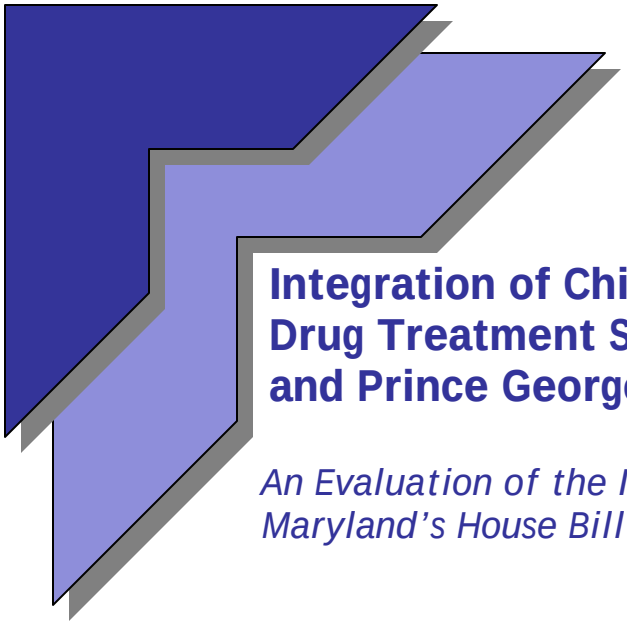

Integration of Child Welfare and Drug Treatment Services in Baltimore City and Prince George's County:

An Evaluation of the Implementation of Maryland's House Bill 7

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Table of Contents

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Executive Summary

Child abuse and neglect have devastating and long-term emotional, social, and economic consequences in Maryland and communities across the United States. Decades of scientific research have clearly demonstrated that substance abuse and child maltreatment are linked in a destructive cyclical fashion: child abuse increases the risk of subsequent substance abuse in adulthood, and parental substance abuse is a precipitating factor in 40-80% of confirmed child abuse and neglect cases. To end this seemingly intractable cycle of family dysfunction, states like Maryland have attempted to better integrate child welfare systems with drug abuse treatment systems, so that parents can get the services they need to treat their addiction and learn to become better parents to their children.

The Integration of Child Welfare and Substance Abuse Services Act (House Bill 7: HB 7) was passed in the 2000 session of the Maryland General Assembly. It provided for the placement of qualified Addiction Specialists in child welfare offices in two jurisdictions (Baltimore City and Prince George's County) to screen, assess and refer cases to needed substance abuse treatment. It also attempted to institute a process by which reciprocal reporting of progress on cases would occur, and mandated cross-training for personnel in both systems.

This evaluation of HB 7 was conducted by researchers at the University of Maryland Center for Substance Abuse Research in collaboration with the Alcohol and Drug Abuse Administration and the Department of Human Resources. The first part of the evaluation involved examination of administrative records of all individuals (n = 213) who had been referred to drug treatment by Addiction

Specialists located in Baltimore City in 2006. Results revealed that close to half (45.5%) did not enter a treatment program in the year following the referral. The second part of the evaluation involved personal interviews (n = 46) with Child Protective Service Caseworkers, Addiction Specialists and Treatment Center personnel to better understand the process of screening, referral and follow-up of cases. The primary aim of these interviews was to identify "system gaps" that could be closed to ensure that individuals referred to treatment might receive treatment in a timely fashion, and their progress be monitored continuously.

Interviews revealed that despite the high level of commitment by staff and well-intentioned efforts to implement HB 7, the following important programmatic issues should be addressed:

- Procedures for **screening and assessment** of drug problem severity in parents entering the child welfare system need improvement. The current assessment tool (the PADS form) may not be sufficient to capture the parent's problem. It is likely that cases are being missed and not properly assigned to treatment.

- Accessibility to tracking information on parents going through the system is limited. HB 7 did not provide resources for **information technology**, resulting in reliance on a paper record system that is outdated, and which does not provide for monitoring of outcomes.

- Due to a lack of funding, there is no ongoing cross-training of staff. Normal staff attrition and turnover necessitate regularly scheduled cross-training for new CPS Caseworkers, Addiction Specialists, and substance abuse treatment personnel who monitor parents in treatment programs. HB 7 did not specify **requirements for intensive cross-training**.

- HB 7 did not specify **how the process of entering treatment should be monitored** or how feedback should be provided to CWS after treatment entry.

- HB 7 did not specify the **interagency communication responsibilities of treatment center** staff.

