NCSACW Researchers Forum:
Developing Knowledge to Improve Outcomes for Families with Substance Use Disorders in the Child Welfare and Family Court Systems
December 10, 2003 – December 11, 2003

Summary of Proceedings

December 10, 2003, 9:00am – 12:30pm **Morning Plenary**

Presenters: Christine Grella, Ph.D., Research Psychologist, Integrated Substance Abuse Program University of California, Los Angeles.
Rick Barth, Ph.D., Frank A. Daniels Distinguished Professor for Human Services Policy Information University of North Carolina, School of Social Work.
Nancy Young, Ph.D., Children and Family Futures; Director, National Center on Substance Abuse and Child Welfare (NCSACW).

Dr. Christine Grella – Overview of Current Issues in Substance Abuse Treatment Research

The Researchers Forum began with Dr. Grella discussing current issues in substance abuse treatment research. She reported that research has provided the field with a good understanding of substance abuse treatment outcomes and how the substance abuse treatment system works. Dr. Grella discussed two key variables of concern in substance abuse treatment research: understanding patient profiles as they enter treatment (i.e., their motivation) and retention (i.e., is it less time in the community or a dynamic treatment process where changes take place?). Dr. Grella then presented the Evidence-Based Treatment Model, a generic model that can be adapted for special populations (e.g. women, parents).

Dr. Grella described how the Drug Abuse Treatment Outcome Study (DATOS) examined the question of whether participation in drug treatment affects child custody. This study found that treatment modality was one of the most important control variables affecting child custody. The DATOS study also found that having child custody issues was associated with being African American, having less than a high school degree, being referred by a community agency, receiving public assistance, having prior drug treatment (which is an indication of greater severity), being unemployed or on parole, having unstable shelter, current physical and/or sexual abuse, having multiple psychiatric disorders, and engaging in illegal activities. All of these indicate a greater need for intensive services.

Dr. Grella reported that despite these indications, less than half of treatment programs provide parenting and family services, domestic violence services, women's groups, pregnant/parenting services, and childcare. She said that these services were more likely to be provided in intensive programs (modalities) and gender specific programs. Dr. Grella also indicated that there are large gaps between services needed and received by women in substance abuse treatment, yet, a

greater a number of services received is associated with improved the outcomes, and completion of treatment has been found to lead to higher reunification rates.

Dr. Grella also discussed other studies of specialized substance abuse treatment for women which revealed that treatment retention is greater in women-only programs and in programs with greater concentrations of pregnant/parenting women. Treatment outcomes are improved in residential programs with live-in accommodations for children and in outpatient programs that provide comprehensive case management services. She also stated that while specialized treatment services are more costly, they have greater benefit-to-cost ratios.

Dr. Grella stated that, overall, research on substance abuse treatment effectiveness demonstrates reductions in alcohol and drug use, improvements in post-treatment functioning, longer time in treatment, and more intensive services lead to improved outcomes for pregnant/parenting women and children, and women involved with child welfare present a different profile at intake to substance abuse treatment.

Dr. Grella then discussed several service system issues, including access to treatment, service system co-ordination, and treatment intervention models. She stated that the structural barriers to treatment involve level of impairment, lack of treatment availability, and lack of coordinated services. She indicated that there have been positive indications for the use of motivational interventions and stages of change models. The recent hot topics include the shift from prenatal substance abuse and birth outcomes to care-giving environment after birth and child placement outcomes in relation to treatment participation, compliance and completion.

Finally, Dr. Grella discussed the need to talk about the conflicting mandates of the different systems (i.e., goals and timeframes), focusing on both the needs of the parents (recovery) and children (safety, placement) and the need to expand the definition of "outcomes" to include family functioning, examining outcomes in relation to services needed and received across service systems, and expanding the timeframe for evaluating outcomes.

Questions/Comments

- What kind of services would be provided for a woman paroling from prison after successfully completed treatment in prison? How would she go about getting her children back from child welfare?
- When are we measuring CW during treatment? You will get different answers depending on where the parent is in treatment.
- You are saying treatment outcomes are getting better, but this is coming at a time when there is less treatment available. You are saying more services means better outcomes, but in the gender specific studies, more services are provided. If men were getting more services, would they do better?
- What do we know about time to relapse in relation to the AFSA timelines?
- Some states do not have the funds to provide treatment and you are finding that treatment is following the money. This speaks to the need for specify the kind of treatment one would receive because the system is under siege.
- Women in treatment have a different profile, what is that?

Dr. Rick Barth – Overview of Current Issues in Child Welfare Services Research

Dr. Barth provided a discussion of current issues in child welfare services research. He reported that epidemiology counts vary by:

- Definition – 14% with substance abuse as primary reason for specialized foster care, 76% affected in some way by parental substance abuse, 79% of children in foster care with parental abuse
- Locale – urban vs. non-urban – most studies are in urban areas with broad definitions
- Where children are – 76% foster care, 79% foster care with parental substance abuse, 67% care and protection, 11% and 13% investigations

Dr. Barth then presented a study in which he stated that substance abuse is present in 50% of out of home care cases, 20% of in home child welfare cases, and 6% of in home closed cases. He stated that among infants there are higher rates of substance abuse problems among caregivers with children in out of home care, but this is opposite for children 11-years-old and older. Dr. Barth also reported that infants and 6-10 year olds have the highest rates of parental substance use compared to other age groups of children involved in the child welfare system.

