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Child Welfare, Domestic Violence And Substance Abuse: A Report on Protocols and Practices Preliminary Report

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Background

Across the country and in Maine a significant number of children enter the child welfare system because a parent or caregiver abuses drugs or alcohol. As a result of this growing concern, last March the Maine Child Abuse Action Network and the Department of Human Services sponsored a day long conference called "No Safe Haven: Children of Substance Abusing Parents." The title for the conference was taken from a l999 national report by Columbia University's National Center on Addiction and Substance Abuse with the same name.

According to Susan Foster, Vice President and Director of Policy Research and Analysis at the National Center for Addiction and Substance Abuse, their l999 study "showed that 40% of the child welfare professionals surveyed said that substance abuse is responsible for 50% to 74% of their cases." An additional 40% reported that substance abuse is responsible for 75% to 100% of their cases. The study also indicated that alcohol was the drug of choice in 90% of the cases.

The observations from this conference were also identified by the Commission on Child Abuse. The Commission, established by the 119th Legislature, highlighted in its report (November, 2000) the relationship between child abuse/neglect and substance abuse and called for additional analysis of the issue.

Furthermore, the problem of substance abuse and child abuse/neglect has received attention due to the passage by Congress in l997 of the Adoption and Safe Families Act (ASFA). The Act requires that a child have a plan for permanency within a year of being removed from his/her home. Because substance abuse treatment does not always coincide with this time frame, child welfare professionals and substance abuse providers are often faced with conflicting goals.

Along with child abuse and neglect, the state faces a serious problem related to domestic violence. Over the last ten years almost half of the state's homicides involved domestic violence. Consequently, Governor Angus King and Supreme Court Chief Justice Daniel Wathen have identified domestic violence as one of the most important social problems facing the state. Both law enforcement officials and social service professionals have reported that cases of domestic violence also involve substance abuse.

Introduction

The Substance Abuse Protocols Project (SAPP) was initiated January l5, 2001 through a cooperative agreement between the Office of Substance Abuse (OSA) and the Muskie School's Institute for Child and Family Policy. The purpose of the Project is to examine issues related to child abuse/neglect and substance abuse and domestic violence and substance abuse. In particular, the Project is interested in determining how the child welfare system and domestic violence programs interact with substance abuse services. The Project has attempted to identify the existence of treatment protocols and pathways for individuals or families needing substance abuse services. More specifically, the Project has sought to answer the following questions in the areas of child welfare and domestic violence.

- To what extent are substance abuse services available for situations involving child abuse/neglect and domestic violence?
- What type of screening and assessment is conducted for substance abuse?
- What type of referral process is utilized involving primarily public or non-profit agencies.
- What criteria are used to determine progress in treatment?
- Do substance abuse treatment providers offer relapse prevention planning?
- What are the most significant barriers to services?
- What practices appear to be the most effective?

These questions were intended to gain a better understanding of: 1) how the referral system works; 2) the availability of services; 3) the barriers that impede access to services; and 4) what services work and what would make current practices and services more effective.

Research Methodology

Given the time and funding restraints of this project, a four pronged research methodology was utilized including an analysis of secondary data, and the collection of primary data through telephone surveys, focus groups and mailed surveys. This approach has allowed for the collection of both quantitative and qualitative data.

1) A review of existing data from the Office of Substance Abuse and Department of Human Services was completed. This analysis examined demographic and incidence data related to child abuse/neglect and substance abuse and domestic violence and substance abuse.

2) Telephone surveys were conducted with key informants to identify treatment protocols, the availability of services, barriers to services and best practices. The Project completed interviews with forty-three (43) persons. The surveys were conducted with child welfare professionals, domestic violence service providers, law enforcement officials, judges and attorneys.

3) Focus groups were conducted with two groups of substance abuse service providers and two groups of caseworkers and supervisors at the Department of Human Services.

4) A substance abuse provider survey was mailed to all agencies/individuals licensed by the Office of Substance Abuse. The survey was returned by eighty-seven (87) agencies/individuals.

5) A survey was also mailed to individuals who had completed cross-disciplinary training in Caring for the Abuse Affected Child. Fifty (50) individuals returned the survey.

The first phase of this research methodology has been implemented and completed. The data from this phase will assist the Office of Substance Abuse in understanding the relationship between the child welfare system and substance abuse providers as well as the relationship between domestic violence service providers and substance abuse programs.

Timeline

This preliminary report represents the first of two reports that will be produced by the Project. The preliminary report is intended to provide an overview and analysis of the current protocols and practices that now exist related to child welfare, domestic violence and substance abuse in the state. The final report will be completed by May 1, 2001 and will concentrate on best practices and model programs that have been adopted within the state and nationally.

STATISTICS

One task of this project was to review existing data on the nature of substance abuse within the context of domestic violence and child abuse. Project staff contacted both the Office of Substance Abuse and the Department of Human Services.

The following analysis is based upon data retrieved from the Office of Substance Abuse Data System (OSADS) for two fiscal years beginning July 1st 1997 and ending on June 30th 1999. In Maine, licensed substance abuse treatment providers are required to complete a form to submit to OSA on each individual receiving substance abuse treatment services. Information from OSADS is collected and maintained by the Maine State Office of Substance Abuse which is housed in a centralized database that captures basic demographic information as well as data pertaining to treatment services, treatment history, drug and alcohol use, mental health and criminal history.

For the two year period, a total of 19,928 records were obtained of which 13,787 records (69.2%) represent unduplicated/per-client level data which serves as the basis for the analysis which follows.