The following recommendations are made:

- Improve and standardize screening and assessment of drug problems.
- Provide in-service cross-training of CPS Caseworkers and Addiction Specialists.
- Provide regular opportunities for communication among personnel who handle child welfare cases.
- Implement a secure online assessment system with automated emails to Addiction Specialists that contain assessment and locator information.
- Increase access to intensive treatment and continuing care services for HB 7 clients.

1. Introduction

It is estimated that 11 percent of all children (8.3 million) in the United States live with at least one parent who is alcoholic or in need of substance abuse treatment[1]. Parental substance abuse is a precipitating factor in approximately 40-80 percent of confirmed child abuse and neglect cases[2,3].

> *Parental substance abuse is a precipitating factor in approximately 40-80 percent of confirmed child abuse and neglect cases.*

The link between parental substance abuse and child maltreatment is complex. Compared to non-users, substance-using parents are likely to display less responsiveness to their children, more impulsivity, and tend to be more socially isolated[4-5]. Moreover, the risk for child abuse and neglect, including physical punishment, is also partially related to irrational and aggressive behavior as a result of the intoxicating effects of alcohol abuse as well as stimulant drugs like cocaine [6,7]. It has also been well-documented that substance-using parents are at increased risk for neglecting the emotional, academic, health and material needs of their children, often as a result of preoccupation with seeking and using alcohol or drugs, and using already limited financial resources for the purchase of alcohol or drugs[8-10].

Child abuse and neglect have severe long-term consequences. Victims of abuse and neglect in childhood experience a wide array of negative physical, emotional, and behavioral health consequences, including injury, depression, substance abuse, hyperactivity, and suicidal behavior[11]. Similarly, children from substance-abusing families are at high risk for hyperactivity, conduct disorder in early childhood[12], drug and alcohol use[13]and impaired academic functioning[14], as well as anxiety and depression[15] in adolescence. The combination of child maltreatment and parental substance abuse is especially detrimental, and often results in intervention by social service agencies and out-of-home placement[16]. Interestingly, child neglect, rather than abuse, has been found to be the overwhelming reason for removal of a child from substance-abusing families[17,18].

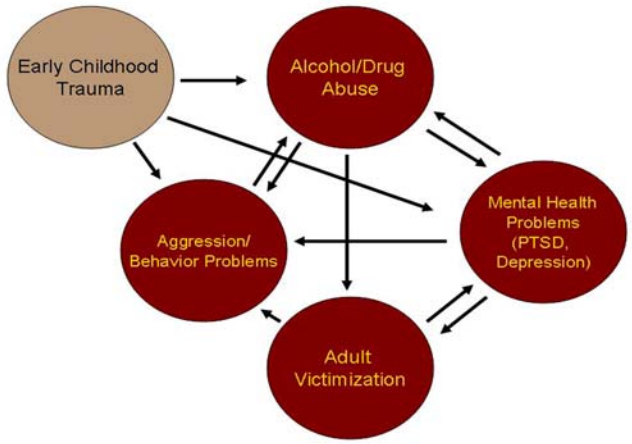
> *Substance abuse is probably the most significant contributor to the growing number of child protective service cases in the United States.*

The problem appears to be increasing at an alarming pace. The U.S. foster care population has grown by 65 percent in the last decade, with more than 750,000 American children currently residing in some form of out-of-home care[19].

Furthermore, the growing number of children in foster care has increased federal spending to approximately $4.5 billion in 2000[20]. Parental substance abuse is believed to be the most important factor in the growing number of child protective services caseloads[21].

Substance abuse and child maltreatment are linked in a destructive cycle. Complicating these issues is the fact that drug treatment is more difficult for clients who have been reported for child abuse and neglect, because they are likely to have experienced physical and sexual abuse during their own childhoods. These adverse childhood experiences, as well as related psychiatric disorders such as post-traumatic stress disorder and depression, all contribute to ineffective parenting skills in such individuals. It is estimated that 30 to 75 percent of drug-abusing women are victims of childhood sexual abuse and sexual trauma themselves[22-25]. Similarly, between 40 to 80 percent of women in substance abuse treatment report having been physically or sexually abused as children[22,26-27]. In addition, co-occurrence of psychiatric comorbidity, such as depression[22], bipolar disorder[28], personality disorder[42], and anxiety disorder[29] is estimated to be as high as 90 percent[30]. As adults, many victims of child abuse find themselves trapped in a cycle of domestic violence with their partners, and the high level of exposure to family conflict serves to exacerbate the risk for adverse childhood outcomes[31-32].