Dr. Barth also reported that although 24% of caregivers had a positive alcohol or drug screen, only 4% met criteria for alcohol or drug dependence. He stated that best estimates of parental substance abuse range from 6.0% of in home care with no child welfare case to 46.1% in out of home care cases. Dr. Barth also stated that previous estimates of caregiver substance use should be changed because studies are dated, entry cohorts which may be changing, measurements may be improving, and estimates are now more inclusive of in home services. He also stated that when in home services are occurring, agreement between child welfare worker and caregiver at home regarding substance abuse problems is about 64.4%, indicating high sensitivity, but only 30.7% when no in home services are provided, indicating less specificity. Thus, in home child welfare services is thought to increase substance abuse detection. Dr. Barth also stated that child welfare services misclassifies dependent caregivers the majority of the time, with child welfare workers being about twice as likely to identify substance abuse problems when a case is open.

Finally, Dr. Barth discussed demographics differences between those who are dependent, screened, and no have no substance abuse problems (i.e., poverty, recent arrest, another supportive caregiver), and differences in child well-being scores. He stated that neglect and failure to provide cases are the majority of the child welfare cases they are seeing. Dr. Barth reported that caretaker substance abuse problems are more likely to be followed by termination of rights (about 10 months) and in shorter time periods than for children with non-drug-involved caregivers. Dr. Barth discussed CFSR findings which revealed that there is a low and wide range of child welfare cases involving parental substance abuse as a primary factor (not more than half the cases), although the poor quality of assessments was noted. He reported that that caretaker substance abuse was most associated with failure to provide and least associated with physical abuse, with 80% of caregivers self-reported to be substance dependent but reported not receiving services (at baseline) and a modest proportion still not receiving services at 12 months. Lastly Dr. Barth stated that caregivers with substance abuse problems are much more likely to receive substance abuse treatment services at baseline if their child welfare case is open.

Questions/Comments

- Have you looked at adverse complications, such as parental fatalities?
- What kind of services would be provided for a woman paroling from prison that has successfully completed treatment in prison? How would she go about getting her children back from child welfare?
- Do we know anything about the competencies of the workers (degrees, training)? Do they matter in his study?

Dr. Nancy Young – Highlights from the Retrospective Phase of the Cross-Site Evaluation of Family Drug Treatment Courts

Dr. Young explained that Family Drug Treatment Courts (FDTC) is a two part retrospective study using a comparison group made up of cases in the system that were not offered services or entering prior to FDTC implementation. National Poverty Center Research will continue to follow these groups so there will be 8 years of outcomes data in the future. Dr. Young reported that the FDTC study provided extensive documentation of its program model and looked at multiple types of outcome measures (engagement, retention, and completion, safety/permanency, timeliness). Each FDTC site has 50 cases, except San Diego which has an additional 50 Substance Abuse Recovery Management Specialist (SARMS) cases.

Dr. Young discussed the two distinct types of FDTC models: integrated (Jefferson, Reno, Santa Clara, Suffolk) and Two Tier (San Diego). The common components of the models were specific eligibility criteria, more timely access to substance abuse treatment (and with specialized providers), additional case management, more frequent/standardized reporting of substance abuse treatment participation and compliance, a team approach by child welfare and substance abuse treatment with more frequent case conferencing, defense bar cooperation in non-adversarial approach to substance abuse treatment and recovery access, and increased judicial oversight of case with more frequent court hearings.

Dr. Young reported that FDTC parents successfully completed treatment in shorter time, had less criminal and child protective services recidivism, participated in more intensive levels of treatment, and their children reunified more quickly. She stated that there were no differences in time of out of home care and type of child permanency.

Questions/Comments

- It looks like effects were not as robust for some of the permanency outcomes you hope to see. Were there cross site differences indicating that some of the programs were better in implementing them?
- It looked like there were time differentials. Were there differences between those who got into treatment earlier vs. those who took longer to enter treatment?
- To understand the permanency outcomes, there were a big proportion of the cases that were not yet closed and data collection is still continuing

- There were positive effects of remaining with parents. Over what period of time? Have you looked at the developmental needs (mental health, developmental problems) of children?
- Have you looked at adverse complications, such as parental fatalities?
- What kind of services would be provided for a woman paroling from prison that has successfully completed treatment in prison? How would she go about getting her children back from child welfare?
- How many were out of home placements, placed with relatives?
- Do we know anything about the competencies of the workers (degrees, training)? Do they matter in this study?
- Not clear that the number of graduates is huge. Is she misinterpreting it? What was the time period for the subsequent CPS investigations? You don't know the effect of the drug treatment court on subsequent investigations.