Approximately 20% of the overall population of substance abuse treatment recipients in Maine were identified as victims of domestic violence. Table 1 (below) presents client-level demographic information for those whom received substance abuse treatment services within this two-year period. The first column of Table 1 displays varying demographic characteristics of clients identified as victims of domestic violence (DV). The second column displays similar information for those clients not identified as victims of domestic violence (non-DV) and the third column presents the same information for the population of substance abuse service recipients on the whole. Important differences between the DV and non-DV populations are highlighted in red for easy reference.

As shown in Table 1, we find no substantial differences in the demography of the DV/non-DV population across the following characteristics: Age Group, Last Grade Completed, Population Density, Type of Service Provided, Living Arrangements, Number of Prior Treatment (Tx) Episodes and Primary Drug of Choice. Important differences between DV and non-DV populations have been found, however, across the following 12 categories:

1) **Gender** – Nearly two-thirds (65.5%) of all persons receiving substance abuse treatment services in Maine are male whereas the vast majority of persons identified as victims of domestic violence were female (72.7%).

2) **Marital Status** – Over two-fifths (40.2%) of DV substance abuse treatment recipients had never been married in contrast to over half (50.9%) of non-DV clients. Additionally, the percentage of DV clients who identified themselves as separated were over double that of their non-DV counterparts (5.6%) and nearly double that of the population as a whole (7.3%).

3) **County** – The percentage of DV clients in Androscoggin County (13.4%) are nearly double that of their non-DV counterparts (6.9%).

4) **Employment Factor** – There are two important differences in the employability classification between DV and non-DV clients. DV clients are more likely to be on disability (24.8%) or classified as a homemaker (8.9%) in contrast to non-DV clients (16.2% and 24.8% respectively) and are less likely to be employable or working now (DV=40.1% versus non-DV=56.2%).

5) **Mean Household Income** – DV clients have an average monthly income nearly $300 less than non-DV clients.

6) **Primary Source of Household Income** – DV clients are more likely to rely upon AFDC (16.8%) and SSI (10.0%) as their primary source of household income in contrast to non-DV clients (4.8% and 5.4% respectively). In addition, DV clients are less likely to have a primary income based on either wages/salaries (DV=39.1% versus non-DV=58.5%).

7) **Number of Dependent Children** – DV clients (53.9%) are more likely to have dependent children than non-DV clients (37.2%).

8) **Reimbursing Agency** – DV clients are far more likely to have their substance abuse treatment services reimbursed by DHS (40.6%) than non-DV clients (19.3%).

9) **Age at First Use** – DV clients start using drugs and/or alcohol at a much earlier age than non-DV clients as well as the entire population of substance abuse treatment recipients on the whole.

10) **Primary Presenting Problem** – DV clients are more likely to be classified as Affected Other/Co-Dependent (26.1%) than non-DV clients (8.2%).

11) **Co-existing Mental Illness** – DV clients (43.2%) are far more likely than non-DV clients (22.5%) to have a co-existing mental illness.

12) **Number of Times Treated for Medical Reasons (last 12 months)** – DV clients are more likely to have been treated at a physicians office (43.8%) or emergency room (13.3%) more frequently (three or more times) than non-DV clients (24.9% and 6.4% respectively).

Table 1: State-wide Demographics of Maine's Substance Abuse Treatment Service Recipients

Demographic	Victim of Domestic Violence	Non-Victim of Domestic Violence	Overall Population
Gender			
Male	27.3%	74.9%	65.5%
Female	72.7%	25.1%	34.5%
Age Group			
Under 18 years	17.3%	16.1%	16.4%
18-29 years	28.1%	28.9%	28.7%
30-39 years	31.8%	28.5%	29.2%
40-49 years	17.9%	18.2%	18.1%
50 years and older	4.9%	8.3%	7.6%
Last Grade Completed (Adults)			
8th grade or less	7.1%	5.7%	6.0%
9th grade	6.3%	5.2%	5.4%
10th grade	6.8%	7.0%	7.0%
11th grade	7.8%	7.6%	7.6%
12th grade	49.6%	50.2%	50.1%
Beyond 12th grade	22.4%	24.4%	24.0%
Marital Status			
Never Married	40.2%	50.9%	48.8%
Now Married/Cohab.	19.1%	22.5%	21.8%
Separated	13.9%	5.6%	7.3%
Divorced	25.4%	19.7%	20.8%
Widowed	1.4%	1.3%	1.3%
Population Density			
Urban	38.3%	36.2%	36.6%
Town/Village	20.0%	21.2%	21.0%
Rural	41.7%	42.6%	42.4%
County			
Androscoggin	13.4%	6.9%	8.2%
Aroostook	6.2%	7.6%	7.4%
Cumberland	15.1%	19.4%	18.5%
Franklin	1.4%	1.3%	1.3%
Hancock	1.7%	2.5%	2.4%
Kennebec	13.1%	10.7%	11.2%
Knox	5.0%	4.9%	4.9%
Lincoln	2.0%	3.4%	3.1%
Oxford	4.5%	3.4%	3.7%
Penobscot	14.0%	11.3%	11.9%
Piscataquis	0.8%	1.7%	1.5%
Sagadahoc	2.0%	3.7%	3.3%
Somerset	3.6%	4.4%	4.2%
Waldo	5.9%	4.4%	4.7%
Washington	2.2%	3.7%	3.4%
York	9.1%	10.6%	10.3%

Table 1: State-wide Demographics of Maine's Substance Abuse Treatment Service Recipients

