry and exit (involuntary discharge or graduation) from drug court
- Develop incentives and sanctions for use with drug court participants
- Set up dockets
- Consider decision on integrating or separating drug court hearings and permanency hearings

B. Training

Training is essential in order to facilitate an integrated child welfare, substance abuse and judicial system. Training and, particularly cross training, will help each discipline understand the other. Below are some recommendations for training for each component of an integrated system.

Guiding Principles for Training

1. Training is essential to a successful integrated child welfare, substance abuse and judicial system
2. It is imperative that each discipline understands the other
3. Training will be taught and attended by all of the disciplines together

Recommended Training

All:

- Identification and screening for domestic violence
- Trauma Informed Services and Motivational Interviewing
- NCSACW On-line training(s)
- FASD: The Course (FAS Center for Excellence)

Child Protective Services:

- Addictive disease: identification, treatment & recovery
- How to use a substance abuse screening tool and other strategies to gather information about substance use and abuse
- How to identify children who may have prenatal exposure to alcohol/drugs and how to refer the child for an in-depth assessment
- Relapse and safety planning
- Family Drug Treatment Court requirements, protocols and procedures

Substance Abuse Treatment Agencies and Staff:

- CPS training on the identification of child abuse and neglect
- Counselors treating clients referred by CPS must document completion of on-line coursework in child protection services via NCSACW;
- Counselors treating clients referred by CPS must have continuing education in issues of child development, child safety and family dynamics.
- Identification of alcohol and other drug related disorders in children.
 - Training should include knowledge of indicators of emotional, behavioral and cognitive problems including those related to prenatal exposure and how to refer for appropriate evaluations
 - Research based, standardized information about Fetal Alcohol Spectrum Disorder (FASD) and training to assist their clients in screening their children for FASD
- Court procedures including Family Drug Treatment Court requirements, protocols and procedures

Judiciary:

- Addictive disease: identification, treatment & recovery

Attorneys (Attorney Ad Litem, Guardian Ad Litem, CASA, Parent’s Attorney, and Attorney for CPS):

- Addictive disease: identification, treatment & recovery
- Identification of children who may have prenatal exposure to alcohol/drugs and how to refer the child for an in-depth assessment
- Relapse and safety planning
- Family Drug Treatment Court requirements, protocols and procedures

Substitute Caregivers (foster parents, kinship caregivers, etc.):

- Addictive disease: identification, treatment & recovery
- How to work effectively with and care for children of alcoholics and addicts

C. Client Identification and Initial Screening

The initial stage focuses on identification of a client that is involved with CPS and has a substance abuse problem. There must be an open CPS case and the parent/caregiver must have a substance abuse problem to be an appropriate candidate for the integrated services system or FDTC (as applicable). The family can be referred to CPS by making a report to the Child Abuse Hotline (see Appendix D).

Guiding Principles for Client Identification and Initial Screening

1. Agencies must rule out, rather than rule in, substance abuse as a contributing factor
2. Agencies need to work as a team to best meet the needs of the family
3. Information sharing must be continuous among the agencies
4. Agencies need to assess a client's need for involvement with other agencies

Action Steps for Client Identification and Initial Screening Stage

Child Protective Services Agency and Staff:

- Ensure that substance abuse is part of the risk assessment. (See Appendix E for tools that can be used for screening)
- Use standardized agency Referral Form and Release of Confidential Information Form to refer clients for substance abuse assessments and treatment (See Appendix E)
- Screen for domestic violence (see Appendix G)
- Refer clients and children for mental health evaluations as appropriate

Substance Abuse Treatment Agencies and Staff:

- Utilize BHIPS for all substance abuse screenings and assessments.
 - Screen to include standardized questions to determine if a client is involved with CPS, mental health, domestic violence, and criminal justice
- Refer clients to CPS if there is not an open case and there is a concern the child is a victim of abuse and/or neglect (see Appendix D)
- Incorporate standard screening for trauma into treatment protocols for all clients
- Ensure appropriate Release of Confidential Information Forms have been signed to allow communication with CPS and the judiciary
- Send screening and assessment results to appropriate parties (CPS, FDTC, Attorney's, etc)
- Participate in Service Plan Staffing and Family Group Decision Making meetings
- Utilize Trauma Informed Services practices in all client contacts
- Develop a plan for and provide interim services for clients on waiting lists for treatment
- Refer client's family members for prevention and intervention services as appropriate

Attorney Ad Litem and Guardian Ad Litem/CASA:

- Consider whether it is appropriate to report to CPS staff and/or judiciary that a child and/or their parent/caregiver has a substance abuse problem that is not being addressed
- Support a child's access to prevention or intervention services
- Meet with substance abuse treatment providers when a child is placed in a treatment facility with their parent/caregiver

Parents' Attorney:

- Ensure that clients understand the FDTC process and agrees to abide by the terms of the court, if they are determined to be eligible for FDTC
- Advise clients about signing a Release of Confidential Information Form to allow substance abuse treatment providers, CPS, attorneys and the judiciary to discuss progress and share information
- Support treatment and recovery and the contract to participate in the drug court

Judiciary:

- Inquire if a substance abuse screening/assessment has been conducted and if recommendations have been made
- Inquire if the FDTC process has been explained to the client and that the contract to participate in the drug court has been signed.
- Ensure the client understands the process and agrees to participate
- Inquire if a Release of Confidential Information Form has been signed

Families/clients:

- Participate in the substance abuse screening/assessment
- Follow requirements for entering the FDTC program
- Sign required Release of Confidential Information forms, allowing for the sharing of information between the substance abuse treatment providers, CPS, attorneys and the judiciary

Substitute caregivers:

- Ensure children participate in screenings, therapy or therapeutic services as recommended by CPS
- Evaluate children for substance or alcohol use/abuse. Notify the CPS caseworker, Attorney or Guardian Ad Litem if it is suspected a child is using/abusing alcohol or drugs

D. Service Delivery

Families must be willing and able to share confidential information with others and participate in services to be successful in the Family Drug Treatment Court or other integrated services system. As the family will be involved with several agencies, service integration is paramount to meet the needs of the family. During the Service Delivery Stage, the family is actively involved in an array of services, which are managed by the integrated services team.

Guiding Principles for Service Delivery

1. Agencies need to work as a team to best meet the needs of the family
2. Substance abuse agencies must assess the safety of the children of all clients
3. Information regarding client progress should be shared on an ongoing basis
4. Case plans should be congruent, with specific identified tasks and goals
5. Assessments should focus on children as well as adults
6. Rewards and sanctions should be in place to support families
7. Agencies must identify substance abuse problems as they emerge and support recovery of families in treatment

Action Steps for Service Delivery Stage

Child Protective Services Agency and Staff:

- Offer Family Group Decision Making on each case
- Include CPS Substance Abuse Specialists and substance abuse treatment providers in case Service Plan Staffing

- Refer children for age appropriate services that will specifically address issues related to their parents/caregivers substance abuse
- Refer for and ensure that an FASD screening has been conducted on each child where need for screening is indicated (see Appendix F)
- Along with substance abuse treatment providers, discuss the tasks that will be required of a client. Agreements should be reached and documented as to who will provide the services in both the Family Plan of Service and the substance abuse treatment plan. (Recommended resources for services, e.g. daycare, mental health evaluation, extracurricular activities for children, incentives for parents, etc. are located in Appendix G)
- Participate in all scheduled Family Drug Treatment Court Service Plan Staffing (generally weekly at the beginning of the case, then less often as progress is made by the client).
 - Be prepared to discuss the progress of the parent/caregiver as well as the children
- Invite the substance abuse treatment provider to participate in CPS case Service Plan Staffing in person or by phone
- Inform the substance abuse treatment provider of the permanency plan(s) for the child and update the substance abuse treatment provider if the permanency plan changes
- Incorporate treatment goals, compliance information and client progress into their reports to the courts.
 - Include information about the client’s participation in treatment as well as toxicology reports. Maintain contact with the client and participate in Service Plan Staffing to maximize client engagement and retention
- Support client recovery

Substance Abuse Treatment Agencies and Staff:

- Along with CPS caseworkers, discuss and assign required tasks and services.
 - Agreements should be reached and documented in both the Family Plan of Service and the substance abuse treatment plan.
- Integrated client files must include:
 - Current copies of the Family Service Plan I including case notes documenting attendance at interagency Service Plan Staffing
 - Interagency Service Plan Staffing should occur at least once every 90 days
 - Clients should be included in interagency Service Plan Staffing
- Each case file should include results of screening for child safety and discussion of child safety issues completed within 30 days of intake and at each treatment plan review thereafter (see Appendix E for suggested questions for child safety issues)
 - Placement and custody status of each child should be clearly documented in the case file, as well as, developmental information including results of the developmental screen used, date of screen and name of screener. If referred for assessment and services, results of the assessment and current status of services should also be documented
 - Signed consents to release information to client’s caseworker, caseworker supervisor, guardian ad litem, attorney ad litem, CASA worker and respondents parent’s attorney;
 - Client file to include current court protective orders, visitation orders, custody orders and treatment orders, as well as, date and nature of the next hearing
 - Discharge planning should include documentation that plans have been made to assure child safety in case of relapse
 - Treatment plan

- Client engagement and retention plan
- Assist client in referring the child for FASD screening as appropriate (see Appendix F)
- Ensure appropriate Release of Confidential Information Forms have been signed, allowing communication with CPS caseworker, attorney's and the judiciary
- Share copies of the substance abuse treatment plan and updates with CPS and the judiciary, informing them of the client's treatment goals and progress
- Participate in all scheduled Family Drug Treatment Court Service Plan Staffing (generally weekly at the beginning of the case, then less often as progress is made by client).
 - Substance Abuse treatment provider should be prepared to discuss progress of the client as well as the children.
- Provide Trauma Informed Services
- Maximize client engagement and retention activities through active case coordination and intensive client services
- Refer and provide case management for prevention and intervention services for significant family members and significant others
- Refer and case manage client access to community based services and resources

Attorney Ad Litem and Guardian Ad Litem/CASA:

- Monitor substance abuse treatment services to children and families
- Inquire about a child's prenatal exposure to alcohol/drugs and advocate for appropriate assessments and services
- Provide information to the judiciary regarding substance abuse treatment, services and impact on permanency for children including concurrent planning for permanency
- Provide an opportunity for children and youth in care to express their wishes and needs relating to their parents substance use/abuse issues
- Participate in all scheduled FDTC Service Plan Staffing (generally weekly at the beginning of the case, then less often as progress is made by the client).
 - Ad Litem should be prepared to discuss progress of the parent as well as the children during the Service Plan Staffing.

Parents' Attorney:

- Maintain contact with the CPS caseworker and substance abuse treatment provider, to stay informed about client progress
- Encourage the client to participate in interagency Service Plan Staffing with CPS and the substance abuse treatment provider
- Review the Family Plan of Service and substance abuse treatment case plan to ensure they meet the client's needs
- Participate in all scheduled FDTC Service Plan Staffing (generally weekly at the beginning of the case, then less often as progress is made by client).
 - Parent's attorney should be prepared to discuss progress of the client during staffing, being mindful of the Attorney-Client privilege and only after being directed by their client to participate.

Judiciary:

- Inquire if the client has had input on their Family Plan of Service and substance abuse treatment case plan

- Inquire about client compliance and progress including attendance and toxicology results
- Provide incentives and sanctions to acknowledge progress, or lack thereof
- Ensure children are participating in appropriate services, including services specifically designed for children of alcohols/addicts, as appropriate
- Participate in all scheduled Family Drug Treatment Court Service Plan Staffing (generally weekly at the beginning of the case, then less often as progress is made by the client).
 - Judge should be prepared to discuss and gather information about the progress of the client as well as the children during staff

Families:

- Participate in interagency Service Plan Staffing with CPS and substance abuse treatment providers
- Participate in court ordered and other needed services for self and children
- Ensure children are receiving proper evaluations and treatment.
- Families should be actively involved in providing information for assessment, including information about alcohol and substance use while pregnant
- Attend and participate in Service Plan Staffing and court proceedings and share with the FDTC team progress made in treatment, milestones reached, etc

Substitute caregivers:

- Ensure children participate in services as recommended by CPS staff
- Keep CPS, attorneys, guardian ad litem, the Court and families (as appropriate) updated on the child's progress
- Participate in interagency Service Plan Staffing with CPS, substance abuse treatment providers and families as appropriate
- Participate in training and cross-training

E. Case Closure

Agencies need to work together to ensure that the services provided have adequately addressed the needs of the entire family. The family needs to have adequate support in place to assist in the transition period following case closure. This stage covers activities towards achieving permanency for the child and preparing for case closure.