December 11, 2003, 1:45pm – 3:30pm **Panel Discussion on Evaluations of the Substance Abuse Title IV-E Waivers**

Moderator: Gail Collins, M.P.A., Senior Child Welfare Program Specialist, Children's Bureau

Presenters: Dennis McGrath, Ph.D., Research Associate, Schaefer Center for Public Policy, University of Baltimore
Dorothy Dillard, Ph.D., Consultant
Glenda Kaufman Kantor, Ph.D., Research Associate Professor, Crimes Against Children Research Center and Family Research Laboratory, University of New Hampshire
Mark Testa, Ph.D., Director, Children and Family Research Center, University of Illinois at Urbana Champaign

Gail Collins-Moderator

Ms. Collins began the afternoon session by briefly describing Title IV-E waivers. She stated that child welfare is a joint federal-state enterprise with states providing the legal framework and a great deal of the money. Ms. Collins reported that the largest pot of money is IV-E foster care, which reimburses states for keeping eligible children in foster care with the amount States receive is tied to Medicaid, depending on the wealth of the State. She said there are currently twelve demonstration projects, which can apply to use IV-E money in more flexible ways, but they have to be cost neutral to the federal government and they must be evaluated by an independent evaluator. Ms. Collins said that these demonstration projects cover topics including subsidized guardianship, flexible funding and innovative services as an intervention.

Dr. Dennis McGrath – Maryland.

Dr. McGrath explained that Maryland put together a proposal for women in danger of losing custody, in which they would receive team intervention. Intake workers would identify women with substance abuse problems and there would be immediate substance abuse treatment slots available for them to enter treatment. In the first month of the program, Dr. McGrath reported that they only received two referrals to the program. He said that they overestimated the ability of intake workers to identify substance abuse problems. Dr. McGrath stated that if the intake workers had a choice between identifying substance abuse or another problem, they went with the easier one. Dr. McGrath reported that Maryland also has a decentralization problem and a bureaucracy that is hard to negotiate through. He reported that the outcomes data regarding treatment status and children's placement was unreliable and that they need a better measurement system requiring an extensive remodeling involving 8 autonomous groups working within the state.

Dr. Dorothy Dillard – Delaware.

Dr. Dillard reported that Delaware has a mixed case: in federal government's eyes, the project did not meet its goals or cost neutrality, but on the state level there were a lot of successes. She stated that a substance abuse worker was assigned in Division of Family Services unit in each of the three counties to help link the parent with substance abuse treatment. Dr. Dillard stated that this role expanded during the life of the project to include assessment, counseling and working with families. She said that there was also a comparison unit in each county (on same floor), which led to contamination because the substance abuse counselor also inadvertently provided education and consultation to these units as well. She also stated that there was a quasi-random assignment of cases in which they tried to develop some matched cases by number of children and foster care status. Dr. Dillard reported that they conducted an extensive evaluation and cost analysis and found that the program only served about half as many families as expected because families needs and problems were so complex that they needed the services of the substance abuse counselor for two to three times as long as originally expected. She reported that there was some cost savings and some reduction in foster care days, however, they were unable to measure parent's ability to provide adequate care (a goal of the project) since they did not collect the information. Program results indicate that the effort to integrate the two systems was a success and the program increased line workers understanding of substance abuse problems.

Dr. Glenda Kaufman Kantor – New Hampshire

Dr. Kantor explained that standard services involve meeting with the family and deciding on an intervention using child protective services (CPS) and legal consultation. She stated that the enhanced services that were offered involved assessment of substance abuse at referral, and the CPS and LADC consultant team would then work with the family. Dr. Kantor stated that people awaiting treatment received individual counseling and on-going contact with LADC. For families receiving services, LADC participated in case planning, kept the focus on parent issues and aftercare, including treatment goals and parenting. She said that families were randomly placed in enhanced or standard services and that process and outcome measures were taken for evaluation purposes. Dr. Kantor reported that the initial goals of the program included better

assessment of parental substance abuse, improved risk assessment, strengthening ties with the treatment community, and a substance abuse role for consultants. In meeting these goals, the Substance Abuse Subtle Screening Inventory (SASSI) identified substance abuse associated with case substantiation and found that there was a higher substantiation rate at initial referral (fewer subsequent referrals, fewer placements and shortened placement length), contracting with treatment providers improved, and families were provided with assessment, psycho-education, interventions and case management.

Dr. Mark Testa – Illinois

Dr. presented recent findings from the Children and Family Research Center's (CFRC) independent evaluation of the Illinois Department of Children and Family Services (IDCFS) use of a Title IV-E waiver to fund Recovery Coaches. Dr. Testa stated that, in 1999, IDCFS requested a waiver to improve reunification and other family permanency and safety outcomes for children in foster care as a result of parental substance use disorders. Using funds from this waiver, IDCFS created Recovery Coach positions to provide parents in the child welfare system with a proactive case management plan that provides continual and aggressive outreach strategies to engage and retain parents in substance abuse treatment and recovery services. Dr. Testa reported that research on this approach supports the idea that increased levels of treatment engagement and treatment compliance are associated with faster rates of reunification. In this evaluation, he stated that CFRC was asked to look at the efficacy of Recovery Coach services relative to the regular substance abuse service option that would have been available in the absence of the IV-E waiver to determine if the service improved the safety, well-being and permanency of the children of parents participating in this program. CFRC evaluated the program by comparing outcomes between a control group with no access to Recovery Coach services and the experimental group that benefited from the regular substance abuse treatment services and the Recovery Coach services. Overall, the findings were not statistically significant. Testa reported that parents in the experimental group did appear to access substance abuse services at faster rates; however, no significant relationship could be identified between these services and children being reunified with their families at faster rates or spending less time in a foster care placement. Additionally, no significant findings were found between the numbers of cases reported to child protective services.