Figure 1. Interconnections between childhood trauma and adverse outcomes in adulthood



Although female substance abuse treatment clients with children in their care often report that parenting or child custody concerns are an important reason for their participation in treatment[33], only a limited number of alcohol and drug treatment programs are targeted toward parents with a history of child maltreatment. In the United States, very few publicly funded treatment programs have the staffing resources to comprehensively address parenting concerns of clients[34], or to consider custody status and overall family functioning when evaluating substance abuse treatment outcomes[35]. A lack of child care offered by substance abuse treatment programs may contribute to shorter lengths of stay in treatment programs for clients with children in their care[36]. Policies that provide for comprehensive and successful integration of child welfare and

substance abuse treatment services are critical to reduce the intergenerational cycle of family violence, child abuse, and subsequent drug problems[37].

The Critical Need for Integration of Child Welfare and Substance Abuse Services

In 1998, the National Center on Addiction and Substance Abuse (CASA) at Columbia University conducted a national survey of 915 child welfare professionals to gather information about confronting the problems of child maltreatment and parental substance abuse. The survey asked respondents about their perceptions related to the problem of substance abuse and child maltreatment, characteristics of the clients that they serve, and about the process of determining appropriate treatment services for parents[38]. Consistent with previous research, most survey respondents (79.6 percent) reported that substance abuse causes or contributes to at least half of all cases of child maltreatment. Despite these reports, almost half (42 percent) of all caseworkers reported that they were not required (or were unaware of a requirement) to record the presence of substance abuse when investigating child maltreatment. Equally disappointing, 61.3 percent of respondents said that the availability of a particular substance abuse treatment program determined what treatment is deemed "appropriate" for a parent. These results validate longtime concerns with the policies and practices of child welfare agencies with respect to parental substance abuse and child maltreatment.

Additionally, the results demonstrate the benefit of gathering perceptions and opinions directly from service providers.

Policies that call for comprehensive and successful integration of child welfare and substance abuse treatment services are critical to reduce the intergenerational cycle of family violence, child abuse, and subsequent drug problems.

To resolve these complex problems, there is a critical need for substance abuse and child welfare interagency collaboration. Representatives from social service and substance abuse agencies should convene regularly to identify gaps in service delivery and to facilitate consensus about interagency responsibilities. Additionally, joint training is necessary for addiction counselors and child protective service workers, so that child protective service workers may have the knowledge and skills necessary to effectively identify and refer substance abusers for services.

Child protective service cases must be processed in a timely manner. In an effort to address concerns about the size of the foster care population and the amount of time children spend in foster care, the Adoption and Safe Families Act (ASFA) of 1997 set more stringent limits on the amount of time provided for reunification efforts[39-43]. Under ASFA's timelines, hearings to determine permanent placement for children must occur within 12 months after a child enters care, and state child welfare and foster care agencies must initiate a petition for termination of parental rights when children have been in foster

care for 15 of the most recent 22 months. The combined effects of this increased speed of termination of parental rights and the increasing number of children placed in out-of-home care due to parental substance abuse has led to more demand for substance abuse treatment than can be currently accommodated within the treatment system. The ASFA has been criticized for imposing unreasonable time limits for substance abusers who often experience cycles of treatment dropout, relapse and recovery[42]. Continued parental substance abuse is frequently associated with child abuse and neglect recidivism[43,44], a greater likelihood of noncompliance with court-ordered services, and eventual loss of child custody[45]. According to one study[46], over one third of children involved with CPS return to the system due to additional maltreatment, and earlier studies suggest that the number of children who return to the system may be even higher (50-66%)[47,48]. For child safety, it is imperative that parents be screened for substance abuse problems at the onset of child welfare service involvement, referred to appropriate treatment services in a timely manner, and that high-quality treatment services are readily accessible on a continuous basis.

It is imperative that parents who come to the attention of child protective services are comprehensively screened for alcohol and drug problems.

Very few systematic research studies have been conducted on the impact of substance abuse treatment on child welfare outcomes, and the few preliminary studies available have produced mixed results. For example, court-ordered substance abuse treatment has been found to have no effect on subsequent reports of child maltreatment or duration of child welfare services received[49]. In contrast, court-ordered treatment has been found to increase rates of family reunification[50]. It has also been demonstrated that clients who receive substance abuse treatment are nearly twice as likely to have another child abuse report within 18 months, although these results may reflect a greater severity of problems among parents who are compelled to engage in substance abuse treatment[51].

