

Final Report

A Policy Guide on Collaborative Models for State Alcohol and Other Drug Directors and Child Welfare Administrators

Prepared by:

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The National Association of State Alcohol and Drug Abuse Directors
(NASADAD)

For:

The Center for Substance Abuse Treatment (CSAT)

July 7, 2004
Washington, D.C.

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TABLE OF CONTENTS

Introduction and Background	1
Guidance and Policy Recommendations	4
Interagency Agreements: A Basic Tool for the Articulation and Implementation of State Child Welfare and AOD Collaborative Policy.....	8
Discussion.....	10
References.....	11
APPENDIX A. NASADAD Resolution In Support of AACAP and CWLA Values and Principles for Mental Health and Substance Abuse Services and Supports for Children in Foster Care	A-1

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By Kathleen M. Nardini, M.A.

National Association of Alcohol and Drug Abuse Directors

Introduction and Background

The Adoption and Safe Families Act (ASFA), P.L. 105-89, was enacted in 1997 and reauthorized in 2003 with minor modifications to ensure safety for abused and neglected children, to promote permanency for children in foster care, and to accelerate permanent placements of children. Under ASFA, Title I – Section 103, States are required to initiate proceedings to terminate parental rights after children have been in foster care 15 of the most recent 22 months. If children are removed from the home, permanency hearings must be held no later than 12 months after a child enters foster care.

Many parents who come to the attention of the Child Welfare System (CWS) and/or the Child Protection System (CPS) are identified as having substance use disorders which may contribute to their inability to care for their children and may result in their children being removed from the home. Under ASFA, Title IV –Section 405, requires that within one year of the law’s effective date, the Secretary of Health and Human Services (HHS), using information from the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Administration for Children and Families (ACF) was required to submit a report to Congress describing 1) the scope of the problem of substance abuse in the child welfare population, the types of services provided and the outcomes, and recommendations for legislation that could improve coordination of services.

In addition to ASFA, Title IV-B, Child and Family Services, and Title IV-E Foster Care and Adoption Assistance, both components of the Social Security Act, which provide funding to States, include provisions that may allow for the delivery of substance abuse services. Under Title IV-B, child welfare services should prevent, remedy, or assist in the solution of problems of neglect, abuse, exploitation or delinquency of children, and provide services to the child and families in an effort to return children, who were previously removed, to their families. Under Title IV-E, case plans to determine the appropriateness of and necessity for foster care placement should assure that the child receives proper care and that services are provided to parents that will improve the home environment and facilitate the child’s return.

Once a parent is identified as having a substance abuse problem, it is critical that the parent be referred immediately to an Alcohol and Other Drug (AOD) treatment provider, participate in substance abuse treatment, treatment status be monitored, and that AOD service providers inform child welfare, child protective service, and court personnel

about treatment progress and effectiveness. Timely information from AOD providers at each decision point in the case management process should permit decision makers to make better (more informed decisions) that are in the best interests of the child. Since those decisions must be made within ASFA time constraints, processes and practices must be mutually developed to ensure that the necessary substance abuse treatment information is available when it is needed while still honoring confidentiality requirements.

To operate efficiently and effectively within the constraints of the time frames specified in ASFA, it is important for policy makers and practitioners in both the Child Welfare System (CWS) and the AOD system to collaborate with each other as well as to collaborate with other related systems such as mental health (MH), social services, primary health care, maternal and child health, and the dependency court to provide needed and timely services to children and families. The safety, permanency, and well being of children and the treatment needs of parents who have substance use disorders must be considered together as professionals coordinate their work in an effort to either reunite the family or find another permanent placement for the children if a child has been removed from the home. This demands that significant progress toward recovery from addiction or substance abuse, and the resolution of social and other health issues, must occur within 15 months for families to stay intact.