Dr. Testa noted that issues of containment in the design and implementation of the evaluation (which is not uncommon) and what is known about the adequate lengths of treatment required to treat chronic alcohol and drug use likely influenced these findings. He said these families are the most adversely affected by substance use and require the most time to recover, but yet are limited by the timeframes established by a dependency court. Dr. Testa also said that one interesting and unanticipated finding that is clear to him is that more needs to be done to engage court staff in treatment and progress of parents in recovery. He said that often judges are not seeing the entire picture and what they do learn about the case they feel cannot always be trusted.

December 10, 2003, 3:45pm – 5:15pm **Roundtable Topic Discussions**

Three peer-facilitated discussions were organized to clarify the knowledge base and identify the gaps in knowledge on these issues. The topics for discussion were prenatally exposed infants, assessing engagement and retention of parents in care, and using existing information systems to fill information gaps. Groups were asked to report to the larger Forum on the key points what "we know" from research and practice as well as the key things "we need to know" for knowledge development.

December 11, 2003, 8:30am – 10:00am **Feedback from Roundtable Discussion Groups**

Moderator: Nancy Young, Ph.D., Children and Family Futures; Director, National Center on Substance Abuse and Child Welfare (NCSACW).

Presenters: Kathleen Nardini, M.A., Senior AOD Research Analyst, National Association of State Alcohol and Drug Abuse Directors
Steve Hornberger, M.S.W., Director of Behavioral Health, Child Welfare League of America
Terry Cross, M.S.W., A.C.S.W., L.C.S.W., Executive Director, National Indian Child Welfare Association

Kathleen Nardini – Prenatally Exposed Infants

Ms. Nardini presented the following report from the discussion group on research issues regarding prenatally exposed infants:

Three things we know

1. Urine toxicology screen is a really bad way of determining if a child has been affected by prenatal exposure, or if mother is addicted/dependent on drugs or alcohol and should not be presumed to mean child abuse/neglect.
2. This is a complex issue in which alcohol, tobacco and other drug exposure is one factor combined with family environment, genetic predisposition, child welfare issues, trauma, etc. affecting higher executive functioning.
3. States that have used models where newborns who test positive for prenatal substance exposure are referred to public health nurses and other neutral providers have shown promise in addressing needs/providing services.

Things we need to know

1. What is the relationship between a positive toxicology report, addiction/dependence and child abuse/neglect?
2. How do we define well-being of the child and how do we determine the interventions that will improve child well-being?

3. Research the degree to which women are avoiding treatment and/or prenatal care for fear of losing their children and test interventions that increase prenatal engagement and retention in treatment.
4. How do you work with CWS to provide a neutral approach to prenatally exposed infants?
5. What kind of assessment strategies and tools are effective?
6. Research on impact of reunification and other placements on child well-being outcomes
7. What training/other interventions motivate providers to change their attitudes towards treatment and practice?
8. What organizational structures/policies allow for change in practice?

Feedback from Roundtable Report – What we know

The discussion participants stated that instead of urine screening, interviewing techniques should be used to determine risk of parental substance use, and those who show risk should be moved toward assessment. The participants noted that this is not to say that a urine screen is a bad thing, but rather that it should not be used alone. Furthermore, they stated that toxicologies do not detect alcohol, even though it is the most damaging drug to a fetus. They also noted the problem of trying to get people to use quantity/frequency tools. Another consideration is that most screening instruments were developed with White males, and thus do not work with other populations (e.g. women and minorities). The group recommended the use of Ira Chasnoff's 4Ps – Parent use, Partner use, Past use, Present Pregnancy (developed by Hope Ewing) – which uses 5 questions to identifying women at risk and can be used in a primary care setting. The problem with this instrument is that this only identifies risk and that a more specific assessment instrument would have to be used for assessment. The participants noted the need to look at different ways of screening and how to pair it with good available treatment.

The participants also stated that it is important to consider the role of health care professionals and the need to normalize the screening process by reducing the stigma by medical professionals. They noted the need to make health care providers do more before the woman becomes pregnant (note: Kaiser study in Journal of Perinatology has identified which has a cost effectiveness component on the importance of prevention). The participants discussed the problem of getting medical professionals to use screening tools and stated that giving screening tools is useful, but many medical practitioners do not how to use them. Training medical personnel thus becomes important. It was suggested that medical professionals should be given a "cheat sheet" about how to screen and assess for substance use. The participants also discussed that State welfare agencies need guidance about what to do after a child is born exposed. It was suggested that the National Center provide guidance about what to do (i.e., best practices) and when to do it. Several best practice models were identified. They include: Fresno, Kentucky is using the 4 P's process, New Jersey is doing statewide work, and California and Illinois have county public health nurses.

Feedback from Roundtable Discussion – What we need to know

One of the priorities that the participants noted was the need to get women into treatment earlier, which involves identifying what can be done in the community. The participants also identified a need for a public health response which is less threatening than having child welfare becoming involved. More research on what types of interventions work with women, including a

discussion of service response instead of child welfare response was also identified. Finally, the participants posed the question of how to provide guidance for non-child welfare/public health audiences (i.e., head start, early start programs).