Guiding Principles for Case Closure

1. Family progress should be recognized, noted and shared with family members
2. Services need to be in place for the family, allowing for a continuity of care
3. Support systems need to be identified and in place for the family prior to case closure

Action Steps for Case Closure Stage

Child Protective Services Agency and Staff:

- Notify the substance abuse treatment providers if the permanency plan for the child changes
- Work with the substance abuse treatment providers to plan for a clients discharge from treatment and aftercare services

- In consultation with substance abuse treatment providers, discuss relapse safety planning with the parents/caregivers and the family’s support system to ensure a plan is in place to keep the children safe in the event of a relapse
- Ensure court permanency reports include the relapse safety plan
- As appropriate, ensure that children are involved in community services

Substance Abuse Treatment Agencies and Staff:

- Develop discharge plans that include specific steps to ensure relapse prevention and safety of the client’s children
- Include continuing care plan with necessary referrals and case coordination in discharge plans
- Include ancillary service referrals and case coordination with TANF, WIC, Medicaid, CHIP, and other agencies to support the clients self-sufficiency and recovery in discharge plans

Attorney Ad Litem and Guardian Ad Litem/CASA :

- Ensure that clients have an adequate support system and safety plan in place to protect the children, in the event of a relapse
- Ensure that children are involved and continue in community services, as appropriate

Parents’ Attorney:

- Ensure clients have an adequate support system and safety plan in place in the event of relapse
- Collaborate on development of Relapse Safety Plan

Judiciary:

- Approve the permanency plan for the children and ensure that adequate services have been provided and sufficient progress made to ensure the child’s safety
- Provide acknowledgement of a client’s successful completion of Family Drug Treatment court
- Approve of the Relapse Safety Plan for the family upon exiting the system

Families:

- Identify support systems
- Collaborate on the Relapse Safety Plan to ensure child safety
- Share the relapse safety plan with the CPS caseworker, substance abuse treatment provider, attorneys, judge and support system

Substitute caregivers:

- Assist in preparing the child for reunification or permanent placement, as appropriate.

IV. Timelines for Substance Abuse Treatment & CPS:

SUBSTANCE ABUSE		STAGE	CHILD PROTECTIVE SERVICES	
Duration	Activity		Activity	Duration
I-14 Days	<ul style="list-style-type: none"> • Screening, Assessment & Referral • Interim services as needed • Intake & admission 	Client ID	<ul style="list-style-type: none"> • Allegations of possible child abuse/neglect • Investigate to assess need for immediate safety services 	I – 45 Days

			<ul style="list-style-type: none"> Investigate to assess risk of future abuse & neglect Investigate to determine need for continuing services 	
1 Day to 3 Months	<ul style="list-style-type: none"> Initial Treatment: <ul style="list-style-type: none"> Detox Inpatient or outpatient care per Clinical Assessment Assess Treatment Progress Review Service Needs Continuing Care <ul style="list-style-type: none"> May move from Outpatient to Residential or less intensive Outpatient Attend Family Group Conferencing and other Service Coordination Meetings as required 	Service Delivery	<ul style="list-style-type: none"> Offer Family Based Safety Services (Time Limited In-Home Services) Removal of child from home/Granting of Temporary Managing Conservatorship: DAYS from date of removal <ul style="list-style-type: none"> 0 - Ex Parte Hearing 14 – Full Adversary Hearing (If Placed in Care) 59 - File Service Plan with Court 60 - Status Hearing 180 - Initial Permanency Hearing Regardless of services offered, caseworker monitors service provision and compliance throughout service delivery 	1 Day to 6 Months
3 – 24 Months	<ul style="list-style-type: none"> Continuing Care Monitor: Progress & current recovery status Recovery stabilizing If Relapse occurs, recovery may be fragile 	Case Closure	<p>(In DAYS from removal, if Conservatorship case)</p> <ul style="list-style-type: none"> 290 – File Permanency Progress Report 300 – Permanency Review and progress on Permanency Plan to assess reunification or termination of parental rights 365 – Final Order or dismissal: <ul style="list-style-type: none"> Dismissal Date: must be achieved by 12th Month One-Time 180 day extension may be granted If Permanent Managing Conservatorship is given to DFPS, the court holds Placement Reviews every 6 months until age 18 or dismissal 	6- 18 Months

V. Glossary of Terms and Concepts

Throughout this document a variety of terms and concepts will be included, many of which may not be familiar to all the disciplines involved. Each of these is defined below:

Assessment: An in depth interview with an individual that includes medical, mental health, legal, family, education/employment, mental health and substance abuse histories and needs. The interview conducted by a provider prior to and to inform service needs and case planning.

Attorney Ad Litem – includes both the attorney for the child and the attorney for the parent. The duties and responsibilities of an attorney ad litem for a child are governed by Texas Family Code Sections 107.003, 107.004, and 107.0125. Parent attorneys are governed by the Texas Disciplinary Rules of Conduct.

Behavioral Health Integrated Provider System (BHIPS) The DSHS Internet-based computer system for contracted service providers that offers contractors the tools to meet State and Federal requirements for reporting, including capturing required client and billing data.

CASA – see Court Appointed Special Advocate

Case Manager - the person or persons responsible for helping families gain access to required services and resources. The case manager coordinates and sequences the services, tracks the impact and facilitates feedback, information sharing and related service planning.

Child Plan of Service-A written plan to address the needs of the child and services to be provided while the child is in substitute care. The plan is developed by CPS within 45 days after a child's placement in substitute care.

Child Protection Court (Rural Cluster Court) – The Child Protection Courts, also referred to as Cluster Courts, are not true courts; they are specialized dockets that consist of substitute care and child protective services cases that are originally filed in the district and statutory county courts and are heard by associate or visiting judges. The Child Protection Courts were conceived as a means of allowing judges who specialize in child abuse and neglect cases to ride circuit to hear these types of cases in clusters of primarily rural counties.

The concept of using associate judges to hear substitute care and child protective services cases was first implemented by the Supreme Court Task Force on Foster Care through the Court Improvement Project (“CIP”), a federally-funded grant to the Supreme Court of Texas designed to improve judicial handling of child abuse and neglect cases. CIP funded two cluster courts pilot projects to hear child protective services cases exclusively, and contracted with participating counties to reimburse them for the costs of the project. Under the pilot project, the cluster courts were staffed by county employees.

There are currently fifteen Child Protection Courts serving 123 counties. They are staffed with twelve associate judges, three assigned (or “visiting”) judges, nine court coordinators, five court reporter/court coordinators, and one court reporter.

Concurrent Permanency Planning –a secondary permanency goal that is pursued at the same time as the primary permanency goal. The concurrent plan serves as a backup plan in the event that circumstances do not allow for the fulfillment of the primary plan.

Continuing Care Plan - The identified support services that an individual or family will receive when discharged from a service or by the court that will support their on-going recovery and support.

Court Appointed Special Advocate (CASA) - advocate for abused and neglected children in the court system. CASA volunteers may provide a variety of services in support of children, including fact finding and information gathering, negotiation and mediation, case monitoring and resource brokering.

Culture of Recovery - A social network of recovering people with their own recovery-based history, language, rituals, symbols, literature and values. (*The Varieties of Recovery Experience: A Primer for Addiction Treatment Professionals and Recovery Addict*; W. White & E. Kurtz, Great Lakes Addiction Technology Transfer Center, 2005).

Ex Parte Emergency Order - An order issued authorizing the removal of a child without prior notice or hearing. See Texas Family Code Section 261.102.

Family Drug Treatment Court (FDTC) - A juvenile or family court docket consisting of selected abuse, neglect, and dependency cases where parental substance abuse is a primary factor. Judges, attorneys, child protection services, and treatment and other social and public health personnel unite with the goal of providing safe, nurturing, and permanent homes for children while simultaneously providing parents the necessary support and services to become drug and alcohol abstinent. Family dependency treatment courts aid parents in regaining control of their lives, ensure the provision of necessary services for children, and promote long term stabilized recovery to enhance the possibility of family reunification within mandatory legal timeframes (Wheeler & Siegerist, 2003).

Family Group Decision Making Conference - Family Group Decision Making (FGDM) is the preferred method in case planning to ensure effective permanency plans. The FGDM method recognizes that families possess the information needed to make well-informed decisions, and that children can find security and a sense of belonging within their own families. Each conference is conducted by an independent facilitator that assists the family in making the best possible decisions on issues of child custody, placement and permanency.

Family Plan of Service - an agreement between CPS and the parents of children in substitute care. It outlines expectations for change needed in order for the child to be returned home safely, and the services CPS will provide to help the parent make those changes.

Fetal Alcohol Spectrum Disorder (FASD) - FASD is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. It refers to conditions such as fetal alcohol syndrome (FAS), fetal alcohol effects (FAE), alcohol-related neuro-developmental disorder (ARND), and alcohol-related birth defects (ARBD).

Guardian Ad Litem - their role is to represent what is in the best interest of the child (as distinguished from what the child may want). CASA often serves in this capacity.

Mental Health, Mental Retardation (MHMR) - "Local mental health authority" means an entity to which the board delegates its authority and responsibility within a specified region for planning, policy development, coordination, including coordination with criminal justice entities, and resource development and allocation and for supervising and ensuring the provision of mental health services to persons with mental illness in the most appropriate and available setting to meet individual needs in one or more local service areas. "Local

mental retardation authority" means an entity to which the board delegates its authority and responsibility within a specified region for planning, policy development, coordination, and resource development and allocation and for supervising and ensuring the provision of mental retardation services to persons with mental retardation in one or more local service areas.

Outreach, Screening, Assessment and Referral (OSAR) - DSHS funded agency contracted to provide outreach, screening, assessment and referral for substance abuse treatment. The OSAR must approve residential treatment. Outpatient substance abuse programs may admit persons without OSAR approval. OSARs are required to provide interim services when persons are on a waiting list for treatment.

Permanency Hearing - A hearing held in accordance with Texas Family Code Section 263.304 and 263.306. The purpose of the hearing and the findings required by judge are set out in the statute. In addition to the elements required by the statute, the judge may review

- The child's placement;
- Whether the child's parents are willing and able to provide the child with a safe environment;
- A summary of the child's medical care; and
- Other determinations pertinent to the care, custody, and control of the child.

Permanency Planning - The identification of a safe and permanent living situation as the goal towards which CPS services are directed. Permanency planning specifies the steps to be taken to achieve that goal, and the time frames for taking those steps.

Relapse Safety Planning - A plan developed by the family in partnership with CPS, the Court and substance abuse provider that clearly states where and how the family's child(ren) will be cared for in the event of a relapse.

Service Plan Staffing(s) - Intra or inter-agency multi-disciplinary review of family needs, progress and next steps. Family participation is recommended.

Status Hearing - Within 60 days after the court renders a temporary order appointing the department as temporary managing conservator of a child, the court must hold a status hearing to review the service plans and advise the parents that unless they are willing and able to provide the child with a safe environment within the period of time specified in the plan their parental rights may be terminated or their child may not be returned to them.

Substance Abuse Assessment - An ongoing process through which the counselor collaborates with the client and others to gather and interpret information necessary for developing and revising a treatment plan and evaluating client progress toward achievement of goals identified in the treatment plan, resulting in comprehensive identification of the client's strengths, weaknesses, and problems/needs. (Texas Administrative Code, General Provisions, Substance Abuse Rules, General Provisions Chapter 44I.101 (12))

Substance Abuse Prevention - A proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles. The goal of substance abuse prevention is the fostering of a climate in which (a) alcohol use is acceptable only for those of legal age and only when the risk of adverse consequences is minimal; (b) prescription and over-the-counter drugs are used only for the purposes for which they were intended; (c) other

abused substances, e.g., aerosols, are used only for their intended purposes; and (d) illegal drugs and tobacco are not used at all.

Substance Abuse Screening - a set of routinely administered observations and questions leading to a determination that a person has a potential substance use disorder. Screening is conducted by child welfare service staff as well as community-based providers, hospital staff, other health or social services agency staff or may be a specialized service conducted by an alcohol or drug counselor.

Substance Abuse Treatment/Chemical Dependency Treatment - A planned, structured, and organized chemical dependency program designed to initiate and promote a person's chemical-free status or to maintain the person free of illegal drugs. It includes, but is not limited to, the application of planned procedures to identify and change patterns of behavior related to or resulting from substance-related disorders that are maladaptive, destructive, or injurious to health, or to restore appropriate levels of physical, psychological, or social functioning.

Substance Abuse Treatment Plan & Treatment Planning - A collaborative process through which the provider and client develop desired treatment outcomes and identify the strategies for achieving them. At a minimum, the treatment plan addresses the identified substance use disorder(s), as well as issues related to treatment progress, including relationships with family and significant others, employment, education, spirituality, health concerns, and legal needs.

Toxicology Report – Confirmation and written results of drug testing/screening. The toxicology report must be in a format admissible and defensible in court. The toxicology report will state the type and level of substance found in the specimen.

Trauma Informed Services - Trauma, such as abuse, is often the central issue for people with mental health problems, substance abuse problems, or co-occurring disorders. Trauma informed services are provided within an organizational structure designed to prevent re-traumatization. Treatment services follow one of the several evidence based models and curricula for trauma informed substance abuse and mental health treatment.