The report to Congress mandated by ASFA entitled, “Blending Perspectives and Building Common Ground; A Report to Congress on Substance Abuse and Child Protection” (HHS, 1999) focused on the importance of understanding relationships between child maltreatment and substance abuse in families as well as emphasizing the critical need for greater understanding of addiction, substance abuse treatment, and recovery among all parties. It was noted that 8.3 million U.S. children are living with a parent who has a substance use disorder and that child neglect cases are often found in those families. Also, children in foster care whose parents have substance use disorders tend to be in foster care longer than other children, children of parents who have substance use disorders experience more developmental problems when compared to other children, and are at risk of developing substance use disorders themselves. There is a need to improve services to children who have come to the attention of the CPS system and those who are in foster care. A recommended means to that end is to assure timely access to comprehensive substance abuse treatment services for those in need of treatment which facilitates engagement and retention in the treatment process and otherwise supports recovery.

The report further recommended that the CWS and the AOD system examine barriers to collaboration, develop an enhanced mutual understanding of the two systems, develop shared expectations, and improve service delivery models to improve both child and family outcomes. Areas to be addressed included: 1) prevention, 2) training, 3) risk assessment, needs assessment, referral, and treatment plans, 4) increase access to, and the availability of, substance abuse treatment, 5) emphasize treatment retention and effectiveness, 6) consideration of timelines for children’s development and permanency decisions, and 7) support for the recovery process for parents. Next steps centered on the

need for Child Welfare and AOD leaders to recognize, discuss, and communicate the issues, increase knowledge, build collaborative working relationships and make changes as necessary.

In addition to their contributions to the Blending Perspectives and Building Common Ground Report to Congress, passage of ASFA provided the impetus for other collaborative initiatives by ACF and SAMHSA. Notable among these initiatives was the decision by ACF and SAMHSA's Center for Substance Abuse Treatment (CSAT), to create, through a jointly funded program, a National Center on Substance Abuse and Child Welfare (NCSACW).

The NCSACW was created in September of 2002 for the purpose of collecting and disseminating information on substance abuse and child welfare issues, delivering technical assistance, and promoting the development of knowledge in the field to effect system change at various levels within and across systems. The NCSACW is focusing on developing knowledge to improve collaboration between the CWS, the AOD system, and dependency courts and is providing assistance in policy and practice areas. The Center is supported by a five year contract and is utilizing a Consortium approach that includes organizations that have expertise and interest in the CWS, AOD system, and the dependency courts. (NASADAD is one of the consortium members.) For more information about the NCSACW, its products and services, please refer to <http://www.ncsacw.samhsa.gov>.

The intent of this document is to provide a reference source for State AOD Directors and Child Welfare Administrators which includes recommendations developed by a workgroup composed of State AOD Directors and Child Welfare Administrators, and related information on agreements which have been developed by States that may be of value to other States seeking ways to facilitate the creation of systems more responsive to the requirements of ASFA and the welfare of children. The policy recommendations focus on the elements, content, and development of collaborative models between the State CWS and the AOD system as well as other systems to guide AOD Directors and Child Welfare Administrators as they develop policies and oversee services delivered to families in the child welfare system who are involved with substance abuse.

Specifically, these recommendations are based on the product of a 2002 workgroup meeting of representatives of the National Association of State Alcohol and Drug Abuse Directors (NASADAD)/ the American Public Human Services Association (APHSA)/ the National Association of Public Child Welfare Administrators (NAPCWA), organization staff, and a guest participant, Dr. Nancy Young. Materials on State substance abuse and child welfare collaborative tools and programs were requested from State AOD and Child Welfare Agencies prior to the meeting and reviewed at the meeting. The materials were previously organized in categories that closely matched the organizational scheme of a matrix under development for a CSAT Treatment Assistant Protocol (TAP) publication (Young and Gardner, 2002). Child welfare and AOD information on system linkages was organized in the matrix according to ten identified elements and three practice levels, and it was revised at a later date (NCSACW, 2003).