Steve Hornberger – Engagement and Retention

Mr. Hornberger presented the following report from the discussion group on research methods in assessing engagement and retention of parents in care:

Three things we know:

1. Involvement with child welfare and the substance abuse treatment system is threatening, therefore providers need to establish rapport with clients so they can build trusting relationships to increase engagement and retention. It takes time to establish relationships with the family and engage them into treatment and therefore service delivery should integrate child welfare, substance abuse, mental health, and violence concerns.
2. Families involved with these systems have complex multiple needs. Thus, there needs to be a unified case plan that is comprehensive, addresses the basic needs of the clients, is coordinated between the systems, and is re-evaluated periodically as needed.
3. There are effective engagement and retention strategies that increase the involvement and success of families. They include stages of change, motivational interviewing, contingency management, family group decision making and family-to-family. Such affective strategies should be more widely implemented.

Three things we need to know:

1. We need to know how the culture of clients and workers affects outcomes. We need to know culturally specific strategies to address well-being and disparities.
2. Need to know more about peer/consumer involvement in service design, delivery, and evaluation for both child welfare and substance abuse treatment.
3. Need to know more about how to apply emerging knowledge base (i.e., trauma, brain research) and its impact on the organizational environment and on outcomes. For example, looking at the strengths and resiliency of families and its impact on success.

Feedback from Roundtable Discussion – What we know

The discussion participants noted that to become or stay engaged in treatment, clients need to believe that they will get something out of the process. For example, they need to have hope or an expectation that something will change. Several strategies were identified to assist in engagement and retention. They include one stop shopping, co-location of services, and bringing in specialists where we know people will be coming. Culturally competent services were also identified as being essential. A NIDA-funded Start Early, Start Smart program was reported to have helped to reduce stigma. The participants also stated that families have strengths and case plans must be unique and tailored, including families in making the treatment plans. The participants also discussed the need to look at how to use threat in a positive way.

Several studies were identified as important to engagement and retention. The American Humane Association conducted a meta-study on the effectiveness of family group decision-making (Tisa McGhee has information about using the family group decision-making process; Mary Nakashian stated that Oklahoma has successfully adapted family group decision-making). However, Jon Morgenstern reported the a study of bringing women into case management used these strategies but they did not work. He stated that there is still the perception that the system is punitive, trying to impoverish women and take their children away. He also said that women need to buy into the belief that the intervention will help them. The participants added that it is important to not only engage the woman, but also their family since a woman being in treatment can be threatening to her relationships (Hendrich Jones has a NIDA-funded methadone study about bringing partners into treatment, and there is a monograph about working with partners).

Feedback from Roundtable Discussion – What we need to know

The participants stated that engagement and retention strategies need to be evaluated to see if they are effective. Many have been shown to be promising but not necessarily effective. The participants felt more information was needed before they can be called effective.

Terry Cross – Filling Information Gaps

Mr. Cross presented the following report from the discussion group on using existing information systems to fill information gaps:

Things we know:

1. There is an underreporting of substance abuse problems in Adoption and Foster Care Analysis and Reporting Systems (AFCARS) and National Child Abuse and Neglect Data System (NCANDS).
2. Some data that is collected does not get into automated systems but is available in case records. Data not recorded may include data regarding why cases were screened out or not substantiated, or data from court files.
3. States have improved their capability to collect data in response to large scale policy reform efforts, e.g. CFSRs and Performance Partnership Grants. It appears hat states will collect data when they know that results will be published and disseminated widely. We know that technology and methodology can be improved.
4. We know we are not asking questions in the right way, we are not asking the right questions, and there is no consensus on what terms mean. For example, the National Household Survey on Drug Abuse will indicate whether the respondent is a parent, but will not indicate whether she has lost custody of the children. In addition, the AFCARS questions do not distinguish between drug use, abuse and dependence.
5. Databases and data requirements drive practice, rather than practice driving data.
6. Workforce capacity influences the integrity of the data collected.
7. If a data element has too many options associated with it (i.e., drop down menus), the meaning of the data is diluted.

Things we need to know:

1. We need to examine why substance abuse problems are under-reported and why they are not recorded even when they are known.
2. We need to make it worth the workers' investment to ask questions about substance abuse and to record the answer.
3. We need to know how to make substance abuse problems a higher priority within the next generation of AFCARS and NCANDS data collection.
4. We need to understand what motivates child welfare workers to report or not report a substance abuse problem when they know that it is present.
5. We need to know how to incorporate information gathered after intake and as it becomes available. For example, workers may unearth problems of substance abuse over time as they work with a family.
6. How do we use data to solve issues of social justice; i.e. disproportionate representation of children of color within child welfare?
7. How do we use data elements to identify family strengths?
8. Is it feasible to develop measures/domains that would cross substance abuse and child welfare systems? If not, what is a fallback?
9. Is it possible to go beyond administrative data and conduct more in-depth analyses of targeted cohorts across systems? For example, CWLA has multi-system case analyses upon request from states.

Feedback from Roundtable Discussion – What we know

The discussion participants noted that there is tremendous underreporting in both systems, and this influences how people think about these issues. They also noted that there is also missing data in the case records and a lack of consistency between data sets. The participants stated that the questions being asked are not the right questions, and are not being asked the right way. They felt that comprehensive information about children, risk factors for children, children's health/development, family stability are not being collected.