Demographic	Victim of Domestic Violence	Non-Victim of Domestic Violence	Overall Population
Employability Factor			
Employable or working	40.1%	56.2%	53.0%
Student	16.2%	12.9%	13.6%
Homemaker	8.9%	2.6%	3.9%
Retired	0.4%	1.6%	1.4%
Disability	24.8%	16.2%	17.9%
Inmate of Institution	4.0%	5.3%	5.0%
Seasonal Worker	0.5%	0.7%	0.7%
Temporary Layoff	0.7%	1.2%	1.1%
Unable Due to Skills/Resources	1.7%	0.9%	1.1%
Unable due to Program Req.	2.6%	2.4%	2.4%
Mean Household Income (monthly)	$823.53	$1,096.31	$1,039.75
Primary Source of Household Income			
None	14.5%	15.7%	15.4%
Wages/Salary	39.1%	58.5%	54.6%
Retirement	0.5%	1.3%	1.1%
Alimony	0.1%	0.1%	0.1%
Food Stamps	2.7%	1.0%	1.4%
AFDC	16.8%	4.8%	7.2%
SSI	10.0%	5.4%	6.3%
Disability, Other	6.1%	5.0%	5.2%
Town Welfare	1.4%	1.0%	1.1%
Child Support	1.5%	0.5%	0.7%
Unemployment	1.7%	2.0%	1.9%
Social Security	3.3%	2.3%	2.5%
Dealing Drugs	0.3%	0.2%	0.2%
Workers Compensation	0.3%	0.4%	0.4%
Other/Investments	1.8%	1.7%	1.7%
Living Arrangements			
Lives Alone	19.7%	19.3%	19.4%
Independent Living, w/ Others	54.9%	56.4%	56.1%
Dependent Living	19.8%	19.4%	19.5%
Homeless	5.6%	4.8%	5.0%
Number of Dependent Children			
None	46.1%	62.8%	59.5%
One	21.0%	16.6%	17.5%
Two	19.3%	13.0%	14.3%
Three	9.8%	5.3%	6.2%
Four or More	3.8%	2.3%	2.5%

Table 1: State-wide Demographics of Maine's Substance Abuse Treatment Service Recipients

Demographic	Victim of Domestic Violence	Non-Victim of Domestic Violence	Overall Population
Referral Source			
Self	26.9%	23.8%	24.4%
Family Member	7.7%	5.8%	6.1%
Employer	0.3%	0.9%	0.8%
SA Professional (Private Practice)	1.7%	1.2%	1.3%
Substance Abuse Agency	5.5%	5.0%	5.1%
Physician	3.6%	2.5%	2.8%
Other Professional	10.4%	4.3%	5.5%
DEEP	5.5%	20.5%	17.5%
DHS – Adult Protective	0.4%	0.2%	0.3%
DHS – Child Protective	5.9%	2.1%	2.8%
DHS – Substitute Care Services	0.6%	0.2%	0.3%
Probation/Parole	6.5%	13.4%	12.0%
Correctional Facility	1.8%	3.6%	3.2%
County Jails	2.4%	1.9%	2.0%
AMHI	0.4%	0.9%	0.8%
Mental Health Agency	3.5%	1.5%	1.9%
Friend	3.5%	2.8%	2.9%
EAP	0.4%	0.6%	0.6%
SAP	0.1%	0.1%	0.1%
State/Federal Court	0.4%	0.7%	0.6%
Formal Adjudication	0.1%	0.1%	0.1%
Self-Help Group	0.5%	0.1%	0.2%
Hospital	7.3%	4.7%	5.2%
School	2.1%	1.4%	1.5%
Other	2.5%	1.7%	1.9%
Reimbursing Agency			
DMHMRSAS	38.4%	37.4%	37.6%
DHS	40.6%	19.3%	23.5%
Corrections	0.9%	1.4%	1.3%
Other	20.2%	41.9%	37.6%
Type of Treatment Service Provided			
Inpatient/Short-term	5.8%	4.7%	4.9%
Extended Care/Shelter	2.3%	4.2%	3.8%
Outpatient	77.7%	75.7%	76.1%
Intensive Outpatient	3.1%	4.2%	4.0%
Evaluation Only	3.3%	6.0%	5.4%
Half-way house	1.9%	1.5%	1.6%
Other	5.9%	3.7%	4.2%
Age of First Use			
Nine and Under	10.0%	5.6%	6.4%
10-12	21.9%	15.0%	16.2%
13-14	23.3%	22.9%	23.0%
15-16	22.0%	28.1%	27.1%
17-18	11.7%	17.0%	16.1%
Over 18	10.9%	11.3%	11.3%