APPENDIX A

AN INTEGRATED SYSTEM: RECOMMENDATIONS FOR ADVISORY COMMITTEE COMPOSITION, MEETINGS AND AGENDAS

ADVISORY COMMITTEE COMPOSITION

Judiciary

- Judge
- Parent's attorney
- CPS attorney
- Child's attorney

Child Protective Services

Substance Abuse

- Treatment Providers
- OSAR

CASA

Mental Health Providers

- Adult provider
- Child provider

Family Violence

Board President or Texas Workforce Board Staff Member

- Employment/Adult Education

Children of alcoholic/addict therapy provider

Parent in recovery and/or Youth

School/Education System

MEETINGS AND AGENDAS

I. Core Team meeting #1 –

- Discuss what each person does and what he or she brings to the table.
- Discuss who else needs to be a member of the team – Advisory Committee.
- Decide on frequency of meeting by Core Team. It is recommended that the Core Team meet regularly (even weekly at times).
- Decide on mode of communication – including all Core Team members' e-mails, phone numbers, etc
- Decide on who will be responsible for organizing meetings, keeping notes, etc.
- Discuss Core Team attending FDTC in a city with established court

2. Core Team meeting #2–

- Plan initial Advisory Committee meeting
- Decide who will invite Advisory Committee members.
- Discuss what decisions will be made by the Core Team, and what decisions will be made by the Advisory Committee
- Discuss development of Memorandum of Understanding
- Develop a schedule for future Core Team meetings

3. Advisory Committee meetings –

- Core Team provide overview of goals/mission at initial Advisory Committee meeting
- Do values exercise (if utilizing CVI – have AC members participate in CVI prior to meeting and present findings at that time to allow for values discussion)
- Complete CCI if it is to be utilized
- Decide what role the Advisory Committee will have in the development of the integrated service system or FDTC
 - Will they function as an active participant in decisions or
 - Will they provide support for Executive & Core Team decisions made on how integrated services system or FDTC will function

Decisions need to be made about the following components of the integrated services systems or FDTC. If the Advisory Committee is to be an active participant in the planning of the integrated services system or FDTC, it is recommended that workgroups be developed (led by Core Team members) to address the following:

1. Determine Eligibility for the integrated services system or FDTC – which clients will be eligible, is admission mandatory or can a client refuse entry?
2. Referral process – how will referrals be made to court – who will accept them – who makes final decision
3. Court process – how frequently will court hearings be held, will meeting be held prior to court – if so who will attend, how long can a client remain in the integrated services system or FDTC, what sanctions/awards will be used
4. Forms developed – referral form, court progress reports, contracts for clients entering the integrated services system or FDTC, release forms allowing CPS, Substance Abuse Treatment Provider and Judiciary to talk about progress
5. Assessment process – who will refer for assessment and screening, will OSAR or assessor be in court, what substance abuse treatment services are available in the community
6. Case plans – how will case plans for the family be developed and be congruent between CPS and Substance Abuse Treatment Provider, should there be a separate case plan focusing only on the integrated services system or FDTC issues? Should issues such as mental health or domestic violence be included in the case plan
7. Rewards and Sanctions
8. Training
9. Termination of services

APPENDIX B

SAMPLE VALUE STATEMENTS, THE COLLABORATIVE VALUES INVENTORY AND THE COLLABORATIVE CAPACITY INSTRUMENT

SAMPLE VALUE STATEMENTS:

Related to Families

- Children deserve to live in safety.
- Children deserve stable and loving families (biological, foster or adoptive).
- All families have strengths.
- Families deserve the support needed to improve their lives.
- Substance abuse addiction is a treatable disease.

Related to Families and Professionals

- Families with substance abuse problems deserve to be supported by the agencies they are involved with.
- Sometimes, for a variety of reasons, children are not able to live with their biological parents. When this happens, other arrangements must be made quickly and humanely.
- Families and helping professionals believe that setting realistic goals can lead to positive change and each step toward change should be recognized.
- Substance abuse treatment providers, child welfare, legal professionals and other service providers, along with families must respect each other to collaborate effectively. Respect can be demonstrated by taking time to understand each other.
- Open and honest communication among family members, child welfare, substance abuse treatment providers and legal professionals is a prerequisite for success.
- Families should be allowed to direct treatment and recovery with input and consensus by involved professionals.

Related to Professional Development and Support

- People providing services must learn about and respect gender, ethnic, racial, religious, cultural and socio-economic backgrounds of families and tailor programs and policies accordingly.

- On-going professional development is essential to policy making, organizational growth and service provisions.
- Service teams (all disciplines) must be in a constant process of learning about what can help strengthen families.
- The type of caring work that is required to assist families in need cannot happen without caring for the people who deliver the services.

Related to Collaborations and Integrated Services

- Substance abuse treatment providers, child welfare, legal professionals and other service providers, who share a common set of values and goals and who create a network of services will support families in need in a more comprehensive and effective way.
- Child welfare, substance abuse treatment providers and legal professionals have a responsibility to strengthen families' natural and informal networks within their own communities and reduce reliance on professional systems.
- Child welfare and substance abuse treatment providers should work together to best meet the needs of the families they are serving.
- Child welfare, substance abuse treatment providers, legal professionals and others must make difficult, sensitive, and emotional decisions about child safety. They need unbiased, competent and caring input to make these decisions.
- Strengthening families in crisis, who are trying to stay together or reunite, requires an action-oriented approach.



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

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

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

Identify your own role in your organization:

1. Staff Level:

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

2. Gender:

- Male
- Female

3. Area of Primary Responsibility:

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

4. Age: _____ Years

5. Jurisdiction of Agency or Court:

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

6. Race/Ethnicity:

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

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

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

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

- 9) There is no way that a parent who uses alcohol or other drugs can be an effective parent.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

28) Changing the system so that more services were delivered closer to the neighborhoods and community level would improve the effectiveness of services.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

37) Our judges and attorneys' response to parents with problems of addiction is generally appropriate and effective.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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

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

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

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

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

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



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

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

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

Identify your own role in your organization:

<p>1. Staff Level:</p> <p><input type="checkbox"/> Front-line staff</p> <p><input type="checkbox"/> Supervisor</p> <p><input type="checkbox"/> Manager</p> <p><input type="checkbox"/> Administrator</p> <p><input type="checkbox"/> Other, Specify: _____</p>	<p>2. Gender:</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p>
<p>3. Area of Primary Responsibility:</p> <p><input type="checkbox"/> Substance Abuse Services</p> <p><input type="checkbox"/> Child Welfare Services</p> <p><input type="checkbox"/> Dependency Court Judicial Officer</p> <p><input type="checkbox"/> Attorney Practicing in Dependency Court</p> <p><input type="checkbox"/> Domestic Violence</p> <p><input type="checkbox"/> Mental Health</p> <p><input type="checkbox"/> Other, Specify: _____</p>	<p>4. Age: _____ Years</p>
<p>5. Jurisdiction of Agency or Court:</p> <p><input type="checkbox"/> Federal Government/National</p> <p><input type="checkbox"/> State Office</p> <p><input type="checkbox"/> Within State Regional Office</p> <p><input type="checkbox"/> County</p> <p><input type="checkbox"/> Community-Based Organization</p> <p><input type="checkbox"/> Reservation</p> <p><input type="checkbox"/> Other: Specify _____</p>	<p>6. Race/Ethnicity:</p> <p>African-American</p> <p>Asian/Pacific Islander</p> <p>Caucasian</p> <p>Hispanic</p> <p>Native American</p> <p>Other: _____</p>

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

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

I. Underlying Values and Principles of Collaborative Relationships

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

II. Daily Practice – Screening and Assessment

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

III. Daily Practice – Client Engagement and Retention in Care

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

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

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

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

IV. Daily Practice – Services to Children

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

4) Our state ensures that all children in CWS are screened for:

a) Neurological effects of prenatal substance exposure

Disagree Somewhat Agree Agree Not Sure/Don't Know

b) Developmental delays associated with parental substance abuse

Disagree Somewhat Agree Agree Not Sure/Don't Know

c) Emotional/mental health problems associated with parental substance abuse

Disagree Somewhat Agree Agree Not Sure/Don't Know

d) Substance use disorders

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

V. Joint Accountability and Shared Outcomes

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

VI. Information Sharing and Data Systems

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

VII. Training and Staff Development

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

- | | | | | |
|--|----------|----------------|-------|---------------------|
| | Disagree | Somewhat Agree | Agree | Not Sure/Don't Know |
|--|----------|----------------|-------|---------------------|
- 5) Our state has developed joint training programs for AOD, CWS and court staff and providers to learn effective methods of working together.
- | | | | | |
|--|----------|----------------|-------|---------------------|
| | Disagree | Somewhat Agree | Agree | Not Sure/Don't Know |
|--|----------|----------------|-------|---------------------|
- 6) Our state has a multi-year staff development plan that includes periodic updates to the training and orientation received by the staff of both CWS and AOD agencies on working together.
- | | | | | |
|--|----------|----------------|-------|---------------------|
| | Disagree | Somewhat Agree | Agree | Not Sure/Don't Know |
|--|----------|----------------|-------|---------------------|
- 7) Our state has training programs that include cultural issues to improve staff's cultural relevance and competency in working with diverse AOD-CWS client groups.
- | | | | | |
|--|----------|----------------|-------|---------------------|
| | Disagree | Somewhat Agree | Agree | Not Sure/Don't Know |
|--|----------|----------------|-------|---------------------|
- 8) Our state has revised the state university and social work pre-service educational programs so that future staff are prepared to work across systems on substance abuse and child welfare issues.
- | | | | | |
|--|----------|----------------|-------|---------------------|
| | Disagree | Somewhat Agree | Agree | Not Sure/Don't Know |
|--|----------|----------------|-------|---------------------|
- 9) Foster parents, guardians, kinship placement providers and group home providers are sufficiently trained to work on issues related to substance abusing families.
- | | | | | |
|--|----------|----------------|-------|---------------------|
| | Disagree | Somewhat Agree | Agree | Not Sure/Don't Know |
|--|----------|----------------|-------|---------------------|
- 10) Training programs regarding substance abuse, child welfare and dependency court issues that are offered in our state are multidisciplinary in their approach and in their delivery.
- | | | | | |
|--|----------|----------------|-------|---------------------|
| | Disagree | Somewhat Agree | Agree | Not Sure/Don't Know |
|--|----------|----------------|-------|---------------------|

VIII. Budgeting and Program Sustainability

- 1) Our state CWS agency currently uses a portion of its funding for AOD treatment services (excluding drug testing).
- | | | | | |
|--|----------|----------------|-------|---------------------|
| | Disagree | Somewhat Agree | Agree | Not Sure/Don't Know |
|--|----------|----------------|-------|---------------------|
- 2) Our AOD treatment agencies currently use a portion of their funding for services to improve clients' parenting skills.
- | | | | | |
|--|----------|----------------|-------|---------------------|
| | Disagree | Somewhat Agree | Agree | Not Sure/Don't Know |
|--|----------|----------------|-------|---------------------|

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

IX. Working with Related Agencies

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

X. Working with the Community and Supporting Families

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

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

Disagree Somewhat Agree Agree Not Sure/Don't Know

APPENDIX C

SAMPLE MEMORANDUM OF UNDERSTANDING

TEMPLATE RECOMMENDED BY THE TEXAS PARTNERSHIP FOR FAMILY RECOVERY

Article I. General Provisions: Purpose

This memorandum of understanding (MOU) is entered into by the following agencies and entities, hereinafter collectively referred to as “agencies” or the “XXX OF XXXXX”:

The agencies recognize that the neglect and abuse of children is frequently associated with parental/caregiver substance use/abuse or mental health disorders and that no single agency has the resources and expertise to comprehensively respond to the needs of the parent/caregiver, the child or the family as a whole. A significant number of individuals and families in Texas who are involved in child protective services cases and who have substance use/abuse or mental health disorders are being mutually, and often simultaneously, served by the agencies. The agencies acknowledge that procedures to provide integrated legal, substance abuse, mental health and child welfare services must be developed in order to address these issues and that professionals and caregivers at both the state and community level need to develop a common knowledge base and shared values about child welfare and substance use/abuse or mental health disorders.

The xxx's mission is to reduce the number of children in out of home placements, shorten time in care, and increase the number of children successfully reunited with families by building and sustaining integrated and coordinated substance abuse and mental health services, policies, protocols and tools for children and families who are involved with the judicial and Child Protective Services (CPS) systems due to substance use/abuse or mental health disorders. The purpose of this MOU is to set forth the expectations and responsibilities of the agencies in accomplishing this mission.