The participants stated that there have been improvements in CFSR, with people being more conscientious about entering the data. They noted that process is not linked to outcome, however and data requirements and databases drive practice. They felt that data should not drive the question.

The participants stated that if people do not get something out of collecting the data or know why they are collecting data, they will not collect it with any diligence. The participants discussed the need for those collecting the data to buy into the process of collecting the data, possibly using a stipend or collaboration on publications.

Feedback from Roundtable Discussion – What we need to know

The participants discussed the need to reduce the gap between practice and research. They also discussed the need for people to know why questions are being asked such as "what substance use data needs to be collected by child welfare and vice versa? They also reported a need for

community level data and that in order to facilitate cross system linkages we need cross system identifications.

December 11, 2003, 10:15am – 12:00pm **Discussion of SAFERR draft**

Moderator: Nancy Young, Ph.D., Children and Family Futures; Director, National Center on Substance Abuse and Child Welfare (NCSACW).

General Recommendations

The participants reviewed a draft of the SAFERR document and offered comments and suggestions. In general, the participants emphasized that the information and recommendations in the SAFERR document should not just be a specialized care issue, but integrated as a part of regular treatment. They suggested that the document needs to approach this as a paradigm shift.

The participants also reported that they would like to see formal collaborative referral agreements between the courts and treatment systems, including putting pressure on States to require a minimum standard of quality for programs to which families are referred. Despite financing issues, they said that States can provide guidance by making a statement about what is important, including some performance measures around linkage between levels of care and requiring a minimum of 90 days of treatment. The participants reported that the SAFERR document needs to address the impact of state confidentiality laws in developing multidisciplinary teams, as some are not allowed to share information.

Discussion participants suggested that part of the SAFERR document's message should be advocating an integrated policy agenda and accountability such that everyone shares responsibility for outcomes. The group suggested utilizing the NIDA and CSAT research-to-practice movement since they have structures for helping to facilitate and fund these linkages.

Discussion participants commented that the federal government is emphasizing improving treatment and giving agencies resources to fund treatment. It was reported that ONDCP's access to recovery (not treatment) is looking for a return on investment, showing that the services being provided are effective. However, in defining effective treatment programs, while collaboration with mental health and criminal justice are encouraged, and treatment beds are privileged to these populations, child welfare is not included in the discussion. Participants thus emphasized the importance of getting child welfare on the national agenda in discussing effective treatment. The substance abuse treatment field must agree that mothers should receive the first treatment spots and that their children can live with them. They suggested the SAFERR document examine guidelines for effective programs, including how to address child welfare issues, in order to argue for more funding.

Participants proposed that NCSACW can lower the barrier for implementation by providing tools, perhaps posting available resources on the website. They said that changing behavior is not easy without the cultural changes and funding being involved. They also stated that the SAFERR

document could make further recommendations about what types of treatment elements the programs should have in place when a child welfare case is referred to them, and define what a specialized program looks like.

There was also a concern posed by participants regarding wording issues: after-care vs. maintenance care; substance use disorder vs. substance abuse. Participants recommended the use of wording that cuts across different domains.

Defining the Audience

The audience for the SAFERR document is State and local administrators who would implement changes. Participants suggested using this document to present standards for best practice. They said that professionals often do not understand the dependency court system and parents' experience in the system. The participants stated that practitioners should know that this document can be helpful to them if they want to use it and that given the complexity of this document, NCSACW may need to create several documents with different purposes, targeting different audiences. Marion Becker has a handbook for parents and substance abuse workers about how to navigate the dependency court system. The participants also stated that the SAFERR document needs to be able to provide concrete recommendations to the providers.

Data Collection / Information Sharing

One important issue that the participants noted is the fact that substance abuse treatment agencies are not paid to collect information on children. They said that States would need guidance about how to collect information (page 11) since many of them do not know how. For example, in Oregon, 20% of treatment agencies that child welfare services referred to said that they did not see parenting as an issue for their clients. The participants stated that children and families are involved in many other systems than are addressed in the document, but information should be shared across all of them. They said it may be necessary to pay for time to collect data since programs are horribly under-funded, however, States cannot plead poverty as an argument against asking questions about the children. Additionally, the participants reported that more basic information should be included on page 11, acknowledging that the person is a parent.

Children

Participants commented that there is no mention of adolescents or children in the document. They said that there is nothing in the document about the child welfare needs of the child, which should be linked with 0-5 care. Participants noted that discussions about children tend to jump to child welfare services, but there are other needs that should be addressed, including primary care and developmental needs. They also said that treatment approaches should consider the dyadic model of the parent/child relationship to promote recovery and improve outcomes. It was suggested that the SAFERR document could add one or two minimum things about how to integrate children into each level of guidance, including advocating that all children receive diagnostic testing for all needs. However, given the number of children and the need to be realistic, the SAFERR document could identify the population of greatest concern for testing.

Family

The participants expressed a desire to see the "whole family" perspective throughout the document. They suggested that the SAFERR document look at the entire family and address the treatment of specific family member's issues, including family therapy and group therapy. Several clinical trials utilizing the Family Therapy Model were identified which involve the family and address substance abuse, such as Howard Little and Zopotnick, which show promising outcomes. The participants also noted that it is also important to make clear to families what must be conveyed and what can be kept private. A final consideration offered by participants is the issue that the rights and needs of parents may conflict with those of their children. For example, family therapy might not be the best choice, and could even be dangerous or at least not indicated for the child.