Integration of Child Welfare and Drug Treatment Services: Examples from Other States There are examples of successful integration of child welfare and substance abuse treatment from other states. Project SAFE, a joint pilot program of the Illinois Department of Children and Family Services (DCFS) and the Illinois Department of Alcoholism and Substance Abuse was implemented in 1986, and shown to be associated with decreased childhood maltreatment recidivism rates and increased family reunification rates as compared to mothers not participating in the program[39]. Project SAFE also served as a partial model for a 1995 Illinois initiative to further integrate child welfare services and substance abuse treatment services by establishing joint screening tools, consent forms, and reporting documents for treatment providers. In addition, protocol required that parents be screened for alcohol and drug problems and referred to a treatment provider for further assessment within 30

days of the opening of the case[39]. Cross-training is also provided for child welfare caseworkers on the basics of addiction, screening, and treatment. Although collaboration has grown as a result of the initiative, caseworkers and treatment providers indicate that continuing challenges include collaboration, communication, staff turnover, co-occurring mental health problems among clients, and treatment capacity. As the movement toward integrating child welfare services and substance abuse treatment services has gained momentum, several states have adopted a framework similar to that of the Illinois initiative.

Another example of attempted integration of child welfare and substance abuse treatment services can be found in the state of Connecticut. After the Department of Children and Families (DCF) found that substance abuse was a contributing factor in many child welfare cases and that DCF was not systematically screening parents for substance abuse, the Connecticut Project SAFE (Substance Abuse Family Evaluation) was established in 1995 to implement a substance abuse screening questionnaire to be used by child welfare workers, followed by intervention of addiction counselors hired to work in DCF offices[3]. While 68 percent of referred caregivers completed an initial evaluation for substance abuse, only one third of those individuals referred to substance abuse treatment returned to the clinic to begin treatment[52]. With a greater emphasis being placed on client engagement and retention in substance abuse treatment, the DCF has paired with the state agency responsible for managing adult behavioral-health issues to make better use of existing alcohol and other drug assessment and treatment resources[3]. Recently, these state agencies have paired with treatment providers and researchers to conduct a study on the efficacy of using motivational enhancement therapy (MET) techniques in the evaluation interview to engage clients in treatment[52]. Nearly twice as many clients who completed a MET evaluation interview and were referred for substance abuse treatment returned for at least one treatment session, when compared with clients who received the standard evaluation[52]. The results of this study provide considerable insight into the difficulty of engaging parents with substance abuse problems in treatment, the impact of substance abuse evaluation techniques, and the importance of conducting systematic research studies to determine what factors influence the likelihood of parents involved with child welfare services becoming engaged in substance abuse treatment.

Several other states have incorporated a Drug Court model to address substance abuse and child maltreatment-related problems among families. In 1995, the Sacramento County Department of Human Resources implemented a training program for all staff focusing on recognition and assessment of substance abuse, as well as motivating parents to enter treatment through participation in support groups. Preliminary data suggest that graduates of the support groups show a decrease in alcohol and drug use over three months, a greater rate of in-home child placement, and are more likely to attend

Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings[50]. In October 2001, the Sacramento County Dependency Drug Court (DDC) was established to provide specialized court services for parents before any noncompliance of court-ordered recovery occurs[50]. Child welfare clients are given priority access to treatment, and early intervention specialists review every court petition to determine if substance use disorders may be present. In an annual report, three cohorts of court-ordered DDC participants were compared with parents who received standard Child Protective Services (CPS) and Alcohol and Drug Services (ADS) prior to DDC implementation. The results suggested that significantly more court-ordered DDC participants (compared to the non-court-ordered group) entered substance abuse treatment (88.5 percent versus 50.5 percent) and completed more treatment sessions (2.2 sessions versus 1.3 sessions). Additionally, DDC children were more likely to be reunited with their parents while comparison group children were more likely to be in adoption, guardianship or long-term placement[50]. These results demonstrate the positive impact of court-ordered substance abuse treatment on outcomes related to treatment engagement and family reunification, and provide support for linkages between CPS, alcohol and drug service, and family court professionals.

Description and Purpose of Maryland House Bill 7 Enacted in 2001, Maryland House Bill 7 (HB 7), *Integration of Child Welfare and Substance Abuse Treatment Services*, called on the Department of Human Resources (DHR) and the Department of Health and Mental Hygiene (DHMH) to develop a protocol to integrate child welfare and substance abuse treatment services. This protocol was implemented as a pilot in two jurisdictions, Baltimore City and Prince George's County, and included provisions for cross-training of staff, hiring and placement of Addiction Specialists in child welfare offices, and the purchase of substance abuse treatment services. The circular letter attached as Appendix 1 describes the implementation protocol for HB 7.