The agencies have identified the following as key components required to accomplish the XXX'S's mission:

- 1) establishing the membership of an executive committee that will develop, sustain, enhance and expand interagency initiatives designed to integrate legal, substance abuse, mental health and child welfare services for families affected by substance use/abuse or mental health disorders who are involved in a child protective services legal case;
- 2) implementing the initiatives and protocols developed under this MOU;
- 3) defining the roles, responsibilities and goals of the interagency initiatives developed under this MOU.

Article 2. Guiding Principles

The work of the XXX promotes systemic best practice principles that support improved outcomes for all families involved with CPS who have substance use/abuse or mental health disorders.

These best practice principles include:

- family-centered practice;
- cultural competency;
- community-based services;
- early identification and screening;
- strengthening parent capacity to protect and provide for their children;
- access to and availability of appropriate services;
- competent and trained providers;
- consumer and family participation in planning; and
- individualized services that respond to the unique needs of families.

In order to be truly effective and widely accepted coordinated legal, substance abuse, mental health and child welfare systems must be relevant to the entire population. Transformed systems must also include prevention and intervention activities as well as treatment and recovery activities.

Article 3. Interagency Collaboration

The agencies shall work together to achieve cross-system coordination of legal, judicial, mental health, substance abuse and child welfare services and supports designed to address existing fragmentation; reduce or eliminate duplication of services; maximize resources; increase the availability of high-quality services; increase the flexibility of resources used at the state and local levels; expand the array of services and supports; and other transformative activities designed to increase the effectiveness of the systems.

The agencies agree to participate in collaborative planning activities to develop initial and ongoing cross-agency protocols, identify training needs and curricula, coordinate marketing and sustainability efforts and evaluate services and impacts to promote family stability and unity.

Goals and Strategies

- 1. Prevent, intervene and treat to diminish the negative impacts of substance use/abuse and mental health disorders on family stability, child safety and well-being and permanency.**
 - Establish systems to provide comprehensive family-focused services including parenting, domestic violence prevention, health, mental health, legal, nutrition, housing, education and employment.
 - Develop, enhance and sustain a continuum of evidence based prevention, intervention, treatment and continuing care services to promote family unity and child safety.
- 2. Develop, enhance & sustain policies, programs & practices to serve persons affected by substance use/abuse and mental health disorders that are strength based, need driven, family focused and culturally, ethnically & gender specific.**
 - Develop, enhance, provide and sustain cross-training for legal, judicial, mental health, substance abuse and CPS staff.
- 3. Coordinate, integrate and leverage resources to maximize impact of services for families affected by substance use/abuse and mental health disorders.**

- Each agency will assign at least one staff person to monitor, coordinate and facilitate interagency collaboration and integration of judicial, legal, mental health, substance abuse and CPS services.
- The Executive Committee will meet no less than bi-annually for planning, development and problem resolution.

4. Develop, implement and maintain coordinated and integrated data collection & analysis systems.

- Following the Evaluation Plan developed by the Departments of Family & Protective Services, State Health Services, the Court Improvement Project, the Office of Court Administration and TX Court Appointed Special Advocates for Children, coordinate with state agencies and offices to establish data components and procedures for tracking clients and service impact.
 - Integrate and coordinate data needs and systems with the Client Management Behavioral Health System Project, the Mental Health Transformation Grant, the Policy Academy, Supreme Court Task Force on Child Protection Case Management and Reporting, OCA’s Specialty Docket Case Management System and other related initiatives.
- Adopt state recommended and locally defined common outcome measures.
- Develop and implement an on-going process evaluation plan for program development, quality assurance and long-term impact analysis.

5. Adopt a state and local *set of shared performance measures* for treatment of families receiving mental health and substance abuse services.

Article 4. Data Sharing and Evaluation

It is agreed that the ability to share relevant data across agencies will better meet the needs of families. The collection, analysis, evaluation and reporting of this data is essential to a seamless accountable service system.

It is agreed that information technology development will enable cross agency data matching and sharing to the degree necessary to improve outcomes, increase coordination of care across agencies, minimize duplication of services, increase accountability and increase the impact of services.

To this end the agencies agree to:

- Utilize the Evaluation Plan of the Texas Partnership for Family Recovery to ensure consistency of local and state level outcome and impact data.
- provide, consistent with applicable law, data necessary to evaluate system performance, client outcomes and the goals of this initiative, and to develop common data tools as necessary to meet the requirements for evaluation;

- DSHS funded providers to adopt outcome measures for families accessing mental health and substance abuse services based on the Substance Abuse & Mental Health Administration National Outcome Measures (NOMS) domains.
- adopt outcome measures for individuals and families involved with CPS based upon those already utilized and those required by Federal, State and local authorities.

Article 5. Workforce Capacity and Competency

The agencies agree to meet, acknowledge and recognize consistent standards of practice for each of the following services/professions: child welfare, mental health, substance abuse, CASA volunteer, legal and judiciary. The recognized standards will include evidence-based practices, training and competency requirements.

The agencies agree to meet the standards of research-based treatment and intervention strategies for the mental health and substance abuse services they provide, fund or purchase.

The agencies agree to promote ways to increase the number of culturally and linguistically competent, professional and paraprofessional practitioners.

Article 6. Staff Commitments/Grant Expectations

The agencies agree to facilitate meaningful family involvement and participation of all family members in the judicial, legal, CPS and behavioral health services and decisions.

The agencies agree to identify practices to mitigate disproportionate representation of any group in the judicial, CPS and behavioral health service population.

The agencies agree to assign an executive manager or above, to participate in and oversee the agencies' involvement in the Texas Partnership for Family Recovery initiatives.

Article 7. Terms of Agreement

This MOU shall be effective upon adoption by each signatory agency and entity.

This MOU shall be reviewed at least every XXX years and revised as needed to further implementation of the agencies' strategic and long-term plans.

This MOU can be expanded, modified, or amended, as needed, at any time by the consent of all of the agencies.

Approvals:

APPENDIX D

REPORTING CHILD ABUSE/NEGLECT

Laws regarding professional reporting:

The Texas Family Code 261.101 requires professionals to make a report within 48 hours of first suspecting abuse, neglect or exploitation (for licensing only) of children.

The Human Resources Code, Chapter 48 (48.051) requires a person having cause to believe that an elderly or disabled person is in the state of abuse, neglect, or exploitation to report the information required immediately.

How to report:

There are two ways to make a report of child abuse and/or neglect:

- You can make an on-line report at www.txabusehotline.org, or
- You can contact the child abuse hotline at 800-252-5400 if:
 - The situation you are reporting is an emergency
 - You prefer to remain anonymous
 - You have insufficient data to complete the required information online, or
 - You do not want an e-mail confirmation of your report

APPENDIX E
SCREENING AND REFERRAL TOOLS AND
CONFIDENTIALITY FORMS
(FOR BOTH
SUBSTANCE ABUSE AND CHILD ABUSE AND NEGLECT)

The following tools and forms are included in this appendix:

1. Substance Abuse Treatment and Referral Tools
2. Referral for DSHS/Substance Abuse Services Form
3. Substance Abuse Confidentiality Form
4. DFPS Release of Confidential Information to DSHS/Substance Abuse Services Form
5. Screening for Potential Child Abuse and Neglect Questions

SUBSTANCE ABUSE TREATMENT AND REFERRAL

The following tools can be used to screen clients and help to determine appropriate treatment and referral. Each is provided in full below.

- TWEAK
- CAGE
- UNCOPE

In order to obtain a screening and/or assessment from an OSAR, the Referral for DSHS/Substance Abuse Services form must be completed and sent to the OSAR. This form is included in this appendix.

Please note that the appropriate form must be completed to permit the release of confidential information. A Release of Confidential Information Form is included in this appendix that permits exchange of information between the Department of Family and Protective Services (DFPS) and the Department of State Health Services (DSHS).

TWEAK

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

Scoring: Alcohol is likely to be a problem with a score of 2 or more.

CAGE (amended for drug use):

- C** Have you ever felt the need to **cut** down on your drinking or drug use?
- A** Have you ever felt **annoyed** by people criticizing your drinking or drug use?
- G** Have you ever felt bad or **guilty** about your drinking or drug use?
- E** Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover? (**Eye-opener**)

Scoring: If the answer is yes to one or more questions, the parent should receive a formal alcohol and drug assessment. Yes to one or more questions may indicate alcohol or drug dependence (addiction).

UNCOPE

- U** Have you continued to **use** alcohol or drugs longer than you intended? Or, have you spent more time drinking or using than you intended?
- N** Have you ever **neglected** some of your usual responsibilities because of alcohol or drug use?
- C** Have you ever wanted to stop using alcohol or drugs but couldn't (**cut down**)?
- O** Has your family, a friend, or anyone else ever told you they **objected** to your alcohol or drug use?
- P** Have you ever found yourself **preoccupied** with wanting to use alcohol or drugs? Or, have you frequently found yourself thinking about a drink or getting high?
- E** Have you ever used alcohol or drugs to relieve **emotional discomfort**, such as sadness, anger or boredom?

Scoring: Two or more positive responses indicate possible abuse or dependence and need for further assessment.

SUBSTANCE ABUSE PROVIDER SCREENING FOR POTENTIAL CHILD ABUSE AND NEGLECT

The following questions can help a substance abuse provider screen for potential child abuse and neglect. These questions should be asked in a non judgmental or threatening manner during the assessment process.

1. How often do you use drugs/alcohol at home?
2. What do your children do when you are high or have been drinking?
3. When you are using drugs or drinking, where are your children?
4. Have your children missed school or daycare during the last month? How often? Have they been late during the last month? How often?
5. How often do you discipline your children when you have been using or drinking? Explain.
 - If children not with parent:
 - Who are your children living with?
 - Relationship to you?
 - Outpatient programs:
 - Who are your children with?
 - Relationship?

Note: If the children are with a relative who abused the client, notify CPS.

REFERRAL FOR DSHS/SUBSTANCE ABUSE SERVICES Form XX
Release of confidential information must be faxed with this referral form prior to appointment with OSAR
Client Information

Client Name:	Referral Date:
Client Address:	
Client Phone Numbers:	
Social Security Number:	Date of Birth:
County of Legal Jurisdiction:	

DFPS Contact Information

Caseworker Name:	Phone Number:
E-mail Address:	Fax Number:
Supervisor Name:	Phone Number:
E-mail Address:	Fax Number:
Mailing Address:	

- Reason for Referral:** provide explanations for any item checked, including dates, if appropriate
- Allegations that parent is using alcohol/drugs
 - Previous reports alleging alcohol/drug problems
 - Client admitted using alcohol/drugs
 - Criminal history related to alcohol/drugs
 - Positive drug screen (dates/type drug) _____
 - Baby born testing positive for alcohol/drugs _____
 - Home environment indicating alcohol/drug problem (drugs found in home, paraphernalia found in home, meth lab in home, empty alcohol/beer bottle around home, etc)
 - Child reports alcohol/drug use
 - Caseworker screening indicates alcohol/drug use
 - Court ordered screening/assessment – why _____

 - Client appeared to be under the influence
 - Other (describe)

Below to be completed by provider and sent back to caseworker/supervisor within 2 business days of appointment

<p>Date client seen:</p> <p>Result of appointment and recommendations:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Client No-Showed for appointment <input type="checkbox"/> Client does not need any treatment services <input type="checkbox"/> Client refused screening/assessment <input type="checkbox"/> Client referred to community services _____ <input type="checkbox"/> Client referred for outpatient services (location) _____ <input type="checkbox"/> Referred for residential treatment (location) _____ <input type="checkbox"/> If client is on a waiting list, interim services being provided _____ <input type="checkbox"/> Other _____ <p>Information provided to DFPS (must provide information at least two of the following ways)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Called (name and date) _____ <input type="checkbox"/> E-mailed (name and date) _____ <input type="checkbox"/> Faxed (name and date) _____

Counselor Information

Name:

Phone Number:

Release of Confidential Information
DFPS Release of Confidential Information to DSHS/Substance Abuse Services

I, _____, voluntarily give to the Texas Department of Family and Protective Services (DFPS) permission to release the following information to the Department of State Health Services (DSHS) and the person or company that DSHS contracts with to provide substance abuse services:

(Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Name and address | <input type="checkbox"/> Contact phone number(s) |
| <input type="checkbox"/> Date of Birth | <input type="checkbox"/> Social Security Number |
| <input type="checkbox"/> Information from current CPS case
(as it relates to substance abuse) | <input type="checkbox"/> Previous Substance Abuse History |
| <input type="checkbox"/> Results of drug tests | <input type="checkbox"/> Current Substance Abuse Issues |
| <input type="checkbox"/> Other _____ | |

I understand that I am being referred to a person or company that contracts with DSHS, so a screening and assessment (if appropriate) may be conducted to determine whether I have a substance abuse problem, and if so, to determine what level and kind of substance abuse services I need, if any. I understand that this information is needed so the person conducting the screening and/or assessment can discuss the substance abuse issues with me.