The Workgroup decided to organize its recommendations according to the following elements listed in the revised matrix:

- Underlying Principles and Values in Collaborative Relationships
- Daily Practice: Client Screening and Assessment
- Daily Practice: Client Engagement and Retention in Care
- Daily Practice: Services to Children of Substance Abusers
- Joint Accountability and Shared Outcomes
- Information Sharing and Data Systems
- Training and Staff Development
- Budgeting and Program Sustainability
- Working with Related Agencies
- Working with the Community and Supporting Families

Guidance and Policy Recommendations

1. Recommendations for Underlying Principles and Values in Collaborative Relationships

The State AOD system and the CWS should work together to develop an approach for identifying common goals, agree on those goals in a respectful manner, and as equal partners. Important goals to be considered include child safety, child permanence, child well being, and family well being. Both systems should be involved with the family at the beginning of an encounter to facilitate case management and the substance abuse treatment and recovery process. The AOD system, the CWS, and other systems including MH, social services, primary health care, maternal and child health, and parts of the judicial system such as the dependency courts should use a multi-disciplinary approach that promotes and encourages coordination, consultation, and collaboration. Stakeholders including clinicians, administrators, and legislators should work together to support the family and arrange and provide for needed family services.

2. Recommendations for Daily Practice: Client Screening and Assessment, Client Engagement and Retention in Care, and Services to Children of Substance Abusers

A team approach should be used to help families in the CWS and a substance abuse professional should be a member of the team from the start and throughout the period of time the family needs assistance. In addition, the team should include professionals from child welfare, other systems such as MH, social services, primary health care, child and maternal health, dependency courts, and other related services, as needed. Primary health care professionals should play a major role in screening for substance use disorders, delivering brief interventions, and referring family members to substance abuse treatment professionals, as needed. Substance abuse, child welfare, and other related services for the family should be clearly defined and expanded as needed. An intervention continuum should be developed, funded, and specified to guide the delivery of services to families.

For client screening and assessment, appropriate assessment techniques should be available, especially in the areas of child development, parenting, and prevention. Tools could be developed, applied and adapted to assist families who are involved with substance use disorders. Tools could include screening and assessment instruments, risk assessment instruments, model case plans (e.g. treatment plan, recovery plan), and confidentiality procedures. Although there are a number of screening and assessment tools available, the tools or the application of these tools need to be modified to meet the clients' individualized treatment needs.

For client engagement and retention in care, guidelines should be established regarding treatment, recovery, and relapse for families and children. The treatment plan should be customized to meet individual treatment needs identified during the assessment process. Guidelines should be established on how the AOD system, the CWS and other systems should work together. Models could be applied and adapted to assist families who are involved with substance use disorders in the CPS, AOD, MH, and judicial systems. An effort should be made to reduce or eliminate treatment waitlist time for AOD impacted parents, especially women. In those instances in which wait time can not be avoided pretreatment programs and practices should be developed and implemented which ensure early and continuous engagement in the therapeutic process.

In addition to delivering substance abuse treatment to parents, parenting skills training should be made available and provided, as needed. Often substance abusing parents have not been able to develop good parenting skills on their own because their own parents may not have served as good role models, and/or earlier substance abuse may have interfered with their emotional development and maturity level. Parents could benefit from being taught age-appropriate interventions with their children.

For services to children of substance abusers, therapeutic services including mental health and substance abuse treatment services should be made available for all age groups. Children in the child welfare system should have their psychological and emotional needs addressed and receive substance abuse prevention, treatment, and recovery support services, as needed. This policy position is supported by NASADAD and the National Council on Juvenile and Family Court Judges (NCJFCJ) endorsement of the "Resolution in Support of the AACAP and the CWLA Values and Principles for Mental Health and Substance Abuse Services and Supports for Children in Foster Care" that is shown in Appendix A. Treatment services should also be made available for adolescents in independent living arrangements. For young children not in need of substance abuse treatment services, child sitting and child development services should be provided along with any other supportive and therapeutic services which may be indicated.

3. Recommendations for Joint Accountability and Shared Outcomes

The AOD system, the CWS, and other related systems should collaborate on the development of shared outcome measures. Performance measures that could track progress in substance abuse treatment and child development should be developed at the

Federal, State, and community level. The information on substance abuse treatment and recovery needed by the CPS system should be clearly specified. As families become involved with the CPS system, it is essential to be able to track and measure patient progress for substance abuse treatment and recovery. Indicators of progress related to treatment and family variables will assist decision makers as they make important and timely decisions that will impact children and families.