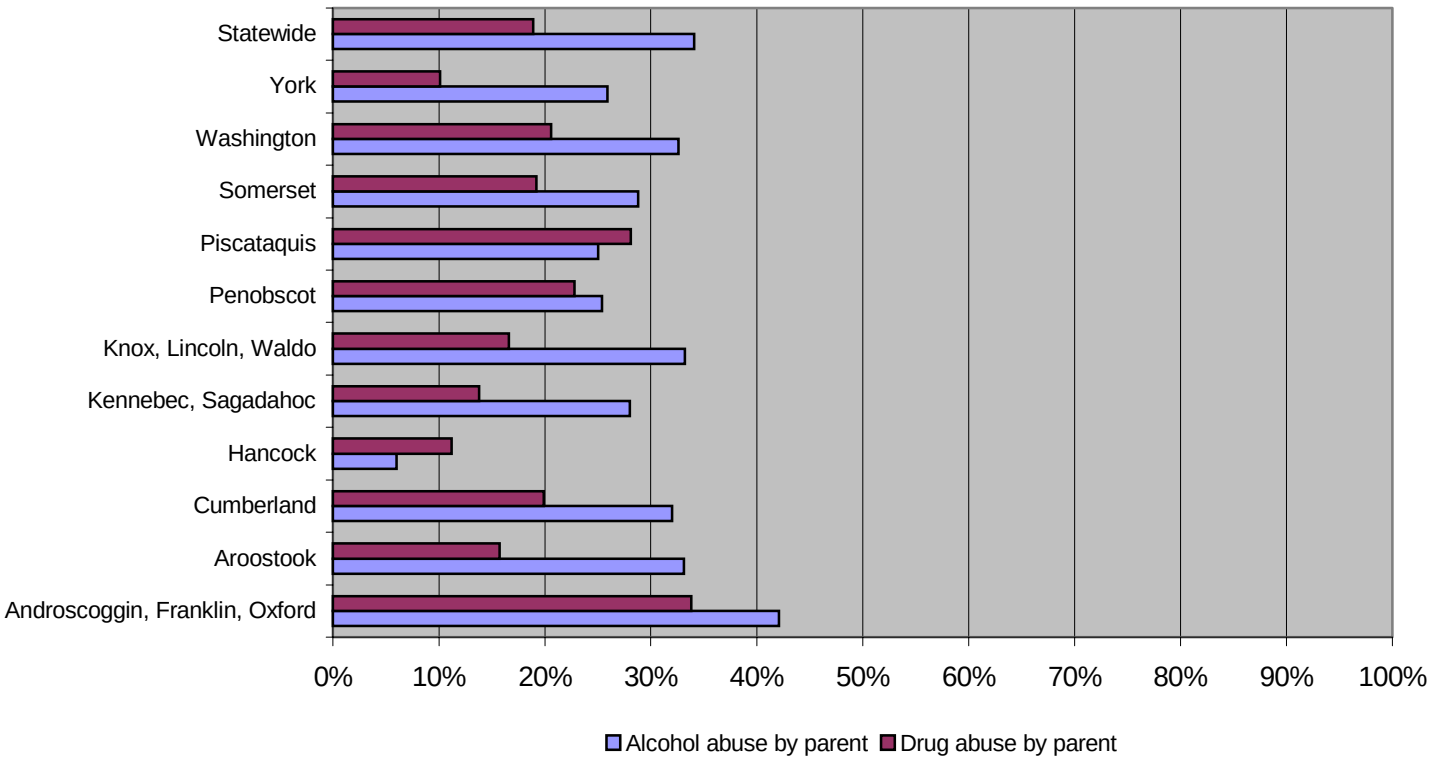
Table 1: State-wide Demographics of Maine's Substance Abuse Treatment Service Recipients

Demographic	Victim of Domestic Violence	Non-Victim of Domestic Violence	Overall Population
Number of Prior Drug/Alcohol Treatment Episodes			
None	49.4%	49.2%	49.2%
One	22.9%	27.0%	26.2%
Two	11.9%	11.0%	11.2%
Primary Drug of Choice			
None	0.1%	0.2%	0.2%
Alcohol	71.9%	75.7%	75.1%
Marijuana	15.8%	14.9%	15.0%
Cocaine/Crack	3.7%	2.0%	2.3%
Heroin	1.8%	2.7%	2.5%
Other Opiates or Synthetics	3.2%	2.6%	2.7%
Hallucinogens	0.4%	0.3%	0.3%
Inhalants	0.2%	0.1%	0.1%
Benzodiazapines	1.2%	0.6%	0.7%
Barbituates	0.7%	0.2%	0.4%
Methamphetamine	0.5%	0.3%	0.3%
Other	0.5%	0.4%	0.4%
Primary Presenting Problem			
Substance Abuse	71.1%	86.9%	83.7%
Affected/Co-Dependent	26.1%	8.2%	11.7%
Evaluation Only	2.8%	5.0%	4.5%
Co-existing Mental Illness			
Yes	43.2%	22.5%	26.6%
No	56.8%	77.5%	73.4%
Number of Times Treated for Medical Reasons (last 12 months)			
Physicians Office			
Not in Last 12 Months	26.2%	46.3%	42.3%
Once	17.9%	18.4%	18.3%
Twice	12.1%	10.4%	10.7%
Three or More Times	43.8%	24.9%	28.7%
Hospital/Emergency Room			
Not in Last 12 Months	51.5%	65.5%	62.8%
Once	24.1%	21.4%	21.9%
Twice	11.1%	6.7%	7.5%
Three or More Times	13.3%	6.4%	7.8%
Hospital/Inpatient			
Not in Last 12 Months	77.6%	84.9%	83.4%
Once	16.3%	11.2%	12.2%
Twice	3.8%	2.4%	2.7%
Three or More Times	2.3%	1.5%	1.7%

Turning to the Department of Human Services, the following data was obtained. During the year 2000, 4,675 child abuse and neglect cases were accepted for investigation. Of those cases, 1,885 (40%) alleged alcohol or drug misuses by a parent or child. Of those allegations, child abuse and neglect was found in 946 (50%) cases and 429 cases were opened, representing 45% of the substantiated cases.