Client Signature

Date

Consent for the Release of Confidential Alcohol/Drug Treatment Information to DFPS

I, _____, authorize _____ to disclose to the Department of Family and Protective Service (DFPS), the following information:

- | | |
|--|---|
| <input type="checkbox"/> Results from screening/assessment
<input type="checkbox"/> Referrals made
<input type="checkbox"/> Diagnostic Impressions
<input type="checkbox"/> Treatment Plans and evaluations
<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Admission Reports
<input type="checkbox"/> Client Progress
<input type="checkbox"/> Clinician's Notes
<input type="checkbox"/> Compliance with Treatment
<input type="checkbox"/> Discharge Plans/Reports
<input type="checkbox"/> Other _____
<input type="checkbox"/> Referral Follow up _____ | <input type="checkbox"/> Written report from screening/ assess.
<input type="checkbox"/> Recommended Services
<input type="checkbox"/> Attendance |
|--|---|

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2., and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand this information will be used or disclosed solely for the purpose specified in the form. I also understand that I may revoke this consent at any time except to the extent that action has already been initiated in reliance on the released information. This consent expires automatically as follows:

 (Specifics of the date, event, or condition upon which this consent expires)

 Client Signature Date

 Staff Signature Date

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient unless otherwise provided for in the regulations.

CPS
FORM TO REVOKE RELEASE OF CONFIDENTIAL INFORMATION

REVOKE CONSENT

• Revocation Date: _____ (mm/dd/yyyy)

Revocation Comments:

Client's Signature

Date

Parent, Guardian, or Authorized Representative's Signature When Required

Date

• Staff Signature

Date

TO BE SIGNED ONLY WHEN CLIENT IS REVOKING CONSENT

DSHS Substance Abuse Release of Confidential Information Form

CONSENT

●=Required Field

● Client Name: _____

● Client Number: _____

● Business Entity: _____

Consent Number: _____

● Activity Begin Date: _____ (mm/dd/yyyy)

● Activity End Date: _____ (mm/dd/yyyy)

● Release Expiration Date: _____ (mm/dd/yyyy)

● Disclosee: _____

Other Disclosee: _____

NOTE: Any item listed below may include information that reveals a client's HIV status

Is it okay to release the following information?

- | | | |
|---------------------------------|---------|--------|
| ● Screening/Intake | 1. Yes | 2. No |
| ● General Assessment Only | 3. Yes | 4. No |
| ● Medical Assessment | 5. Yes | 6. No |
| ● Employment Assessment | 7. Yes | 8. No |
| ● Substance Abuse Assessment | 9. Yes | 10. No |
| ● Legal Assessment | 11. Yes | 12. No |
| ● Family / Social Assessment | 13. Yes | 14. No |
| ● Psychiatric Assessment | 15. Yes | 16. No |
| ● Diagnostic Impression | 17. Yes | 18. No |
| ● Clinician's Assessment | 19. Yes | 20. No |
| ● Assessment Recommendations | 21. Yes | 22. No |
| ● Assessment Summary | 23. Yes | 24. No |
| ● Assessment Narrative | 25. Yes | 26. No |
| ● Wait List Record | 27. Yes | 28. No |
| ● Laboratory Results | 29. Yes | 30. No |
| ● Treatment Plan(s) | 31. Yes | 32. No |
| ● Treatment Plan(s) Evaluation | 33. Yes | 34. No |
| ● Admission Reports | 35. Yes | 36. No |
| ● Procedures and Progress Notes | 37. Yes | 38. No |
| ● Clinician's Notes | 39. Yes | 40. No |
| ● Client Progress | 41. Yes | 42. No |
| ● Medication Records | 43. Yes | 44. No |
| ● Discharge Summary | 45. Yes | 46. No |
| ● Discharge Plans | 47. Yes | 48. No |
| ● Discharge Reports | 49. Yes | 50. No |

• Follow-Up Reports	51. Yes	52. No
• Compliance with Treatment Requirements	53. Yes	54. No
• Attendance	55. Yes	56. No
• Prognosis	57. Yes	58. No
• Referral Information	59. Yes	60. No
• Referral Followup	61. Yes	62. No
• Program Case	63. Yes	64. No
• Program Service	65. Yes	66. No
• Client Interview	67. Yes	68. No
• Authority to Call Phone Number	69. Yes	70. No
• Authority to Leave Message	71. Yes	72. No
• Residential Approval	73. Yes	74. No
• Financial Eligibility	75. Yes	76. No
• COSIG Voucher	77. Yes	78. No
• Other Confidential Information (please specify below)	79. Yes	80. No

Other Information to Release:

• Purpose for Releasing Information:

Comments:

SIGNATURES

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand this information will be used or disclosed solely for the purpose specified in the form. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as noted above.

• Client's Signature **Date**

Parent, Guardian, or Authorized Representative's Signature When Required **Date**

• Staff Signature **Date**

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

APPENDIX F

OTHER SAMPLE SCREENING TOOLS:

- DOMESTIC VIOLENCE
- FETAL ALCOHOL SPECTRUM DISORDERS

DOMESTIC VIOLENCE Sample questions for screening for domestic violence include:

- Has anyone else in the family been hurt or assaulted?
- Has anyone made threats to hurt or kill another family member or himself?
- Have weapons been used to threaten or harm anyone?
- Have the police ever been called to the house? Have arrests been made?
- Has the batterer threatened to leave with the children?
- Has any family member stalked another family member?
- Has anyone taken a family member hostage?

FETAL ALCOHOL SPECTRUM DISORDERS (FASD) RESOURCES AND SCREENING TOOLS

There are a number of resources that will assist a community in addressing Fetal Alcohol Spectrum Disorders (FASD), sometimes referred to as Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE). Since the rate of substance abuse is especially high in child abuse and neglect cases, it is important that the children be screened for FASD. FASD is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications.

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Fetal Alcohol Spectrum Disorders Center for Excellence is devoted to preventing and treating FASD. The Center provides information and resources about FASD as well as materials that can be used to raise awareness about FASD. The Center's web site is <http://fasdcenter.samhsa.gov/>.

The Texas Office for Prevention of Developmental Disabilities (TOPDD) coordinates activity among the many State and private agencies that work to prevent developmental disabilities. TOPDD appointed the Fetal Alcohol Syndrome (FAS) Prevention Task Force to address public awareness and education about fetal alcohol syndrome, focusing on women of childbearing age who are at risk for an alcohol-exposed pregnancy. The web site for the TOPDD FAS Consortium is <http://topdd.state.tx.us/fasdprevention.html>. For more information on the Prevention Project contact the program coordinator at 512.206.4544 or at top@hhsc.state.tx.us.

In addition, Larry J. Burd, Ph.D. an associate professor, University of North Dakota School of Medicine and Health Sciences and Director of the North Dakota Fetal Alcohol Syndrome Center has developed a screening tool for FASD. This tool, *Fetal Alcohol Syndrome Screening Training Manual: The FAS Screen*, is a rapid screening tool designed for community wide use to determine children who are at low and high risk for FAS.

This screen can be very useful for CPS and substance abuse providers in screening for FASD and may be obtained directly from Dr. Burd. The Manual includes the following topics:

- A. What is Fetal Alcohol Syndrome
- B. The importance of early identification of FAS/FAE
- C. The FAS Screen: a rapid screening tool
- D. Training on use of the tool

Dr. Burd may be reached at 701-780-2477 or CETP, 1300 S. Columbia Road, Grand Forks, ND 58201. Dr. Burd also has a web site: www.online-clinic.com.

APPENDIX G

RESOURCE RECOMMENDATIONS TO ADDRESS THE NEEDS OF CHILDREN, PARENTS AND FAMILIES

Below are both basic and additional resources that may be necessary to address the needs of children, parents and families.

BASIC SERVICES

These have been identified as the basic resources that will be provided or are needed to meet the needs of a family.

Children

- Program for Children of Addicts/Alcoholics
 - Evidence based
 - Support and education
- Individual/Play Therapy for Children
- Medical Evaluations
 - Referral for FAS screen if appropriate (see FAS screening tool in appendix)
 - ECI
- Dental Evaluations
- Mental Health Evaluations and Services
 - Psychological
 - Psychiatric
- Daycare
- Educational Support

Parents/Family

- Substance Abuse Treatment (Access to)
 - Assessment
 - Detox
 - Inpatient Substance Abuse/Alcohol Treatment
 - Outpatient Substance Abuse/Alcohol Treatment
 - Women & Children Substance Abuse/Alcohol Treatment
 - Aftercare
 - 12 Step
- On-going parenting education and support
- Transportation
- Individual/Family/Marriage therapy
- Family Group Decision Making (see Appendix H)
- Family Violence Resources
- Mental Health Evaluations and Services
 - Psychological
 - Psychiatric
- Employment/GED

- Job training
- Parenting Classes
- Housing

RECOMMENDED RESOURCES

These have been identified as some of the additional resources that would assist families during this process. This should not be considered as an exhaustive list.

- Concrete Services money or resources
 - Assistance with rent, utilities, etc.
 - Food banks
 - Housing needs – beds, furniture, etc.
- Extra curricular activities for children
 - Scholarships for sports
 - Scouts
 - Dance classes
 - Summer camps
 - Vacations

RECOMMENDED INCENTIVES AND SANCTIONS

- Incentives for parents Rewards (some examples)
 - Gift cards
 - Restaurants
 - Discount stores (Target, Wal-Mart)
 - Movie tickets
 - Verbal praise
 - Rocks handed out as milestones are reached with words of encouragement on them
 - Sports tickets
 - Family outing events
- Sanctions (some examples)
 - Restrictions on associations or travel
 - Community service
 - Home work or writing exercises
 - Increased treatment sessions or court appearances
 - Increased drug testing
 - Delay in moving up in program or graduation
 - Removal from FDTC program
 - Some courts utilize jail time as a sanction for relapse or failure to follow a case plan – this is a decision each court will need to make

APPENDIX H

FAMILY GROUP DECISION MAKING

FGDM emphasizes the family's responsibility to not only care for, but to provide a sense of identity for their children. It encourages families to connect with their communities and for the communities to support their families.

The FGDM practice is family-centered, family strength-oriented, culturally relevant and community based. The practice centers on a family meeting in which the children's and family's needs are discussed. First consideration is given to the family's needs in regard to timing, location, inclusion of extended family, and respect for cultural uniqueness.

FGDM coordinators and facilitators must remain independent as they carry out their coordination and facilitation responsibilities. Their detachment and objectivity helps to ensure a fair process, gain a family's willingness to participate in the process and enhance the family's ability to trust a system that they may view with suspicion.

Part of the coordination process involves determining and inviting participants. The parents own the decision to identify who are the important people in the life of their child. They are invited to create a list of extended blood relatives, as well as fictive kin, teachers, pastors, church members, and others that provide support for and are involved in decision-making with the family. FGDM staff discuss the family situation, the concerns regarding the safety of the children, the process of the FGDM conference and their role as a participant, then contacts potential conference participants. Along with the parents, the participants sign and agree to abide by a confidentially agreement.

APPENDIX I

COURT SYSTEMS AND TIMELINES

FAMILY DRUG TREATMENT COURTS

What is a Family Drug Court?

Family Drug Courts are often called Family Drug Treatment Courts and in other states they are sometimes called Family Dependency Treatment Courts. The following definition of a Family Drug Court is an excerpt from *Painting the Current Picture: A National Report Card on Drug Courts and other Problem-Solving Courts in the United States*, National Drug Court Institute, May 2005.

Family Drug Court (or Family Drug Treatment Court): Family dependency treatment court is a juvenile or family court docket of which selected abuse, neglect, and dependency cases are identified where parental substance abuse is a primary factor. Judges, attorneys, child protection services, and treatment and other social and public health personnel unite with the goal of providing safe, nurturing, and permanent homes for children while simultaneously providing parents the necessary support and services to become drug and alcohol abstinent. Family dependency treatment courts aid parents in regaining control of their lives, ensure the provision of necessary services for children, and promote long term stabilized recovery to enhance the possibility of family reunification within mandatory legal timeframes (Wheeler & Siegerist, 2003).

All Family Drug Treatment Courts are not identical. A Family Drug Treatment Court typically consists of:

- Court Coordinator who serves as the “clearinghouse” and central case management person for the judge.
 - Reviews information from all sources: CPS, Substance Abuse Treatment Provider, Attorney and Guardian Ad Litem/CASA and the family
 - Provides the court with a briefing on each family prior to their initial appearance in court
- Family Drug Treatment Court Judge
 - Presides over the Family Drug Treatment Court cases
 - Conducts all proceedings related to the families compliance with treatment including imposition of sanctions
 - Reviews progress with the family during court hearings
- Family Court Judge
 - Conducts CPS court hearings related to placement and permanency
 - Refers families to Family Drug Treatment Court
 - In some areas, the judge will preside over both the CPS proceedings and the Family Drug Treatment Court case

However, communities take the core concepts of a Family Drug Treatment Court and individualize the components to suit the communities’ needs. Some examples of how Family Drug Treatment Courts and CPS dockets include:

- One judge will hear the Family Drug Treatment Court case and another judge will hear the Child Protective Services (CPS) case
- One judge will hear both the Family Drug Court case as well as the CPS case. In this scenario, the hearings are usually held separate from one another

Both of the examples provided above can be successful. No specific model has proven to be more effective than another. Communities need to develop systems that will work best with their resources.