4. Recommendations for Information Sharing and Data Systems

A Memorandum of Understanding (MOU), a Memorandum of Agreement (MOA), or a similar instrument that describes a joint statement of purpose and commitment and specifies roles and responsibilities between two or more parties at various levels (i.e. Federal, State, Regional, County, operational) should be prepared among Child Welfare, AOD, and other agencies working with families in the CWS who are involved with substance use disorders. These agreements lay the groundwork for collaboration to occur and proceed among the various systems for the benefit of families. These agreements could be prepared at the State level and serve as templates that could be distributed and used at lower levels.

The AOD system, the CWS, and related systems should develop communication protocols for exchanging information and should capture information from initial screening for a substance abuse disorder and assessment of child safety and well being through parent treatment and recovery, family reunification or other permanent placement, and evaluation of family outcomes. Sharing information about a parent's substance use, progress in treatment, recovery, and relapse will help to ensure the safety and well being of the child but it is also essential to protect the privacy rights of the parent at the same time.

Federal Confidentiality laws – 42 CFR, Part 2 and HIPAA Privacy provisions - 45 CFR, Parts 160 and 164 guide and direct the client information sharing process between the AOD and child welfare system, the courts, and other related systems. The parties involved must apply the law and regulations and use informed consent procedures, court orders, and qualified service organization agreements (QSOA), as necessary. Discussions on the application of the confidentiality regulations and privacy issues should continue and confidentiality products should be developed and assembled in a tool kit and used to aid in exchanging information across agencies.

5. Recommendations for Training and Staff Development

The AOD system and CWS should work together to develop their staff by preparing and offering suitable cross training programs for AOD, child welfare and other professionals in related areas such as MH, domestic violence, and the dependency courts (lawyers and judges). A training plan should include core elements that address function, skill sets, and core competencies (with certifications) that are related to value statements for all parties involved with families in the child welfare and substance abuse system.

For example, child welfare and substance abuse professionals could receive training together in child welfare, substance abuse, and collaboration. Another cross training session could include child welfare, substance abuse and court personnel. Court personnel could learn about child welfare and substance abuse issues and child welfare and substance abuse professionals could learn about court procedures, especially as they relate to child status and placement decisions and the ASFA timelines.

Workforce development for child welfare and AOD professionals is a key to improving the delivery of case management and substance abuse treatment services to families in the CWS and/or CPS which have substance abusing parents and/or substance abusing siblings. Educational programs including cross training, and undergraduate and graduate programs in community colleges and universities should be developed and offered. The programs should include core elements of child welfare, CPS and AOD and should be accredited by a body of social work education such as the Council on Social Work Education.

6. Recommendations for Budgeting and Program Sustainability

Collaboration between the CWS and AOD system on budget and funding requests should improve services to families and result in better value for allocated dollars while reducing overall costs. It is important to understand the way in which States create and generate funding streams in the CWS and AOD system so that improvements or enhancements can be made. Joint budget requests that allow for flexibility in the funding process and multiple funding streams are needed. States could explore various funding arrangements and create models under federally funded pilot programs which would document the positive effects of increased federal funding flexibility and amounts, identify the barriers to alternate funding arrangements, and demonstrate the benefits of more effective service delivery at reduced costs.

7. Recommendations for Working with Related Agencies

To provide assistance to families who have family members involved with substance use disorders, the CWS and the AOD system need to collaborate and coordinate efforts with related systems and agencies that include the dependency courts, juvenile justice, MH, social services, primary health care, maternal and child health, and domestic violence. The roles, responsibilities, and operational procedures and interrelationships between State systems and related agencies need to be clearly defined. The CWS, the AOD system, and dependency courts should be knowledgeable and sensitive to each other's timelines for delivering services to families and for meeting the ASFA time requirements. These systems and other related agencies should work together as they make client referrals, deliver services to families, and monitor family outcomes.