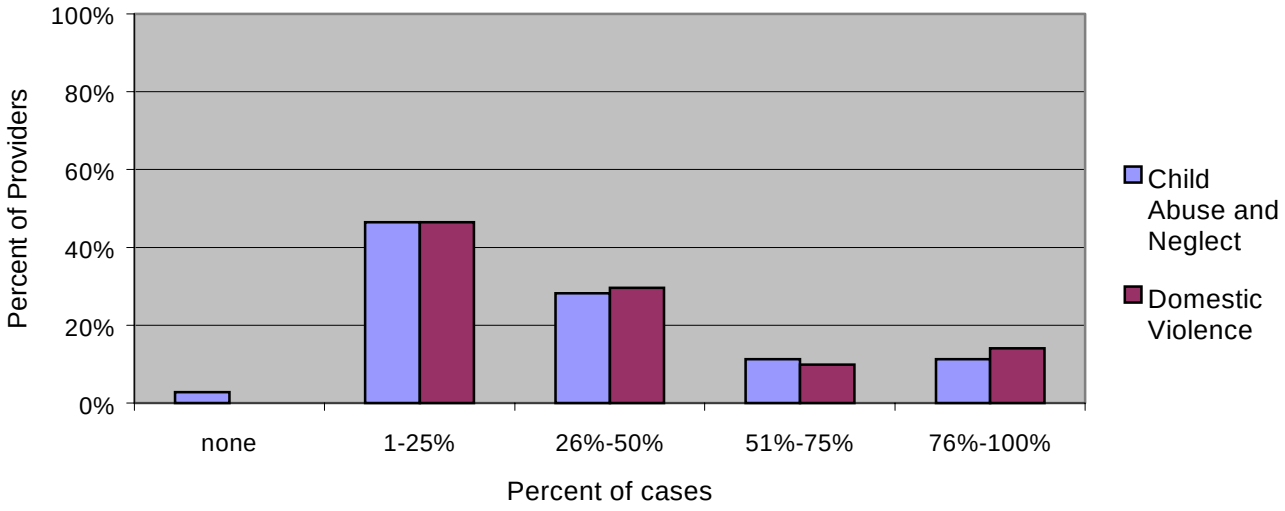
Additionally, we received information from the Adoption and Foster Care Analysis and Reporting System (AFCARS), a system for states to report to the Federal government on children in the state's foster care system. The figures represent all children who were in the foster care system during a six-month period of time, in this case between October 1, 1998 to March 31, 1999. During that time there were 3,412 children with data on 3,272 or 95.9% of those. Of the 3,272 cases, 1,116 or 34.1% involved alcohol abuse by a parent and 617 or 18.9% involved drug abuse by a parent. Alcohol abuse by a child was found in 83 or 2.5% of the cases and drug abuse by a child was present in 73 or 2.2% cases.

Figure 1 describes the incidents of alcohol and drug abuse by a parent:



The project developed a survey that was mailed to all state licensed substance abuse providers, both agencies and individuals. The survey was returned by 87 individuals. When asked what percentage of their cases involved child abuse and neglect or domestic violence, 97.2% said a portion of their caseload involved these issues.

Figure 2: Cases Handled by Substance Abuse Treatment Providers



Further analysis of the data showed that the amount of training was a factor in whether substance abuse providers identified child welfare or domestic violence as part of their caseload. The data also indicated that service providers who said they had received training in the last three years identified, on average, almost twice as many cases involving child welfare and domestic violence versus those who had not received training.

Substance abuse providers also said they received referrals from at least one of the sources listed below:

Figure 3: Child Abuse and Neglect Referrals

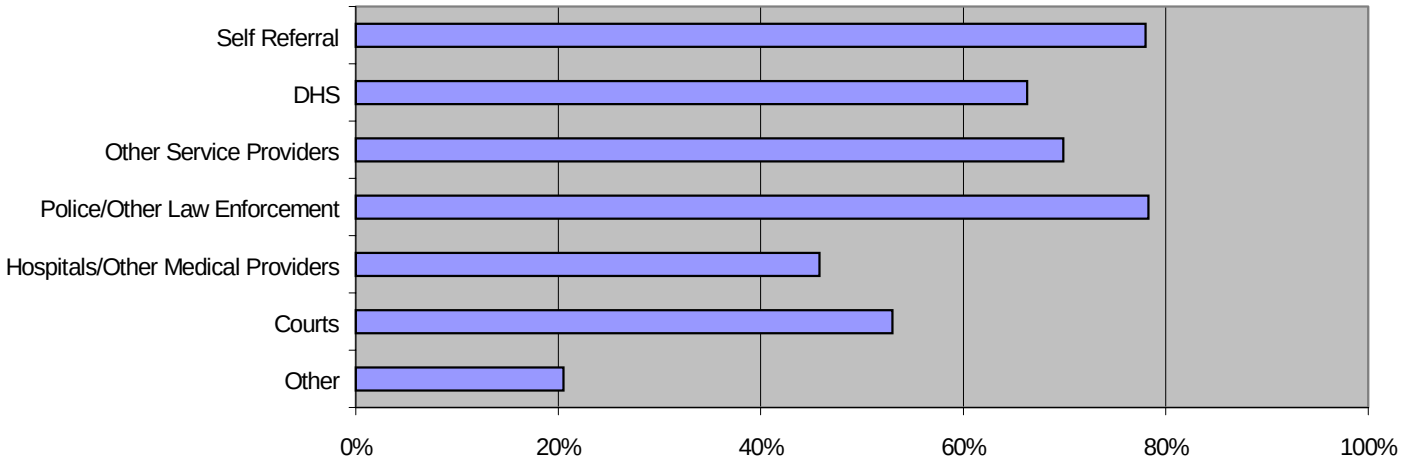
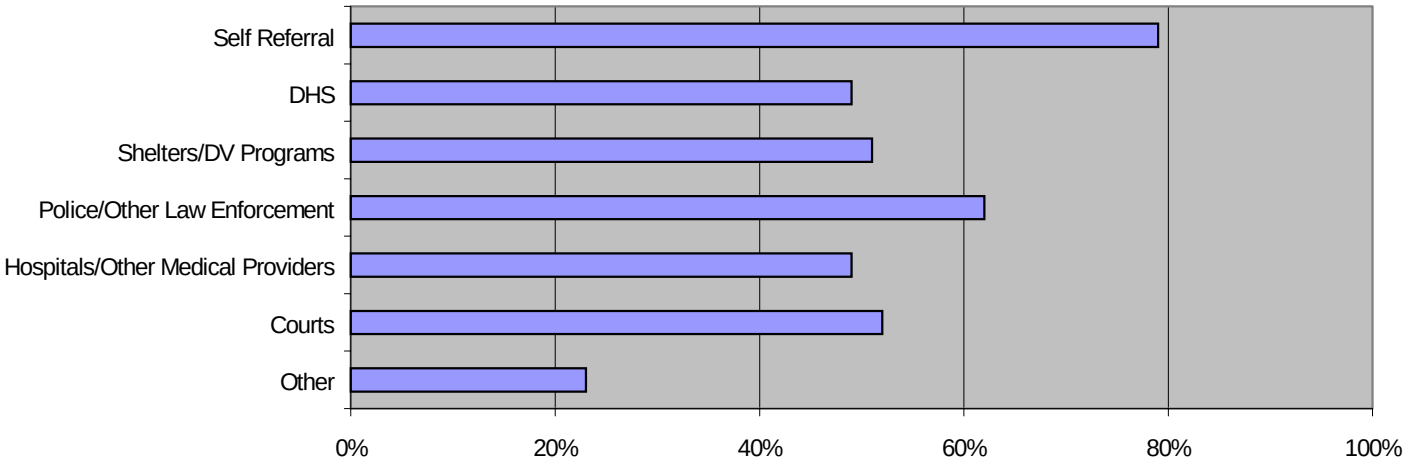
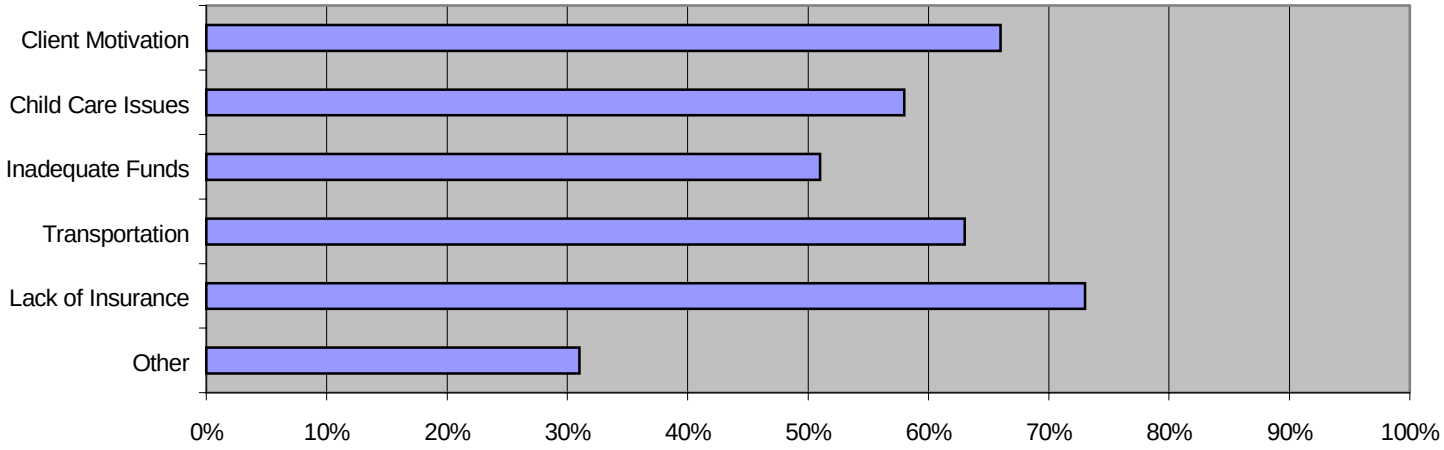


Figure 4: Domestic Violence Referral Sources



When asked to identify barriers to effective treatment, substance abuse providers identified lack of insurance, client motivation, transportation, child care and inadequate funds as the most significant problems.

Figure 5: Barriers to Effective Treatment



FINDINGS RELATED TO CHILD WELFARE AND SUBSTANCE ABUSE

This section summarizes data from the telephone surveys, the focus groups, and surveys of substance abuse providers. The data is organized and presented reflecting the questions posed by the Project.

1. How is substance abuse screened for in child welfare cases?

> *"Often, substance abuse is identified by the referent...other times it is identified in the assessment process...other times it comes out during interviews with the client, the children, or collaterals..."*

DHS workers said substance abuse is identified in "a variety of ways". Most often the issue is identified during the referral process, that is to say the person who calls the Department to make a report of alleged child abuse or neglect also states that substance abuse is a factor in the family. The referent may be the police, a teacher, a family member, a medical provider, or a concerned community member. Each worker assigned to a case conducts a risk assessment, investigating the allegations in the referral. During this process, substance use is routinely explored as a possible risk factor. The worker talks with the client, the children, and other collateral individuals such as teachers, neighbors, or family members. The problem of substance abuse may be identified through these interviews.