There are FDTCs in other states that have had significant success – particularly Sacramento County, California and Washoe County, Nevada. More information is available on each through their websites. For Sacramento County, go to <http://www.saccourt.com/juvenileDep/genInfo/genInfo.asp#3>. For information on the Sacramento County evaluation, go to http://www.cffutures.org/aod_policy/sacramento_county_dependency.shtml. For Washoe Co, go to http://www.washoecourts.com/index.cfm?page=special_drug.

Child Protection Courts (Cluster Courts)

The Child Protection Courts, also referred to as Cluster Courts, are specialized dockets that consist of substitute care and child protective services cases that are originally filed in the district and statutory county courts and are heard by associate or visiting judges. The Child Protection Courts were conceived as a means of allowing judges who specialize in child abuse and neglect cases to ride circuit to hear these types of cases in clusters of primarily rural counties.

The concept of using associate judges to hear substitute care and child protective services cases was first implemented by the Supreme Court Task Force on Foster Care through the Court Improvement Project (“CIP”), a federally-funded grant to the Supreme Court of Texas designed to improve judicial handling of child abuse and neglect cases. CIP funded two cluster courts pilot projects to hear child protective services cases exclusively, and contracted with participating counties to reimburse them for the costs of the project. Under the pilot project, the cluster courts were staffed by county employees.

There are currently fifteen Child Protection Courts serving 123 counties. They are staffed with twelve associate judges, three assigned (or “visiting”) judges, nine court coordinators, five court reporter/court coordinators, and one court reporter. All of the associate judges and the support staff are employees of the Office of Court Administration; the assigned judges are not.

APPENDIX J

EVALUATION

TEXAS PARTNERSHIP FOR FAMILY RECOVERY EVALUATION DESIGN

The Texas Partnership for Family Recovery has developed the evaluation design at the end of this appendix to measure its progress in achieving integrated services for families

In addition, the Sacramento County, California, Dependency Drug Court (DDC) has been engaged in an extensive, long term evaluation of their efforts. The Sacramento DDC operates parallel to the dependency case proceedings, which are conducted on a regular family court docket. The Texas Partnership evaluation design is based largely on the Sacramento County experience since 2001.

Based upon the Texas Partnership evaluation plan, the following are examples of evaluation questions and design for consideration in setting up an evaluation design for integrated services.

DATA EVALUATION

Research Questions:

1. What are the Child Protective Services (CPS), Substance Abuse (DSHS), Office of Court Administration (OCA) and county Family Court (FC), and Family Drug Treatment Court (FDTC) systems' statistics regarding client flow, caseload demographics, and trends?
 - a. DSHS: BHIPS intake, services & discharge data including follow-up.
 - b. CPS: Case tracking information
 - c. COURT: Rural Cluster Court data management system. To be developed for courts in roll-out sites.
 - d. TX CASA: services provided, numbers served
2. To what extent do the various systems (DSHS, CPS) provide timely access to assessments and treatment referrals?
 - a. DSHS: Outreach, Screening & Referral (OSAR) data plus agency waiting lists.
3. What is the length of time that clients are involved in the various service systems?
 - a. CPS: Case tracking.
 - b. DSHS: BHIPS screening, assessment, waiting list, admission, discharge & follow-up data.
 - c. COURT: First & final orders.
 - d. TX CASA: Case tracking/service reports
4. Are service patterns differentiated by key client variables including race/ethnicity and gender?
 - a. DSHS: BHIPS provides racial, ethnic, gender, age, legal, medical, mental health, family, drug history & other data which can be correlated with service type (prevention, intervention, detox, outpatient, residential services).
 - i. BHIPS referral & follow-up data on support services: education, employment, housing, childcare, etc.
 - b. CPS: Compare family variables by category: in-home family support services vs. child placement can be done.
 - c. COURT: Case outcomes.
 - d. TX CASA: Client reports

5. What are the family demographics among integrated service participating families (e.g., age of children and adults, ethnicity, education, employment status, etc.)?
 - a. DSHS: All BHIPS data sources.
 - b. CPS: Case file tracking.
 - c. TX CASA: Client files
6. What are the contributing factors in the case (e.g., legal status, mental illness, homelessness, etc.)?
 - a. DSHS: BHIPS assessment data.
 - b. CPS: Case assessment and service data.
7. What are the alcohol and drug use factors of integrated service clients at the initial assessment?
 - a. DSHS: BHIPS screening & assessment plus admission data.
 - b. CPS: Case assessment data.

Primary Impact Questions Include:

Case Management and Alcohol and Drug Treatment

1. What is the time between the initial hearing and participation in the various aspects of the integrated system (e.g., CPS assessment, OSAR, AOD treatment entry) and comparison clients?
 - a. DSHS: Track BHIPS data for integrated service sites and identified comparison courts & communities.
 - b. CPS: Case tracking for integrated service sites and identified comparison courts.
 - c. COURT: Compare cases for integrated service sites with identified comparison courts.
2. How long do integrated service and comparison clients remain in SA treatment?
 - a. DSHS: BHIPS data.
3. What are the AOD treatment completion and drop out rates for integrated service and comparison clients?
 - a. DSHS: BHIPS data.
4. What are the toxicology screen results for integrated service and comparison clients?
 - a. DSHS: BHIPS for programs providing toxicology screens
 - b. CPS: Case tracking
 - c. COURT: Court files.
5. What are the compliance rates of integrated service and comparison clients (e.g., court appearances, required services, toxicology screens)?
 - a. CPS: Case tracking.
 - b. COURT: Court records. Rural Cluster Courts data system.

Child Protective Services: From Case Tracking data

1. How many placement changes will children of integrated service and comparison clients have before a permanent plan has been developed?
2. What is the length of stay in out-of-home care for integrated service and comparison children?
3. What is the percentage of family reunifications, adoptions, guardianships, long term foster care placements, and foster care re-entries for integrated and comparison families?
4. Among families that reunify, what is the timing to family reunification for integrated and comparison families?

TX CASA:

- I. Do families receiving integrated services and TX CASA volunteer or Guardian ad litem services have higher rate of reunification ?

Dependency Court:

- I. Is there a difference in the rate of cases that meet the statutory timelines for permanency between integrated service and comparison groups?

Primary State Level Cost Questions Include:

- I. What is the estimated total investment in treatment, CPS and court expenses as compared to the total monetary value of outcomes for the integrated program and standard interventions?
 - a. Office of Court Administration to develop cost estimation formula for: legal & judicial time, space, etc.
 - b. DSHS: BHIPS data on LOS, treatment outcomes, readmissions
 - c. CPS: Foster care and related savings

Local Cost Questions:

- I. What is the estimated total investment in treatment, foster care, and court expenses as compared to the total monetary value of outcomes for the integrated program and standard interventions?
 - a. CPS foster care costs compared: Integrated Service families and those not receiving integrated services
 - b. Substance abuse providers: LOS, cost of stay and outcomes
 - c. Other as identified by local participants

PROCESS EVALUATION:

The design of the Process Evaluation should:

- Be integrated with Protocols, Policies and Procedures to provide on-going quality assurance.
- Be designed to quickly identify gaps with particular focus on client flow, engagement & retention.
- Include an “historical” documentation for planning & development purposes.
- Strategies should include:
 - Meet regularly with Judges:
 - Review identified problems and gaps
 - Obtain input regarding what client progress information they need for case action and termination
 - Regular review of time period between initial referral for screening & assessment and access to services.
 - Number of persons referred for treatment who enter a program
 - Engagement and retention
 - Analysis of engagement and retention to identify when and why families may relapse, leave services or otherwise be non compliant
 - Impact and role of TX CASA services on case outcomes
 - Collateral services needed
 - Collateral services accessed
 - Client satisfaction surveys and interview feedback (model surveys being developed)

APPENDIX K

MARKETING AND SUSTAINABILITY

First Principle: Never come to the table empty handed

Budgeting for, and funding of, an integrated services system or Family Drug Treatment Court will require close cooperation and ingenuity. Planning must include immediate, intermediate and long-term funding. For instance, local or state grant funds may be available to start a court. Such funds, however, generally are not permanent and, eventually, on-going local and state funds will be required. New dollars require either establishing a new tax or fee or the redirection of current funds from existing resources. A close analysis of local budgets, along with strategies to leverage or coordinate funds and services should be an on-going central piece of planning. Nationally, some local courts require the participant to pay a fee for participation in a drug court. Fees appear to be more commonly used in criminal drug courts than in family drug treatment courts.

At the state level, there are a range of federal funds that can cover services to address substance abuse and related disorders. (See Appendix L). However, the fact that a service type is allowable does not mean that the Texas legislative budget authorizes expenditure on the particular service or service category. Further, attention must be paid to definitions. Case management, for instance, is allowable in many federal sources but service definitions or components are not uniform across agencies or grants.

All integrated services systems or family drug treatment courts operate most efficiently if there is one person who acts as the conduit of information between the judge and the service agencies. This position is described as the court coordinator. Job responsibilities include case management, service coordination, information gathering, and fact checking along with case admission and assignment. While the ideal is to have funds to hire someone for this position, for planning purposes research the following strategies and resources to identify what you have and can do to “make it happen:”

- I. Is there a local agency or group of agencies that can assign a full or part-time person as court coordinator:
 - a. A local agency or group of agencies may have a client base that will be best served by a family drug treatment court.
 - i. If so, reassignment of staff resources may be both cost effective and improve client outcomes.
 - ii. Local agency may have underutilized program funds that can be assigned to a family drug treatment court.
 - iii. Can this position be shared between two or more persons?
 - iv. Agency or agencies may have contractual or other mandates that promote or require active participation in Family Drug Treatment Courts.
 - v. Canvas and review resources of: substance abuse treatment agencies, OSAR’s, CPS offices and MHMR centers.
 - vi. Are there community volunteers or paraprofessionals that can be utilized to help support clients and reduce workload of a case coordinator.
2. Review staff: family ratios:
 - a. Minimum and maximum number of families per court.
 - i. Analyze the cost efficiency of a half-time and a full time court coordinator and court.

1. What are the maximum & minimum numbers of families for a full or part-time court?
2. Can forms, formats and procedures be implemented that will increase the number served through efficiency of information dissemination and coordination?
3. Other costs:
 - a. Urine testing: who, how much & when
 - b. Office supplies
 - i. Is this a cost that can be shared by participating agencies?
 - ii. If supplies to be purchased, which agency has the best purchasing power?
 - c. Office space
 - i. Can this be “donated?”
 1. Does the County or another agency have a match requirement that can be met through provision of space?
 2. Is there available space that can be utilized at no cost?
 - d. Equipment
 - ii. Can care coordinator utilize existing phone, copying and computer equipment

Leveraging, sharing and reassignment of personnel and resources will demonstrate the ability and commitment to service coordination and integration of the planning group. This, in turn, ensures both cost efficiencies and provides solid justification when requesting funds from public or private sources. That is, identify integrated funding match capabilities before asking outside sources for dollars.

Second Principle: Good data is essential

For marketing, proposal writing, budgeting and policy impact purposes always provide current data on: how many have been served, who they are, what services were provided and the outcomes for the families. Evaluation reports on impact, outcome and fiscal impact are the foundation for long-term financial support and sustainability.

The implementation of universal basic evaluation questions, data sources and measures will provide a base for state level aggregate data for planning and policy purposes. Local implementation of universal basic evaluation plans and systems will provide court specific information for comparative analysis with other courts and quality improvement as well as local marketing, policy development and planning. During planning and start up gather your background data: number of families with substance abuse and related problems, outcomes of those families, demographics on all family members including age, gender, employment, education, presenting drug, race and ethnicity. This data describes who will and do serve.

Demographic data is the foundation for process evaluation, quality improvement, outcome and impact evaluation. Demographics will identify who the program best impacts, procedural problems, and points where families drop out, relapse or fail to move forward. Review the model data based evaluation plan provided in Appendix J and define local evaluation needs and resources, including:

- Identifying data sources and persons responsible for recording and reporting the data
- Establishing guidelines and procedures to review data and process information
- Establishing guidelines and procedures for local data sharing
- Identifying the person(s) responsible for compiling data and providing reports to state and local level entities

- Establishing your cross system quality improvement team
- Develop procedures for team to provide feedback and direction to each system and across systems

Principle Three: Marketing is never-ending and all inclusive:

Marketing is an on-going, continuous process of informing, educating, selling and engaging the public, service providers, policy makers, judges, lawyers, CPS, TX CASA and, most importantly, families. Marketing is really to targeted groups and audiences and includes web sites, brochures and fliers. Include schools, Workforce Centers, doctors' offices and hospitals. Initiate reports to County Commissioners and invite key persons to an information briefing.