8. Recommendations for Working with the Community and Supporting Families

In addition to making substance abuse treatment programs available to families in the child welfare system, evidence-based substance abuse prevention programs should also

be available and implemented. The AOD system should work collaboratively with the CWS, the CPS system, the primary health care system, and special populations on developing community based prevention programs designed to prevent substance abuse and support families. AOD and Child Welfare, professionals, paraprofessionals and community members should work together to address substance abuse prevention in the community. For example, primary care physicians should work with maternal and child health specialists to screen women of child bearing age or pregnant women for substance abuse and deliver brief interventions, as needed, in an effort to prevent Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effect (FAE) in their children.

Prevention models should be evidence-based, have a goal of keeping families together and be applied in the early stages of family assistance programs. Family programs and parenting assistance programs should be strengthened, prevention targets should be better defined (e.g., prevention of substance abuse, prevention of abuse and neglect, etc.) and intervention approaches should be clarified, especially those geared toward children. Prevention of substance abuse in child services should focus on early childhood development, healthy families, healthy start, and healthy kids. The child without symptoms, older kids in after school programs, adolescents, and emancipated/independent living adolescents need services and funding. The implementation of effective community intervention approaches to support families should result in the reduction of families entering the CWS and AOD system.

Interagency Agreements: A Basic Tool for the Articulation and Implementation of State Child Welfare and AOD Collaborative Policy

State Agency Directors should support the development of Memoranda of Understanding (MOU) or Memoranda of Agreement (MOA) for use as policy tools to guide collaborative working relationships among agencies that serve children and families in the child welfare system which have parents involved with substance use disorders. These tools will assist in building the foundation for improved communication and collaboration and coordination at various levels (i.e., administrative, supervisory, front-line) across agencies. Agency administrators who have the authority to establish and execute interagency agreements should lead the development effort and request participation of supervisory and frontline professionals as the scope and content of the agreement is developed. The policy recommendations proposed in the documents should be considered as the agreements are developed and sections on identification of parties, purpose and rationale, roles and responsibilities, procedures for collaborating and coordinating, guidelines for communicating and sharing information, and training are established. A process for reviewing and updating the agreement should be included. In addition, forms that specify necessary information for screening and referral and for sharing confidential information could be developed and attached.

Some States already have developed MOUs and MOAs to define their inter-agency agreements on collaboration between AOD, child welfare, and/or other agencies. AZ, DE, MD, NC, SC, WA forwarded their agreements to NASADAD in response to a request to the State AOD Agencies to send information on collaborative initiatives

between the AOD system and the CWS. The major focus of the agreements is on defining how related agencies will coordinate screening, assessment, referral, substance abuse treatment and recovery services for family members in the child welfare system involved with substance use disorders. There are similarities and differences among the agreements but all of them identify the parties, the purpose, and individual and joint agency roles and responsibilities. Five States include two parties to the agreement while one State (DE) includes three parties to the agreement: AOD, Family Services, and Social Services. In March 2004, DE convened a forum for the purpose of having the three parties (administrators, supervisors, and front-line staff) discuss their State collaborative effort and to update and expand their MOU. Procedures for identification, assessment, and referral, communicating and sharing information, guidelines for adhering to client confidentiality regulations, and cross-training inter-agency staff were major areas that were revisited. WA plans to revisit and revise their agreement in 2004.

The agreements for six States are briefly described below and indicate the Title, Parties Involved, and the Sections in each State's agreement:

Arizona

Title/Parties: Intergovernmental agreement between the Arizona Department of Economic Security (ADES) and Arizona Department of Health Services (ADHS) – March 2001. Parties are authorized to execute and administer contracts and are responsible for services to children and families, are responsible for the joint administration of the Substance Abuse Treatment Fund, and desire to establish a methodology and protocol to define each agency's duties and obligations in jointly administering the Fund.

Sections: Agreement Term, Definitions, Purpose, Mutual Objectives, Partnership Responsibilities, Financing, Payment, Expenditure Reports, Notices, Dispute Resolution, Non-Availability of Funds, Audit of Records, Cancellation for Conflict of Interest, Third Party Antitrust Violations, Applicable Law, Indemnification, Amendments, Compliance With Non-Discrimination Laws, and Termination Provisions.