Respondents also said substance use/abuse could be identified by observation, either by items in the environment or by behavior. If available, having the client tested for drug/alcohol use is a very effective way of identifying the issue. One worker estimated that "in about 1/2 of the cases, substance abuse is identified in the referral, about 1/3 is known, and the remainder comes out during interviews with the client or collaterals..." Child welfare workers were also asked "In your opinion, what percentage of your cases involve substance abuse?" The answer averaged 69.8%, with a low of 33% and a high of 98%. Workers often said their estimations were "conservative" in nature.

The answers to the screening question also varied depending on "where the case is in the system." The issue of substance abuse is often known by the time a child comes into foster care, whether or not it is the primary issue. Interviews with children and collaterals after a visit can help determine ongoing concerns, as well as observation. One respondent said "sometimes on a visit with a biological family, a parent may show up intoxicated, and the visit would need to end..." In cases like this, observation is used to help monitor the problem, as well as reports from the community.

2. What type of referral process is utilized?

> *"It depends on the case...from a DHS point of view, the question is always to what extent the issue of substance abuse affects the child..."*

Most respondents stated they would recommend a professional substance abuse provider evaluate the client. The recommendations of this provider are "key" to developing a service plan with the client. Respondents said an evaluation usually gives the worker an idea of the extent of the problem, and specific recommendations for the client to follow. Respondents also said that if substance abuse is clearly a problem and the client is willing, treatment is sought as quickly as possible.

DHS workers continually stated their mandate is to assess allegations of child abuse and neglect, so they must always consider how substance use is affecting children. One administrator said the next steps "depend on the severity of the problem and the affect on the kids...our authority rests with this...if child abuse/neglect is substantiated, we can do more; if a substance abuse problem exists, but we haven't substantiated abuse or neglect, we'd close the case with recommendations for treatment." One worker stated "we always have to have information on how the kids are affected...such as no supervision, neglect, etc....we have to know how the kids are impacted (by a parent's substance use)..." The degree of impact on the children will determine the actions taken by DHS.

If child abuse or neglect is substantiated and the client is willing, a referral is made for evaluation, testing, and/or treatment. If the client is unwilling to accept services, and abuse/neglect are found to be severe enough, the state can petition for court-ordered services. Often, if the parents are in denial, the Department can use a parental capacity evaluation to assess the nature and extent of the problem. Again, the respondents stated the need to continually evaluate the impact of substance use on the children involved. In cases where substance abuse is a problem, one worker said, "referrals can always be made," even if the case is not opened. In one area of the state, an administrator said they have started a process for cases in which substance use is a problem but not to the point of going to court. In these cases, if the family is willing, the worker helps coordinate treatment with a community agency, closes the case, and has an agreement with the agency that they will recontact DHS if the family falters. This arrangement has worked, although the administrator said it is a "process in evolution." A few respondents also said they assess where the client is at "according to the Prochaska model[1]", and try and use interventions to help the client move from the denial stage to the contemplative stage. Respondents often clarified that any action taken is always based on the

[1] The Prochaska Model is a model of change based on the following stages: Precontemplation, Contemplative, Determination, Action, Maintenance and Relapse. This model of change can be used in substance abuse work.

specifics of that case.

There were several concerns regarding the evaluation process. Judges and attorneys working in the child welfare system stated that they need quick, inexpensive and reliable evaluations. “We waste a lot of time figuring out what we need.” This is particularly true when the court is dealing with these issues as part of a divorce or protection from abuse process, often when the parties are unrepresented and there are no social service agencies involved. Workers in certain parts of the state also reiterated this as a problem. There is also a need for evaluators to understand the child welfare system and the new timeframe the 1997 ASFA guidelines puts on treatment options.

Many professionals said assisting involuntary clients is difficult. Respondents who work in the child protective field stated that a substance abuse provider will rely on the word of the client, which is often unreliable when you are dealing with someone who is not voluntarily seeking evaluation or services. Evaluations work best when the evaluator asks for police and other reports and asks for the caseworker’s “take on the case”. Overall, the interviews showed gaps in the availability of evaluations across the state, questions about the reliability of evaluations, and sometimes a lack of confidence in the findings.

Substance abuse providers were also asked what type of process is used for referrals involving child welfare and substance abuse. Information from the focus groups and the mail out surveys had the following findings: the referral process often contains “inappropriate referrals”, DHS is a system more about “cohersion than motivation” and, in general, there is a lack of understanding about substance abuse issues. One respondent said: “I believe substance abuse and the process of recovery training should be mandatory. We should be getting more referrals from DHS.” A few other providers questioned the assessment skills of DHS workers, wondering if they receive enough training on identifying substance abuse issues to then refer. One woman shared that her region has an in-house counselor at DHS, and it “works well”. Another indicated that when they get a referral from DHS, they do a formal assessment and then determine course of treatment. Another substance abuse provider said “the fragmentation of the system is a big problem” and “philosophical differences exist,” making the referral process less effective. One provider said “often, referrals from Child Protective Services are made only after children have been removed...it places us in an adversarial role with the parent...”

3. To what extent are substance abuse services available in child welfare cases?

> "...we need to be able to get people into treatment when they are ready...not go through negotiations...it should be a smooth process..."