2. Evaluation Objectives and Methodology

In 2006, the Maryland legislature requested that the Maryland Alcohol and Drug Abuse Administration (ADAA) conduct an evaluation of the implementation of HB 7, and the ADAA in turn contracted with the Center for Substance Abuse Research (CESAR) at the University of Maryland College Park to assist with the evaluation. Evaluation of HB 7 involved two complementary research studies. The first part of the evaluation involved an analysis of administrative records of all Baltimore City HB 7 cases (n = 213) that were assessed for drug treatment during CY2006. This analysis, conducted by ADAA staff, gave an overview of the flow of HB 7 clients from the time of assessment through referral to drug treatment, through their experiences in drug treatment. In this way, the proportion of clients assessed for drug treatment and eventually referred to treatment could be determined, as well as the proportion of clients referred to treatment that eventually entered and subsequently completed treatment.

The second part of the evaluation involved conducting telephone surveys with 46 staff (child welfare caseworkers, Addiction Specialists, and substance abuse treatment providers) to assess the process and barriers to HB 7 implementation. The purpose of the evaluation was to clarify the process by which parents are assessed for substance abuse treatment need, and how subsequent referrals to substance abuse treatment services are made. The staff perspective provided insight about how well the process is operating, and what can be done to improve the flow of information between caseworkers, Addiction Specialists, and substance abuse treatment providers regarding client needs and progress in treatment.

Interview Topics included: Parent screening and assessment for substance abuse treatment need; 2) Treatment referral process; 3) Barriers to treatment entry, reasons for not completing treatment, identification of high-risk points for parental drop-out of the system; 4) Level of interagency communication and integration; and 5) Types of cross-training provided.

Taken together, the evaluation aimed to answer the following questions:

1. *How well are child welfare and substance abuse services integrated so that parents being investigated for child abuse are assessed for drug problems, and receive drug treatment when needed?*

2. *How well established is the communication between staff involved in HB 7 (e.g. CPS Caseworkers, Addiction Specialists, treatment center personnel) to ensure that parents are screened for alcohol and drug problems and referred to substance abuse treatment if needed?*

3. *From the staff's perspective, at which stages of the process are parents at risk for "falling through the cracks"?*

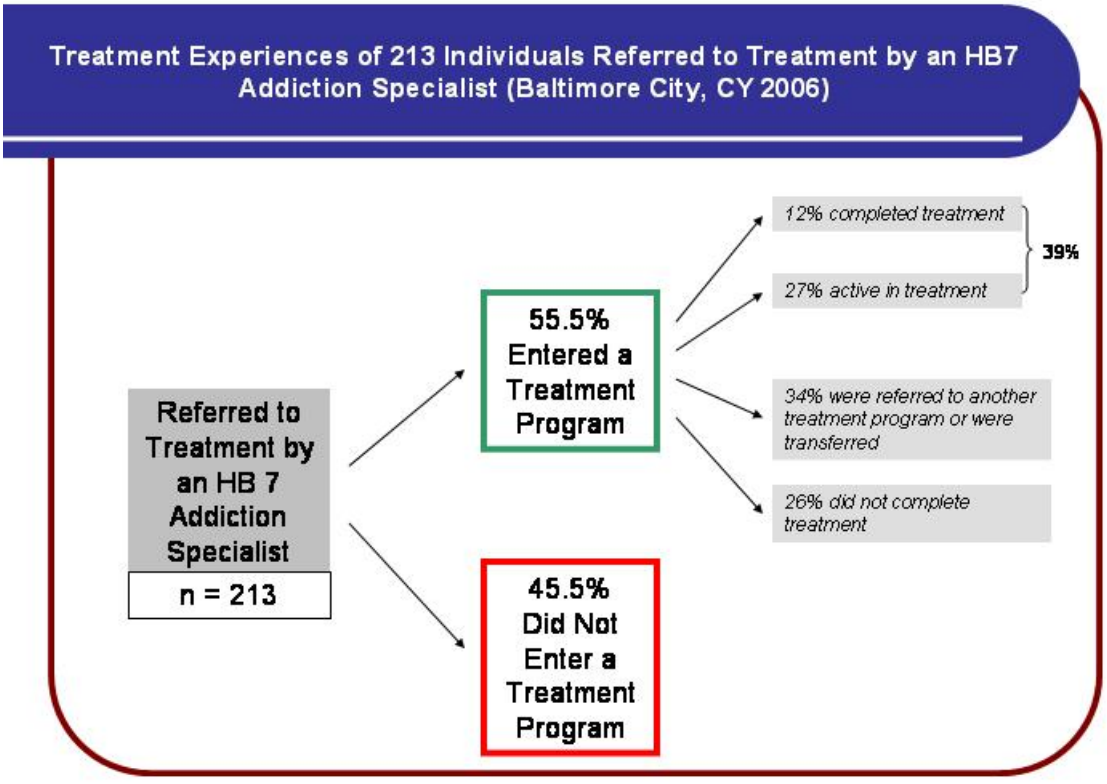
4. *How can the implementation of HB 7 be improved so that parents get services essential to reducing their alcohol and drug involvement?*