Delaware

Title/Parties: Memorandum of Agreement between the Department of Services for Children Youth and Their Families, the Division of Family Services (DFS) and the Department of Health and Social Services, the Division of Substance Abuse and Mental Health (DSAMH), and the Department of Health and Social Services, the Division of Social Services (DSS).

Sections: Introduction and Purpose, Roles and Responsibilities, Collaboration and Coordination, Administration of the Memorandum.

Maryland

Title/Parties: Memorandum of Understanding for Interagency Funding between the Maryland State Department of Human Resources/Social Services Administration (DHR/SSA), and the Maryland State Department of Health and Mental Hygiene, Alcohol and Drug Abuse Administration (DHMH/ADAA) for the implementation of the substance abuse Title IV-Waiver Demonstration Project Initiative – September 2001.

Sections: Background/Federal Statute, Provisions for the Application and Establishment of Community Health Workers and of Purchasing Substance Abuse Treatment Slots, DHR/SSA's Responsibilities, DHMH/ADAA's Responsibilities, and Joint DHR/SSA and DHMH/ADAA's Responsibilities.

North Carolina

Title/Parties: North Carolina Memorandum of Agreement between the County Department of Social Services and the Area Program/Local Management Entity (LME) – 2003. This Memorandum of Agreement establishes procedures surrounding the services of a Child Protective Services/Work First Qualified Substance Abuse Professional (CPS/WF QSAP) with Child Protective Services (CPS).

Sections: Purpose, the Department of Social Services Agreement, the Area Program Agreement, and the Department and Area Program Joint Agreement.

South Carolina

Title/Parties: Memorandum of Understanding between the South Carolina Department of Social Services (DSS) and the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) – March, 1999.

Sections: Purpose, Objectives, Confidentiality of Client Information between DSS and DAODAS, Roles and Responsibilities of DSS and DAODAS, and Protocol for Referrals between DSS and DAODAS and the Local Alcohol and Drug Agencies.

Washington

Title/Parties: Department of Social and Health Services Intra-Agency Agreement between the Health and Rehabilitative Services Administration (HRSA) Division of Alcohol and Substance Abuse (DASA) and the Children's Administration (CA) – January 1999.

Sections: Purpose, Mutual Agreement, Intra-Agency Coordination, Intra-Agency Planning, Alterations and Amendments, Period of Agreement, and All Writings Contained Herein.

Discussion

State AOD, Child Welfare, and other related agencies recognize the need for child welfare and AOD agency collaboration in their State. Collaboration can occur at various levels and degrees among selected agencies. States should determine their current level and extent of collaboration with key agencies and assess their readiness for systems change and collaboration at a new level. Agency leaders and staff should hold meetings to discuss inter-agency collaboration initiatives, parties with whom to collaborate, areas of collaboration, and specific roles, responsibilities, and operational procedures. It is suggested that collaboration initiatives should accommodate consideration and/or adoption of the policy recommendations under the eight recommendation areas identified in this guide, and be formalized as an inter-agency agreement. Such agreements serve as valuable tools in guiding the implementation of inter-agency activities, especially if all involved personnel are aware of the agreement, have an understanding of its purpose, and knowledge of its content. Once collaborative initiatives and programs between agencies are implemented they should be monitored and evaluated, and regularly updated and/or expanded over time. By extension, the interagency agreements underlying collaborative activities should also be subject to periodic review and revision.

Many States will need technical assistance in planning, developing, implementing, and/or evaluating inter-agency model collaborative programs in child welfare, AOD, and other agencies for the benefit of families. State AOD Agencies can make requests for CSAT technical assistance through their State Project Officers. The NCSACW provides various levels of technical assistance to States and currently provides in-depth technical assistance to selected State teams (FL, CO, VA, MI, CT). States that have already made progress in defining their goals and developing and implementing collaborative programs could assist other States to develop shared policy goals and plans. In addition, States could benefit from receiving technical assistance in planning for and facilitating meetings across agencies, and developing and reviewing inter-agency agreements (MOUs or MOAs). Access to relevant reference materials, templates, toolkits, and workshops would aid States as they create their own collaborative model.