Try to maintain a constant level of community awareness. Intermittent public information via the media will not have the same impact on policy makers, fund sources, families, agencies or courts as a steady stream of information. Make the family drug treatment court an institution and a community wide effort.

1. Develop a name for your group and court
 - a. Adopt vision and mission
 - b. Adopt guiding principles
2. Develop brochures, web page, parent information manual and other marketing materials
 - a. Disseminate marketing materials
 - b. Review and update materials bi-annually

Principle Four: Be transparent.

Be open and honest with everyone, including the families, about mistakes, barriers, and gaps. Treatment and recovery require honesty on the part of the client and the provider – so does the quality and success of your family drug treatment court. Building in honesty and open discussion of problems and mistakes will improve client engagement and retention as well as outcomes. Utilize process evaluation to identify and track resolution of problems and barriers.

Adopt “no blame and no shame” policy that includes all participants and systems.

- Conduct case review and problem identification analysis on a review of 30 or 60 day closed cases.
 - Are there service differences between reunified families and those who dropped out or were dropped?
 - If so – what are those differences?
 - Timing of drop-out: is there a point at which most drop outs occur?
 - Is there a greater loss related to any one service gap?
 - What services do all families receive?

APPENDIX L

KEY WEBSITES

National Center on Substance Abuse & Child Welfare: <http://www.ncsach.samsha.gov>

National Association of Drug Court Professionals: <http://www.nadcp.org>

National Clearinghouse of Drug & Alcohol Information: <http://www.ncadi.gov>

Administration for Children & Families: <http://www.acf.hhs.gov>

Substance Abuse & Mental Health Administration: <http://www.samsha.gov>

FAS Center for Excellence: <http://www.fasdcenter.samhsa.gov/publications/cost.cfm>

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APPENDIX M

Legislation and Policy Information

H.B. No. 530

AN ACT

relating to the operation and funding of drug court programs.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 469.001, Health and Safety Code, is amended to read as follows:

Sec. 469.001. DRUG COURT PROGRAM DEFINED; PROCEDURES FOR CERTAIN DEFENDANTS. (a) In this chapter, "drug court program" means a program that has the following essential characteristics:

- (1) the integration of alcohol and other drug treatment services in the processing of cases in the judicial system;
- (2) the use of a nonadversarial approach involving prosecutors and defense attorneys to promote public safety and to protect the due process rights of program participants;
- (3) early identification and prompt placement of eligible participants in the program;
- (4) access to a continuum of alcohol, drug, and other related treatment and rehabilitative services;
- (5) monitoring of abstinence through weekly alcohol and other drug testing;
- (6) a coordinated strategy to govern program responses to participants' compliance;
- (7) ongoing judicial interaction with program participants;
- (8) monitoring and evaluation of program goals and effectiveness;
- (9) continuing interdisciplinary education to promote effective program planning, implementation, and operations; and
- (10) development of partnerships with public agencies and community organizations.

(b) If a defendant successfully completes a drug court program, regardless of whether the defendant was convicted of the offense for which the defendant entered the program or whether the court deferred further proceedings without entering an adjudication of guilt, after notice to the state and a hearing on whether the defendant is otherwise entitled to the petition and whether issuance of the order is in the best interest of justice, the court shall enter an order of nondisclosure under Section 411.081, Government Code, as if the defendant had received a discharge and dismissal under Section 5(c), Article 42.12, Code of Criminal Procedure, with respect to all records and files related to the defendant's arrest for the offense for which the defendant entered the program if the defendant:

- (1) has not been previously convicted of a felony offense; and
- (2) is not convicted for any other felony offense before the second anniversary of the defendant's successful completion of the program.

(c) Notwithstanding Subsection (b), a defendant is not entitled to petition the court for an order of nondisclosure following successful completion of a drug court program if the defendant's entry into the program arose as the result of a conviction for an offense involving the operation of a motor vehicle while intoxicated.

SECTION 2. Section 469.002, Health and Safety Code, is amended to read as follows:

Sec. 469.002. AUTHORITY TO ESTABLISH PROGRAM. The [commissioners court of a county or governing body of a municipality may establish the following types of [a] drug court programs:

(1) drug courts for persons arrested for, charged with, or convicted of:

(A) an offense in which an element of the offense is the use or possession of alcohol or the use, possession, or sale of a controlled substance, a controlled substance analogue, or marihuana; or

(B) an offense in which the use of alcohol or a controlled substance is suspected to have significantly contributed to the commission of the offense and the offense did not involve:

(i) carrying, possessing, or using a firearm or other dangerous weapon;

(ii) the use of force against the person of another; or

(iii) the death of or serious bodily injury to another;

(2) drug courts for juveniles detained for, taken into custody for, or adjudicated as having engaged in:

(A) delinquent conduct, including habitual felony conduct, or conduct indicating a need for supervision in which an element of the conduct is the use or possession of alcohol or the use, possession, or sale of a controlled substance, a controlled substance analogue, or marihuana; or

(B) delinquent conduct, including habitual felony conduct, or conduct indicating a need for supervision in which the use of alcohol or a controlled substance is suspected to have significantly contributed to the commission of the conduct and the conduct did not involve:

(i) carrying, possessing, or using a firearm or other dangerous weapon;

(ii) the use of force against the person of another; or

(iii) the death of or serious bodily injury to another;

(3) reentry drug courts for persons with a demonstrated history of using alcohol or a controlled substance who may benefit from a program designed to facilitate the person's transition and reintegration into the community on release from a state or local correctional facility;

(4) family dependency drug treatment courts for family members involved in a suit affecting the parent-child relationship in which a parent's use of alcohol or a controlled substance is a primary consideration in the outcome of the suit; or

(5) programs for other persons not precisely described by Subdivisions (I)-(4) who may benefit from a program that has the essential characteristics described by Section 469.001.

SECTION 3. Section 469.003, Health and Safety Code, is amended to read as follows:

Sec. 469.003. OVERSIGHT. (a) The lieutenant governor and the speaker of the house of representatives may assign to appropriate legislative committees duties relating to the oversight of drug court programs established under this chapter

(b) A legislative committee or the governor may request the state auditor to perform a management, operations, or financial or accounting audit of a drug court program established under this chapter (c) A drug court program established under this chapter shall:

(1) notify the criminal justice division of the governor's office before or on implementation of the program; and

(2) provide information regarding the performance of the program to the division on request.

SECTION 4. Section 469.004, Health and Safety Code, is amended to read as follows:

Sec. 469.004. FEES. (a) A drug court program established under this chapter may collect from a participant in the program:

(1) a reasonable program fee not to exceed \$1,000[and

(2) an alcohol or controlled substance testing, counseling, and treatment fee[;

in an amount necessary to cover the costs of the testing, counseling, and treatment.

(b) Fees collected under this section may be paid on a periodic basis or on a deferred payment schedule at the discretion of the judge, magistrate, or program director administering the program. The fees must be:

- (1) based on the participant's ability to pay; and
- (2) used only for purposes specific to the program.

SECTION 5. Section 469.006, Health and Safety Code, is amended to read as follows:

Sec. 469.006. PROGRAM IN CERTAIN COUNTIES MANDATORY. (a) The commissioners court of a county with a population of more than 200,000 shall establish a drug court program under Subdivision (1) of Section 469.002.

A county required under this section to establish a drug court program shall apply for federal and state funds available to pay the costs of the program. The criminal justice division of the governor's office may assist a county in applying for federal funds as required by this subsection

(c) Notwithstanding Subsection (a), a county is required to establish a drug court program under this section only if the county receives federal or state funding, including funding under Article 102.0178, Code of Criminal Procedure, specifically for that purpose.

(d) A county that does not establish a drug court program as required by this section and maintain the program is ineligible to receive from the state:

- (1) funds for a community supervision and corrections department; and
- (2) grants for substance abuse treatment programs administered by the criminal justice division of the governor's office.

SECTION 6. Section 469.007, Health and Safety Code, is amended to read as follows:

Sec. 469.007. USE OF OTHER DRUG AND ALCOHOL AWARENESS PROGRAMS. In addition to using a drug court program established under this chapter, the commissioners court of a county or a court may use other drug awareness or drug and alcohol driving awareness programs to treat persons convicted of drug or alcohol related offenses.

SECTION 7. Chapter 469, Health and Safety Code, is amended by adding Sections 469.0025, 469.005, 469.008, and 469.009 to read as follows:

Sec. 469.0025. ESTABLISHMENT OF REGIONAL PROGRAM. (a) The commissioners courts of three or more counties, or the governing bodies of three or more municipalities, may elect to establish a regional drug court program under this chapter for the participating counties or municipalities.

(b) For purposes of this chapter, each county or municipality that elects to establish a regional drug court program under this section is considered to have established the program and is entitled to retain fees under Article 102.0178, Code of Criminal Procedure, in the same manner as if the county or municipality had established a drug court program without participating in a regional program.

Sec. 469.005. DRUG COURT PROGRAMS EXCLUSIVELY FOR CERTAIN INTOXICATION OFFENSES.

(a) The commissioners court of a county may establish under this chapter a drug court program exclusively for persons arrested for, charged with, or convicted of an offense involving the operation of a motor vehicle while intoxicated.

(b) A county that establishes a drug court program under this chapter but does not establish a separate program under this section must employ procedures designed to ensure that a person arrested for, charged with, or convicted of a second or subsequent offense involving the operation of a motor vehicle while intoxicated participates in the county's existing drug court program.

Sec. 469.008. SUSPENSION OR DISMISSAL OF COMMUNITY SERVICE REQUIREMENT. (a) Notwithstanding Sections 13 and 16, Article 42.12, Code of Criminal Procedure, to encourage participation in a drug court program established under this chapter, the judge or magistrate administering the program may suspend any requirement that, as a condition of community supervision, a participant in the program work a specified number of hours at a community service project or projects.

(b) On a participant's successful completion of a drug court program, a judge or magistrate may excuse the participant from any condition of community supervision previously suspended under Subsection (a).

Sec. 469.009. OCCUPATIONAL DRIVER'S LICENSE. Notwithstanding Section 521.242, Transportation Code, if a participant's driver's license has been suspended as a result of an alcohol-related or drug-related enforcement contact, as defined by Section 524.001, Transportation Code, or as a result of a conviction under Section 49.04, 49.07, or 49.08, Penal Code, the judge or magistrate administering a drug court program under this chapter may order that an occupational license be issued to the participant. An order issued under this section is subject to Sections 521.248-521.252, Transportation Code, except that any reference to a petition under Section 521.242 of that code does not apply.

SECTION 8. Subchapter A, Chapter 102, Code of Criminal Procedure, is amended by adding Article 102.0178 to read as follows:

Art. 102.0178. COSTS ATTENDANT TO CERTAIN INTOXICATION AND DRUG CONVICTIONS. (a) In addition to other costs on conviction imposed by this chapter, a person shall pay \$50 as a court cost on conviction of an offense punishable as a Class B misdemeanor or any higher category of offense under:

- (1) Chapter 49, Penal Code; or
- (2) Chapter 48I, Health and Safety Code.

(b) For purposes of this article, a person is considered to have been convicted if:

- (1) a sentence is imposed; or
- (2) the defendant receives community supervision or deferred adjudication.

(c) Court costs under this article are collected in the same manner as other fines or costs. An officer collecting the costs shall keep separate records of the funds collected as costs under this article and shall deposit the funds in the county treasury, as appropriate.

(d) The custodian of a county treasury shall:

- (1) keep records of the amount of funds on deposit collected under this article; and

(2) except as provided by Subsection (e), send to the comptroller before the last day of the first month following each calendar quarter the funds collected under this article during the preceding quarter.

(e) A county is entitled to:

(1) if the custodian of the county treasury complies with Subsection (d), retain 10 percent of the funds collected under this article by an officer of the county during the calendar quarter as a service fee; and

(2) if the county has established a drug court program or establishes a drug court program before the expiration of the calendar quarter, retain in addition to the 10 percent authorized by Subdivision (1) another 50 percent of the funds collected under this article by an officer of the county during the calendar quarter to be used exclusively for the development and maintenance of drug court programs operated within the county.

(f) If no funds due as costs under this article are deposited in a county treasury in a calendar quarter, the custodian of the treasury shall file the report required for the quarter in the regular manner and must state that no funds were collected.

(g) The comptroller shall deposit the funds received under this article to the credit of the drug court account in the general revenue fund to help fund drug court programs established under Chapter 469, Health and Safety Code. The legislature shall appropriate money from the account solely to the criminal justice division of the governor's office for distribution to drug court programs that apply for the money.

(h) Funds collected under this article are subject to audit by the comptroller.

SECTION 9. Chapter 54, Government Code, is amended by adding Subchapter GG to read as follows:

SUBCHAPTER GG. MAGISTRATES FOR DRUG COURT PROGRAMS

Sec. 54.1801. DEFINITION. In this subchapter, "drug court" has the meaning assigned by Section 469.001, Health and Safety Code.