The present evaluation is meant to be a first step in providing insight into the challenges faced by caseworkers, Addiction Specialists, and treatment providers in the state of Maryland.

3. Results

a. Tracking of HB 7 Clients referred to Drug Treatment

Figure 2 below presents the results of ADAA's administrative tracking analysis of all cases (n = 213) resulting in drug treatment referral by Addiction Specialists in Baltimore City during CY2006. As can be seen, 55.5% entered a treatment program at some point after the referral to treatment was made. Conversely, 45.5% of cases could not be located in the treatment services database, and were therefore assumed not to have entered a certified treatment program in the State of Maryland. Among individuals who entered treatment, 26% did not complete treatment, and 39% were completing or still active in treatment. The remaining 34% were referred to another treatment program or transferred directly to a different treatment program.



Further analyses are necessary to track individuals as they move from one treatment program to another. Follow-up after non-completion of a treatment

program presents an additional challenge to Addiction Specialists and CPS Caseworkers. Currently, the responsibility for follow-up of such clients is not clearly specified.

b. Results from Interviews with Staff

Interviews with 46 staff revealed a very complex set of steps taken after an individual is suspected of child maltreatment. These steps can be summarized as follows:

Stage 1. Screening for drug problems in parents investigated for child abuse and neglect.

1. An initial report of child abuse/neglect allegations is made to the Child Protective Services (CPS) Screening Unit.
2. The case is accepted for CPS investigation if the screening unit determines that the allegations meet criteria for child abuse and/or neglect.
3. The case is assigned to a CPS Unit Supervisor, and Intake and Assessment Caseworker.
4. The CPS investigation begins. The mandated timeframe for meeting with neglect victims is 5 days; for physical or sexual abuse victims, the timeframe is 24 hours.
5. The CPS Caseworker completes a *Preliminary Alcohol and Drug Screening* (PADS) form (see Appendix B). The PADS form is typically completed at the initial meeting with parent, but sometimes occurs during the investigation, and other times at the end of the 60 day investigation period. Several individuals discussed the current inadequacies of the PADS form. It may not be comprehensive enough to detect/capture warning signs of substance abuse. Caseworkers reported that the PADS form is likely to result in underreporting of the need for services. Addiction Specialists reported that they do not receive as many PADS forms as they believe they should.
6. For cases resulting in a "positive" PADS form (when there is an indication of an alcohol or drug problem), the CPS Caseworker refers the parent to an Addiction Specialist. No strict guidelines are in place for timeline for communication and follow-up at this stage.
7. The Addiction Specialist and CPS Caseworker agree on a plan to meet the substance abuse treatment needs of the parent.
8. The CPS Caseworker develops a service plan with the parent to address identified needs.

Stage 2. Pre-treatment

1. The Addiction Specialist schedules an appointment with the parent and creates a client case file containing the initial referral information.
2. If the parent shows up for the appointment, the Addiction Specialist completes a comprehensive alcohol and drug assessment. If the parent fails to show up for the appointment, the Addiction Specialist attempts to reschedule; however, contacting the parent is often difficult, given the amount of contact information provided in the referral.
3. The Addiction Specialist notifies the CPS Caseworker if the parent fails to complete the more comprehensive alcohol and drug abuse assessment, but communication is not always adequate at this point.
4. The parent is referred to alcohol and drug treatment if deemed necessary.

Stage 3. Treatment Entry

1. Treatment program staff receive an HB 7 referral (usually by phone or fax from the Addiction Specialist, or from the substance-abusing parent). If the treatment program is at capacity, or the parent cannot be placed on a waiting list, the Addiction Specialist may attempt to contact a different treatment program, or monitor the initial treatment program until a slot becomes available.
2. The initial treatment appointment is scheduled. There may be difficulty contacting parents, given the frequently inadequate amount of contact information in the referral.
3. If the parent shows up for the initial appointment, a brief intake assessment is completed.
4. The parent is admitted to the program or referred to a different program if the treatment program determines that the parent needs a different level of care.
5. Treatment program personnel call the Addiction Specialist and may provide monthly progress reports if requested by the Addiction Specialist or CPS Caseworker. There is a perception of inadequate availability of HB 7 treatment slots, and a perceived need for more intensive treatment services.