Successful collaboration depends on State AOD, Child Welfare and other service systems creating inter-agency agreements, which will support the implementation of agreed upon practices and procedures, provide incentives for professionals to work cooperatively across agencies, and promote a family centered approach. Administrators need to develop collaborative relationships and have the authority to implement agreed upon collaborative programs and initiatives. The workforce should become familiar with inter-agency agreements and attend cross-training sessions to promote mutual understanding between the AOD system, the CWS, the dependency courts, and other service systems such as mental health and social services. A family centered approach allows agencies to attend to the safety, well being and permanency needs of the child and the treatment and recovery needs of the parents, and, at the same time, recognizes and considers family input as services are delivered. Effective systems collaboration and coordination among child welfare, AOD, and other agencies should facilitate the timely delivery of needed family services from multiple agencies, and result in improved services to families for the

benefit of children and parents in need of substance abuse treatment and recovery services.

References

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APPENDIX A

NASADAD Resolution In Support of AACAP and CWLA Values and Principles for Mental Health and Substance Abuse Services and Supports for Children in Foster Care

Resolution in Support of the American Academy of Child and Adolescent Psychiatry (AACAP) and the Child Welfare League of America (CWLA) Values and Principles for Mental Health and Substance Abuse Services and Supports for Children in Foster Care as moved and approved in the June 6, 2004 National Association of State Alcohol and Drug Abuse Directors (NASADAD) Board of Director's Meeting, Portland, Maine.

WHEREAS, children and their families in the child welfare system have a variety of unmet needs; and

WHEREAS, issues related to the mental health and substance abuse service needs of children and their families in the child welfare system must be addressed in a meaningful way; and

WHEREAS, the Child Welfare League of America (CWLA) and the American Academy of Child and Adolescent Psychiatry (AACAP), along with collaborative partners, have developed a statement of values and principles regarding mental health and substance abuse principles and treatment services and supports for children in foster care and their families; and

WHEREAS, these values specify that whenever possible mental health and substance abuse principles and treatment services and supports must be:

- Child-focused,
- Family-driven,
- Integrated, collaborative, coordinated, and community-based,
- Culturally relevant and competent, strength-based and provided by knowledgeable, skilled providers who understand the cultural diversity of the community, and
- Timely, effective, evidence-based, and outcome-driven; and

WHEREAS, these values generate a range of principles:

1. Service coordination and case/care management,
2. Prevention and early identification,
3. Planned and coordinated transitions among agencies and providers and between the child and adult systems,
4. Human rights and responsibilities regarding protection and advocacy pertaining to minor children, family members, and emancipated young people and their family members,
5. Nondiscrimination in access to services,
6. A comprehensive and accessible array of services,
7. Individualized service planning,
8. Services in the least intrusive community-based environment that is consistent with promoting mental wellness,

NASADAD Board of Director's Meeting
Portland, Maine
June 6, 2004
Page 2 of 2

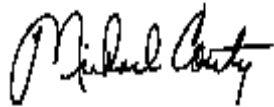
9. Family participation in ALL aspects of service planning, delivery, and evaluation unless otherwise court ordered,
10. Integrated services with coordinated planning across the child serving systems.

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors for the National Association of State Alcohol and Drug Abuse Directors, Inc. endorses these values and principles and recommends that whenever possible these values and principles for mental health and substance abuse services and supports for children in foster care and their families be used to guide reform and innovation as we work collaboratively to improve the outcomes and well-being of these children and their families;

BE IT FURTHER RESOLVED that the Board of Directors for the National Association of State Alcohol and Drug Abuse Directors, Inc. endorses ongoing collaboration with CWLA and AACAP in this effort.

Adopted this 6th day of June, 2004

By the NASADAD Board of Directors representing the membership
In Portland, Maine



Signed: _____

Michael Couty, NASADAD President