Systems

Discussion participants suggested the SAFERR document should take the perspective of systemic change (vertical change) and systems integration, rather than just services integration, and need to develop protocols and policies that bring services to children into the treatment program. One challenge identified is the disconnect in the substance abuse treatment, in that most substance abuse providers are contracted out. It was suggested that the SAFERR document examine the difference between what it is asking the substance abuse treatment system to do versus individual substance abuse treatment providers. Participants further suggested that the SAFERR document should not be limited to the three systems since parents are involved in many others, including public health, criminal justice, and education.

In discussing systems integration, participants suggested that SAFERR the document should not just describe what each section does, but also provide recommendations about where the systems integration should go, focusing on people coming together from the highest State level to the case planning level. Participants noted that child welfare agencies do not want to get into a competition over scarce resources, even though they need substance abuse treatment programs that can offer mother-child, foster parent-child, adolescent and infant treatment opportunities. One of the greatest challenges noted is the fact that substance abuse treatment providers view the parent as the client while the child welfare systems views the child as the client. Participants suggested NCSACW offer to go into the systems and provide cross training. The participants stated that changing the culture of practice must involve education of those entered the social work, child welfare and substance abuse arenas.

Client Fears

Discussion participants commented that an integrated system has implications for clients who fear that getting involved with substance abuse treatment will mean that they will also become involved in the child welfare system. They suggested that the SAFERR document address the issue that clients may fear an integrated system, and emphasize the need for a system that addresses that fear by demonstrating that services are supporting the entire family. Participants

stated that the level of fear exhibited by the client will depend on how service and system integration is implemented. For example, if the child welfare worker is the one who can authorize funding for baby food, etc. then they will be more popular with clients. It was suggested that parents also need something that outlines what each system does, what their rights are and how to advocate for them.

Screening and Assessment

Participants stated that States do not want to know the academics of screening and assessment. They noted that States want to know what other States are doing and whether they are satisfied, and that funds will impact families and their improvement plans. It was suggested that agencies need to be able to do the screening, but as a State is moving toward performance-based funding, it will need guidance as to what assessment tools they should expect their contractors to use. The participants noted that the SAFERR document should offer a few good instruments for global screening to give States a good idea of where to send children and families for treatment.

Discussion participants also suggested that the SAFERR document pare down the list of tools since most of the tools are duplicative. They said that the document should identify the domains that should be examined, and then clearly differentiate the domains. They noted that SAFERR should differentiate between screening and assessment, including roles and responsibilities and what the work of child welfare should be. They also noted that the SAFERR document should be clear about who administers the screen/assessment, the time it takes to administer the screening/assessment, the cost, and who should receive the information obtained. They said it may be necessary to break up instruments into sections (i.e., if you want to screen for X, then use this instrument – and take community/family context into consideration for organization).

Participants also emphasized the need to deal with how providers are going to view the SAFERR document, looking at both implementation and dissemination issues. The participants noted that in terms of screening and assessment, programs are going to say that they have their own instruments that they think fit their needs better.

Screening/Assessment Instruments for Children and Adolescents

Discussion participants noted that there are no screening instruments for the children included in the document and that the assessment tools in the document are mostly screening tools. The participants suggested that the document needs to add the Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire and the Social Emotional (ASQ-SE) to its list of screening tools since these tools are good with all cultural groups, are easy to score, are easy to train, parents are involved in the evaluation, and it is a parent administered questionnaire. These instruments are used in Fresno and with the Air Force, and they are available from Paul Brooks Publishing in English, Spanish, and Korean. The participants also suggested the use of Carter's Drug Use Screening Inventory (DUSI), which is a diagnostic tool for adolescents, and the Child Behavior Checklist (CBCL). They said that rather than worrying about reliability/validity, it may be more important to look at developmentally appropriate screens, family-centered or family-created instruments. The DISC family of instruments was identified as a tool that utilizes both

screening and assessment, and includes the CDISC assessment and CDISC screen for children's mental health issues.

Screening/Assessment Instruments for Adults

Discussion participants suggested the use of the 4Ps Plus and RAPS (Cherpital) for adult screening and assessment. Participants commented that the SAFERR document needs to include more tools for mental health. They suggested that the NCSACW review the NIDA compendium and the work of Michael Dennis. They also said that the SAFERR document should provide cross-systems safety assessment and immediacy tools that substance abuse treatment providers could use. The participants noted that many States are moving away from risk assessment toward safety assessment. The participants also stated that there are also co-morbidity issues to consider, and minimum measures of depression, domestic violence, and PTSD need to be included in the document they are highly correlated with substance use. They also said that the document should examine the actuarial and consensus model in risk assessment, as well as the Edinburgh model.

December 11, 2003, 1:00pm – 2:00pm **Discussion and Recommendations for NSCACW: Children's Issues & Response to the NCSACW Needs Assessment**

Moderator: Nancy Young, Ph.D., Children and Family Futures; Director, National Center on Substance Abuse and Child Welfare (NCSACW).

Participants provided input to NCSACW on services and interventions to promote well-being among children of substance abusers in the child welfare system and reflected on the findings from the NCSACW Needs Assessment.