In general, interviews revealed a wide variety of responses to many of the questions related to responsibilities and timelines for follow-up with clients and treatment center personnel. Table 1 below documents that a majority of survey respondents feel that there is a problem regarding delay of entry into treatment services.

Table 1. Responses to questions about treatment entry process (n=39)

	Never	Occasionally/ Half the Time	Frequently/ Always	Don't Know	Total
Problem with parents not entering a treatment program after referred by an Addiction Specialist.	7.7%	61.5%	15.4%	15.4%	100%
Delay caused by parents failing to take the necessary steps to enter a treatment program.	5.1%	48.7%	33.3%	12.8%	100%

Stage 4. Monitoring of Treatment Progress, Discharge, Non-completion

1. Responsibilities of Addiction Specialist for monitoring of treatment progress, discharge and non-completion of treatment services appear to be at their discretion. HB 7 does not specify clear guidelines.
2. HB 7 does not specify responsibilities of treatment center personnel with regard to monitoring unique to HB 7 clients.

Table 2 presents information collected from CPS Caseworkers, Addiction Specialists, and Treatment Center staff as to whether they believe they have necessary skills and knowledge. Caseworkers, Addiction Specialists, and treatment center staff are united in their desire for increased teamwork and collaboration. Almost 40% of CPS Caseworkers, 50% of Addiction Specialists, and 25% of treatment center staff feel that their skills and knowledge "are very adequate" regarding alcohol and drug abuse problems among parents involved in the child welfare system. Only about one-quarter of CPS Caseworkers rate their skills and knowledge regarding community resources for substance abuse (including treatment facilities and programs) as "very adequate".

Table 2. Responses regarding perceived skills and knowledge

	Not Adequate	Somewhat Adequate	Very Adequate	Don't Know	Total
CPS Caseworkers feel they have the necessary skills and knowledge to talk with HB 7 parents about their AOD problems (n=23)	-	60.9%	39.1%	-	100%
CPS Caseworkers feel informed about community resources for substance abuse, including treatment facilities and programs (n=23)	13.0%	60.9%	26.1%	-	100%
Addiction Specialists feel they have the necessary skills and knowledge to talk with HB 7 parents about their CWS involvement (n=8)	12.5%	37.5%	50.0%	-	100%
Treatment Staff feel they have the necessary skills and knowledge to talk with HB 7 parents about their CWS involvement (n=8)	25.0%	37.5%	25.0%	12.5%	100%

Table 3 presents a summary of results regarding the perception of adequacy of service integration. An important finding is that the vast majority of caseworkers and Addiction Specialists report "frequently or always" communicating with one another. However, a wide range of responses was noted with respect to the degree to which integration of services takes place. For example, a little over half of survey respondents (53.9%) believe that substance abuse recovery plans are linked with the original plan that originated with the CPS Caseworker. In summary, it is fair to say that among staff, there appears to be a desire to improve and clarify the process, and to increase the level of interagency communication.

Table 3. Responses regarding Integration of Services (n=39)

	Never	Occasionally/ Half the Time	Frequently/ Always	Don't Know	Total
CWS and treatment agencies agree on the level of information that will be communicated about clients progress in treatment	5.1%	25.6%	53.8%	15.4%	100%
Substance abuse recovery plans are integrated or linked with CWS case plans	2.6%	17.9%	53.9%	25.7%	100%
CPS Caseworkers report communicating with treatment providers regarding treatment status or progress of parents (n=23)	56.5%	17.4%	26.1%	-	100%
CPS Caseworkers report communicating with Addiction Specialists regarding treatment status or progress of parents (n=23)	21.7%	8.7%	69.6%	-	100%
CPS Caseworkers report that treatment providers routinely contact caseworkers to ask questions about children in the family or CWS involvement (n=23)	47.8%	21.7%	13.0%	17.4%	100%
Addiction Specialists report communicating with treatment providers regarding treatment status or progress of parents (n=8)	-	12.5%	75%	12.5%	100%
Addiction Specialists report communicating with caseworkers regarding treatment status or progress of parents (n=8)	-	-	100%	-	100%
Addiction Specialists report that treatment providers routinely contact addiction specialist to ask questions about children in the family or CWS involvement (n=8)	50.0%	25.0%	25.0%	-	100%
Treatment personnel report routinely contacting Addiction Specialists or caseworkers to ask questions about CWS involvement (n=8)	37.5%	25.0%	25.0%	12.5%	100%