Sec. 54.1802. APPLICABILITY OF SUBCHAPTER. This subchapter applies to each district court and statutory county court with criminal jurisdiction in this state. If a provision of this subchapter conflicts with a specific provision for a particular district court or statutory county court, the specific provision controls.

Sec. 54.1803. APPOINTMENT. (a) The judges of the district courts of a county hearing criminal cases and the judges of the statutory county courts with criminal jurisdiction in a county, with the consent and approval of the commissioners court of the county, may appoint the number of magistrates set by the commissioners court to perform the duties associated with the administration of drug courts as authorized by this subchapter.

(b) Each magistrate's appointment must be made with the approval of the majority of the district court or statutory county court judges described in Subsection (a), as applicable.

(c) A magistrate appointed under this section serves at the will of a majority of the appointing judges.

Sec. 54.1804. QUALIFICATIONS. A magistrate must:

(1) be a resident of this state and of the county in which the magistrate is appointed to serve under this subchapter; and

(2) have been licensed to practice law in this state for at least four years.

Sec. 54.1805. COMPENSATION. A magistrate is entitled to the salary determined by the county commissioners court.

Sec. 54.1806. JUDICIAL IMMUNITY. A magistrate has the same judicial immunity as a judge of a district court or statutory county court appointing the magistrate.

Sec. 54.1807. PROCEEDINGS THAT MAY BE REFERRED. (a) A district judge or judge of a statutory county court with criminal jurisdiction may refer to a magistrate a criminal case for drug court proceedings.

(b) A magistrate may not preside over a contested trial on the merits, regardless of whether the trial is before a jury.

Sec. 54.1808. ORDER OF REFERRAL. (a) To refer one or more cases to a drug court magistrate, a district judge or judge of a statutory county court with criminal jurisdiction must issue an order of referral specifying the magistrate's duties.

(b) An order of referral may:

(1) limit the powers of the magistrate and direct the magistrate to report on specific issues and perform particular acts;

(2) set the time and place for the hearing;

(3) provide a date for filing the magistrate's findings;

(4) designate proceedings for more than one case over which the magistrate shall preside; and

(5) set forth general powers and limitations of authority of the magistrate applicable to any case referred.

Sec. 54.1809. POWERS. Except as limited by an order of referral, a magistrate to whom a drug court case is referred may perform any act and take any measure necessary and proper for the efficient performance of the duties assigned by the district or statutory county court judge.

SECTION 10. Subchapter B, Chapter 102, Government Code, is amended by adding Section 102.0215 to read as follows:

Sec. 102.0215. ADDITIONAL COURT COSTS ON CONVICTION: CODE OF CRIMINAL PROCEDURE. A person convicted of an offense shall pay under the Code of Criminal Procedure, in addition to all other costs, costs attendant to convictions under Chapter 49, Penal Code, and under Chapter 48I, Health and Safety Code, to help fund drug court programs established under Chapter 469, Health and Safety Code (Art. 102.0178, Code of Criminal Procedure) ... \$50.

SECTION 11. (a) Except as otherwise provided by this section, the change in law made by this Act in amending Chapter 469, Health and Safety Code, applies to a defendant who enters a drug court program under Chapter 469, Health and Safety Code, regardless of whether the defendant committed the offense for which the defendant enters the program before, on, or after the effective date of this Act.

(b) The commissioners court of a county required under Section 469.006(a), Health and Safety Code, as amended by this Act, to establish a drug court program shall establish the program not later than the later of:

(1) September 1, 2008; or

(2) the first anniversary of the initial date on which the federal census indicates that the county's population exceeds 200,000.

(c) The change in law made by this Act in adding Article 102.0178, Code of Criminal Procedure, and Section 102.0215, Government Code, applies only to an offense committed on or after the effective date of this Act. An offense committed before the effective date of this Act is governed by the law in effect when the offense was committed, and the former law is continued in effect for that purpose. For purposes of this subsection, an offense was committed before the effective date of this Act if any element of the offense was committed before that date.

SECTION 12. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2007.

LEGISLATIVE BUDGET BOARD

Austin, Texas

FISCAL NOTE, 80TH LEGISLATIVE REGULAR SESSION

May 18, 2007

Estimated Two-year Net Impact to General Revenue Related Funds for HB530, As Passed 2nd House: an impact of \$0 through the biennium ending August 31, 2009.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2008	\$0
2009	\$0

2010	\$0
2011	\$0
2012	\$0

All Funds, Five-Year Impact:

Fiscal Year	Probable Revenue Gain/(Loss) from <i>New General Revenue Dedicated-Drug Court</i>	Probable (Cost) from <i>New General Revenue Dedicated-Drug Court</i>
2008	\$929,000	(\$929,000)
2009	\$2,258,000	(\$2,258,000)
2010	\$2,288,000	(\$2,288,000)
2011	\$2,317,000	(\$2,317,000)
2012	\$2,347,000	(\$2,347,000)

Fiscal Analysis

This bill would amend Chapter 469 of the Health and Safety Code to expand the definition of drug courts to allow other types of problem-solving courts to be established. These new problem-solving courts would include, but would not be limited to, DWI courts, juvenile drug courts, reentry drug courts, and family dependency drug courts. Currently, only counties have the authority to establish drug courts. The bill would also authorize municipalities to establish said programs.

The bill would establish the conditions and procedures for defendants' entry into drug court programs and the final disposition of cases. The bill would lower the population threshold for requiring the establishment of drug court programs in certain counties, provided those counties received federal or state funding for the programs. Currently, drug court programs are only mandatory in counties with a population over 550,000. This bill would reduce that threshold to more than 200,000 people as provided in Section 5 and would make the drug courts mandatory contingent upon funding.

Section I of the bill states that courts may enter an order of nondisclosure under Government Code 411.081 with respect to all records and files related to defendant's arrest for the offense for which the defendant entered the drug court program if the defendant: 1) has not been previously convicted of a felony; 2) does not get convicted for another felony offense in the two years after the completion of the drug court program.

This would allow anyone who has completed a drug court program to have the court give notice to the state and hold a hearing, and then enter an order of nondisclosure for all records relating to the offense that made them eligible for the drug court program. Under 469.002, drug court programs may include drug courts for persons arrested for, charged with, or convicted of an offense in which an element of the offense is the use or possession of a controlled substance, or marihuana. Therefore, a person convicted of possession of a controlled substance or marihuana can be placed in the drug court

program and upon completion of the program (if they have no prior felony or get convicted of a felony within 2 years), the person is eligible for the order of nondisclosure under 469.001(b). Nondisclosure would not apply to the issuance of a driver's license or for offenders who entered the program as a result of a DWI offense.

Section 3 requires drug court programs to notify the Criminal Justice Division (CJD) of the Governor's Office prior to or upon completion of implementation and to provide CJD with performance data on request.

Section 4 of the bill would authorize drug courts to impose, based on a defendant's ability to pay, additional local fees to support the programs. Judges, magistrates, or program administrators would have the discretion to allow defendants to pay the fees on a periodic basis or on a deferred payment schedule.

Section 7 of the bill adds a provision that allows three or more counties or municipalities to work together to establish a regional drug court program as opposed to requiring that each county establish individual drug court programs. The counties and municipalities participating in the regional drug court program would still retain 50 percent of the revenue generated by the \$50 fee, in addition to the 10% service fee.

Section 7 of the bill would also implement recommendations 1, 2 and 3 in the "Rehabilitate DWI Offenders and Conserve Prison Capacity by Creating More DWI Courts," report from the Legislative Budget Board's publication, *Texas State Government Effectiveness and Efficiency: Selected Issues and Recommendations*.

Provisions in Section 7 would amend Chapter 469 of the Health and Safety Code to statutorily recognize DWI courts and apply the existing requirements for drug courts to DWI courts. Some exceptions to the requirements would apply. Counties would have the option of accepting DWI offenders in their existing drug court programs or create a separate DWI court. All operating drug courts in counties without a separate DWI court would be required to serve DWI offenders in the drug court program.

As a way to encourage participation in the DWI court program, this bill would also amend Chapter 469 of the Health and Safety Code to give judges or magistrates administering the program the option to suspend any requirements as a condition of community supervision as it relates to community service hours. The bill provides that upon successful completion of the DWI court program, a judge or magistrate may excuse a participant from any conditions of community supervision as they relate to community service hours.

The bill would amend Chapter 469 of the Health and Safety Code to permit a presiding judge or magistrate of a drug court to order an occupational license as a condition of the program. An occupational license allows a participant to drive to and from designated points like work, court, and treatment meetings. Currently, under Section 521.242 of the Transportation Code, a defendant must file a separate civil petition for an occupational driver's license. Adding this provision to the Health and Safety Code would serve as an incentive to the participant who needs immediate access to a

vehicle to comply with regular court appearances and drug testing, and decrease the cost and time involved in obtaining the license.

Section 8 of the bill would amend Chapter 102, Subchapter A of the Code of Criminal Procedure to impose a new court cost of \$50 on the conviction of certain intoxication and drug offenses to be used to fund drug courts. The State would receive 40 percent of the \$50 fee, to be used to help fund drug court programs established under Chapter 469 of the Health and Safety Code. Counties would be allowed to retain 10 percent as a service fee, and an additional 50 percent of the revenue, if the county keeps record of the total amount collected and remits collections due to the state from this fee, on a quarterly basis, to the Comptroller. Counties would be allowed to use these funds to develop and maintain drug courts. Under Section 8, the Comptroller would be required to deposit and credit the funds to the newly created General Revenue-Dedicated Account—Drug Courts. The bill would direct the Legislature to appropriate revenue in the account to the Criminal Justice Division of the Governor's Office for distribution to applicable drug court programs. The bill would authorize the auditing of the court cost collections by the Comptroller.

Section 9 outlines the powers of a magistrate as they pertain to drug court programs.

Section 10 of the bill would make a conforming amendment to Subchapter B, Chapter 102 of the Government Code to revise the informational listing of court costs.

This bill would take effect immediately upon enactment, assuming that it received the requisite two-thirds majority votes in both houses of the Legislature. Otherwise, it would take effect September 1, 2007. The new court cost would not apply to offenses, in part or whole, committed before the effective date.

This bill would create a dedicated account in the General Revenue Fund, or create a dedicated revenue source. Therefore, the fund, account, or revenue dedication included in the bill would be subject to the funds consolidation review by the current Legislature.

Methodology

Currently, there are nine counties that fit the requirement of a population greater than 550,000. If the population threshold were reduced to over 200,000 people, 12 additional counties would be required to operate drug courts under this bill according to 2005 US Censuses Bureau population estimates. This would bring the total number of counties in Texas statutorily required to have drug courts up to 21.

The annual gain to the State would be \$929,000 in General Revenue-Dedicated Funds in fiscal year 2008 and \$2,258,000 in fiscal year 2009. The gain to the state was based on data from the Annual Statistical Report for the Texas Judiciary-Fiscal 2006 data on the number of convictions and deferred adjudications in three categories (Drug Sale or Manufacture, Drug Possession, and Felony D.W.I.). The total number of convictions is multiplied by the \$50 fee, multiplied by 40% (counties retain

60%), and multiplied by a collection rate of 60% for court costs as estimated by the Comptroller. In the first year, only 5 months will be collected because counties remit to the state each calendar quarter. This is reflected in the fiscal year 2008 revenue gain. The fiscal impact table assumes that all revenue collected in the newly created GR-D (Drug Court) account will be disbursed in the form of grants to counties interested in developing and operating drug court programs.

This newly generated revenue would be in addition to the current biennial \$1.5 million drug court funding available through the Criminal Justice Division of the Governor's Office. The additional revenues generated by the bill would allow the 21 courts to be funded at a higher level per court than is currently provided for the mandated courts.

This bill could potentially result in a cost savings to the State if more offenders are diverted from prison or state jail as a result of participating in drug court or other problem-solving court programs.

Local Government Impact

Local governments will see an increase in revenue due to the new \$50 court cost. This revenue may be used to develop and maintain the drug court programs or other problem-solving courts as defined in Chapter 469 of the Health and Safety Code. Counties will see a revenue gain estimated to be \$1,393,000 in fiscal year 2008 and \$3,387,000 in fiscal year 2009. This estimate assumes that all counties collecting the revenue will use it to develop and maintain drug court programs.

APPENDIX N

BIBLIOGRAPHY (under development)

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APPENDIX O

TEXAS PARTNERSHIP FOR FAMILY RECOVERY LEADERSHIP, CORE TEAM & ADVISORY COMMITTEE MEMBERS

EXECUTIVE TEAM MEMBERS

Honorable John Specia
Senior District Judge, Retired

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Texas Health and Human Services Commission

Joyce James
Assistant Commissioner, Child Protective Services
Texas Department of Family and Protective Services

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Becca Crowell
Executive Director
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