Discussion participants suggested that the focus should be broader than preventing substance use disorders (SUDs) among children. The participants stated that these children often suffer other mental health problems, such as conduct disorder. For example, six-year-olds with executive functioning issues are often those with SUDs in adolescence. Early identification, appropriate placement and interventions, and follow-up were identified as important. The participants noted that there are interventions that can be started at birth, including attachment and sensory integration interventions. Participants offered several resources for NCSACW to consider. For example, there is a new monograph in the Journal of Child Development that shows the efficacy of early identification and early intervention. Centers for Disease Control is also funding a national consortium on treatment intervention work. CSAP has best practice models on randomized studies on prevention and intervention studies for youth. Flavio has a NREP model program based on prevention work with foster children with substance abuse issues in Arizona. His model presents a resiliency model with young children and will be available at the beginning of the year.

Participants also suggested NCSACW review studies that looked at regulatory disorders and childhood trauma as the etiology of substance abuse (Ralph Tarter), as well as Bill Callen's

studies on outcomes of ADHD children. They suggested that it is important to look at the antecedents and longitudinal patterns of youth in adolescence and young adulthood. It was suggested that the literature on resiliency factors could be translated and used by child welfare. Participants expressed concern regarding the use of medication for young children. In particular, participants were concerned about what is being prescribed for children and that medication is higher in the child welfare system. They said it is important to look at this issue because it is unclear whether there have been any randomized control trials of children under the age of four.

Participants commented that there is a split in addressing the needs of the children - some are met through the services to the parents while some are met through services to the child. Trauma interventions, for example, were noted as being good for directly addressing needs with children. The participants noted that some residential programs have integrated therapeutic services for children. Ira Chasnoff published a paper eight years ago about integrating parting into substance abuse treatment. Norma Finkelstein discussed her CSAT PPWI grant parent training program, which integrates substance abuse. The women and violence sub-study (250 kids) on children 5-10 of women with co-occurring disorders and history of violence, looking at issues of parenting and trying to integrate it into treatment, has found good outcomes using CBCL and other instruments at the 6 months (good child outcomes when good mother's outcomes). However, child development and ADS providers still have very different perspectives on children's services, which make it important to create a vision on the State level and on the programmatic level from the very beginning. Participants suggested a legislative change that addresses the best interests of the child.

The major concern and criticism of parenting skills training that discussion participants noted was the one-size-fits-all approach with no attempt to make the parenting program tailored to the needs of the parents. The participants said there has been no evaluation on how well they work (i.e., parents go to a certain number of classes and get their certificate), however, parenting classes are consistently popular with clients. Bavlock's work was identified as one of the only models that has been adapted to different cultures. Discussion participants commented that it is important to acknowledge that parenting is the relationship, not just skills. In addition, the participants noted that parenting classes are deficit models, but it is important to focus on strengths and developing skills. They suggested that the NCSACW could play a role by better disseminating information on effective programs/interventions so that providers are not re-inventing the wheel when designing parenting intervention/curriculum.

December 11, 2003, 2:00pm – 2:30pm **Discussion of the Future of the Group**

Moderator: Nancy Young, Ph.D., Children and Family Futures; Director, National Center on Substance Abuse and Child Welfare (NCSACW).

Participants provided guidance to NCSACW in furthering the development of a research community and related activities. Participants commented that they found this meeting to be very valuable, but somewhat overwhelming. They suggested that future meetings might be more focused on a specific topic and how to promote research and evaluation in that area.

Creating Resources

Participants commented that it is exciting to hear about everyone's work, which is important for collaboration and not re-inventing the wheel. They suggested that NCSACW should create a repository of research, documents, products and tools in order to create further understanding of child welfare issues and cross-system issues. This should include creating a list of websites for individual programs/agencies and research institutes.

Promoting Research

Discussion participants suggested NCSACW look at how to promote research and evaluation in these areas, including model development issues and mounting evaluations (single group designs and more rigorous evaluations). They said that NCSACW could promote a good forum for identifying these issues and getting them on the agenda in the research to practice movement. The participants stated that the first step should be to identify 5-7 priority areas for research and needs assessment that could be the focus for further examination and discussion. In terms of a longitudinal research agenda, some areas have well-researched programs that could be easily adapted. The participants noted that it may be necessary to conduct a feasibility study about research in certain areas and then move into more rigorous studies, creating a national research infrastructure.

Participants acknowledged that this is a large research agenda – a discussion that has lasted 30 years, but still with very little research. CSAT could dialogue with federal agencies to decide what the research needs at the national level are, and could then disseminate results to the Society for Social Work Research to facilitate that dialogue. There also needs to be more joint planning meetings between more federal agencies (NIH, HRSA, SAMHSA, ACYF, etc.). The participants suggested that Program announcements/RFAs could be developed to stimulate cross-system research/evaluation.

Policy

Lastly, discussion participants suggested that the NCSACW help identify how interventions with proven efficacy can be translated and modified from what we already know. The participants stated that it is important to be able to translate what we know into policy measures.

NCSACW Researchers Forum:
Developing Knowledge to Improve Outcomes for Families with Substance Use Disorders in the Child Welfare and Family Court Systems
December 10, 2003 – December 11, 2003

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