4. Summary and Recommendations

A major finding from tracking of client records in Baltimore City was that nearly half (45.5%) of the caregivers (identified originally by Child Protective Services and referred to drug treatment in Baltimore City by an Addiction Specialist) had not received treatment after approximately one year of follow-up. Certainly, there are several explanations for why an individual with a history of substance abuse would "fall through the cracks", and not show up for a scheduled appointment. Reasons range from lack of transportation or childcare, lack of confidence in treatment, or fear of having their child taken away. However, because these particular clients have been called to the attention of authorities for child abuse and neglect, a more concerted effort is needed to close system gaps to ensure that they receive much needed services.

This evaluation is an important first step toward improving the integration of child welfare and substance abuse treatment services. Four important areas should be addressed based on the findings of the interviews with staff involved in the process. First, the PADS form, currently the primary method of screening for alcohol and drug problems among parents in the child welfare system, may not be adequate as an assessment tool. Fortunately, the federal Center for Substance Treatment has recently published a monograph which contains an alternate solution called "S*imple Screening Instrument for AOD Abuse Interview Form"* (CSAT,TIP Series 11, Exhibit 2-2). This instrument should be evaluated for use in Maryland; other similar assessment tools should also be evaluated for this important purpose.

Second, a specific timeline should be developed for key events that occur between entry into the child welfare system, to initial assessment by Addiction Specialists, to entry into treatment, through discharge from substance abuse treatment. Schedules should be developed so that each case can be processed in a timely and efficient fashion.

Third, interviews revealed a need for in-service cross-training of CPS Caseworkers and Addiction Specialists. Staff desired more opportunities for communication, and suggested that a system for automated emails between agencies be implemented when a case is opened. An electronic case record system should be implemented to facilitate closer monitoring of client progress at every step. A repeated concern expressed by interviewees involved the need for information technology resources to facilitate interagency communication. The current paper record system is outdated and does not allow for easy monitoring of outcomes.

Fourth, a lack of standardized follow-up protocols was cited by many of those interviewed. Often, according to staff, they do not have specific guidelines about how many times they should re-contact the client, or check with the treatment program to monitor the client's entry and retention in treatment. Although it is encouraging that Addiction Specialists and caseworkers are communicating with one another, there is room for improvement in communicating with clients and monitoring their progress.

The current system can be improved by closing gaps that have been identified. Improvements are clearly needed in cross-agency collaboration and cooperation. Establishment of an integrated system so that data from multiple systems can be linked together (i.e., child welfare, criminal justice, employment, the courts, schools, and drug treatment) would enable Maryland stakeholders to perform a state-of-the-art comprehensive evaluation of the process where family, child, and parent outcomes are determined. This kind of system could help track the extent of cost-savings to the state that are associated with reduced crime and increased employment following drug treatment services in the special population of child welfare clients, just as has been demonstrated for the general population of clients receiving drug treatment services.

Preliminary results from the study that were presented to key stakeholders in both the Maryland Alcohol and Drug Abuse Administration and the Department of Human Resources have already begun to generate possible solutions in order to improve the likelihood that parents with substance abuse problems get the services they need to treat their addiction. In the summer of 2007, under the direction of the Secretary of DHMH and the Deputy Secretary of DHR, a HB 7 Work Group was established to discuss next steps. The Work Group was comprised of staff and appointed liaisons from ADAA, DHR/SSA, Prince George's County Health Department, Prince George's County DSS, Baltimore City DSS and Baltimore Substance Abuse Systems. The Work Group focused on two key issues: 1) Improvement of cross-training of Addictions and Child Welfare staff and, 2) Improvement of Case Follow-up. The Work Group's recommendations resulted in a meeting on August 29, 2007, between the ADAA and the University of Maryland School of Social Work, Child Welfare Academy to discuss the development and implementation of a cross-training protocol. Recommendations were made to have Addictions staff present at Child Welfare staff meetings when discussing shared client cases, and to establish a protocol for communication flow.

Recommendations were also made to establish a quarterly meeting of all staff participating in HB 7. The first meeting of this group occurred in November, 2007. This group will continue to focus on the objectives established by the Work Group, to implement recommendations, and to make improvements when needed.

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