The answers to this question varied across the state. Some responses indicated services were available; other responses revealed significant gaps. However, several common themes emerged from the respondents: there is a lack of inpatient treatment programs, a lack of funding to pay for services, and a growing concern over how to identify and help drug addiction. Other responses included a lack of detox centers, especially one that would be close to the client's home, long waiting lists, transportation gaps, lack of childcare options, and a lack of qualified evaluators.

Many of the respondents cited a lack of inpatient residential treatment facilities as the greatest concern. One worker said evaluators sometimes use outpatient resources for their clients even if residential is clearly needed due to their distance from a residential facility. One worker said "not having inpatient treatment is an issue...when a treatment service is 90 miles away, the parent and child are separated and visitation is often an issue...there is the lack of mutual support..." Several respondents cited a need to increase places that allow children, as this can be an important motivation for the client to accept treatment. This concern was also shared by substance abuse providers, who said that when a child is placed a great distance from where the mother is receiving treatment, it can prevent successful completion of treatment.

In addition to the lack of inpatient facilities, respondents stated funding to be an issue. If a client has insurance, Medicaid, or if treatment is court-ordered, funding is usually not a decisive factor. However, a problem is created when clients are not in one of those categories. For example, finding inpatient treatment is a problem. One supervisor said "it is extremely difficult to get people into inpatient...it becomes a financial issue." Several respondents said if a client loses custody of their child, and in the process loses Medicaid, it becomes unclear as to who will pay for treatment. One caseworker is presently working with a female client who is ready for inpatient services but "there is no one to pay." A program administrator points out that child welfare cases no longer have "priority status" for substance abuse services. In his opinion, funding becomes the greatest barrier to accessing treatment.

Several workers said the increase in prescription drug use has resulted in efforts to examine better methods of identifying use/abuse. One worker said the tension is high in her area in regards to whether or not methadone clinics should open. She "feels frustrated that nobody has the answers...and there still is nothing out there for the clients..."

Respondents uniformly discussed the need for random urine testing. Caseworkers and supervisors stated they did not have access to reliable testing facilities. Even if they performed the tests themselves, the evidence would not be admissible in court. In one area of the state, a hospital has a contract with the Department and these

tests are routinely conducted. Others stated they could not even get a prescription for urine testing, thus making the tests unavailable.

Some respondents described a need to understand more about what services are available in their community and how to access them. One caseworker suggested a “resource fair” to allow service providers and caseworkers to learn about programs and facilities.

4. What criteria are used to determine progress in treatment?

> "...the parent's ability to understand and acknowledge the impact of their addiction on their children..."

Most survey participants stated criteria for progress revolved around changes in a client's behavior. Workers look for the client to understand and acknowledge the impact their drinking and/or drug use has on their children, and be committed to the "lifestyle choices and changes that come with taking responsibility...” There are several ways to look for changes: Is the client attending treatment on a regular basis? Are they passing urine tests? Are they interacting differently with others? What are the children, family members, and collaterals saying? Have the police been involved? Are they working towards the goals identified in their service plan? These are some of the questions that may be asked, in combination with others specific to the case.

Most respondents said they "rely on the expertise of the substance abuse treatment provider.” Information from the treatment provider is critical in assessing ongoing risk to the children in a case. However, this can also be a place of conflict. One supervisor said "looking at sobriety alone is not enough...some substance abuse providers don't look at the underlying issues enough...can often have 'dry drunk'... we need to always be looking at the effect on the child...(even if client is sober)...” Another worker stated "With some substance abuse providers, the focus is on the sobriety, not necessarily the behavior...even in sobriety the behavior can still continue to be abusive...providers need to treat the behavior along with the sobriety..." One person summed it up like this: "At court hearings, I see substance abuse counselors trying hard to see progress in their patient. This loyalty to the parent can blind them to the child protective concerns. The tolerance seems greater for substance abuse counselors towards issues that concern child welfare...” In determining criteria for progress in a case, there can often be conflict around the degree of progress. Several respondents stated there can be a conflict "between the needs of the child and the needs of the parent" in assessing progress, making collaboration difficult.

Both caseworkers and substance abuse providers said there are often problems

when the treatment and case plans are drawn up in isolation. Ideally, the treatment team approach with caseworker, substance abuse provider and client should be used to develop the case plan, including a method for evaluating progress.

5. Is relapse planning being conducted?

> "...given that relapse may happen...the client must have a relapse plan with their substance abuse provider...there is a need to plan and prepare for it...relapse has an affect on the family..."

The responses to this question varied from "no relapse planning" to "joint planning between DHS and the substance abuse provider". All respondents said relapse planning was an important area to look at, although differences exist in how relapse planning is perceived and conducted. Most child welfare respondents said the substance abuse agency does a relapse plan with the client, and they get a copy of it. If the case is still open, they would help monitor the plan. Monitoring can include ongoing communication with the provider and urine testing. One caseworker said he would "like to be more involved in this process" instead of just getting a copy of the plan. Several other workers said, "joint relapse planning would be best", as DHS would most likely be using the plan with the client. One worker said relapse planning in her area is not done on a regular basis, but when it is done collaboratively it "works well". Other responses included: "DHS may or may not get a copy of the plan... it depends on the persons involved", and "relapse plans are included in the DHS treatment plan..." The answers varied greatly on this question.

A difference also seems to exist with how relapse in itself is perceived. Some child welfare workers wondered how many relapses are "acceptable". At what point are too many relapses a factor in reunification efforts? One worker stated her thoughts on this: "The department's position is that if you relapse, rehabilitation becomes more difficult, and the intervention will be more serious." Another supervisor added: " From a DHS perspective, how many relapses do you allow? Especially with the new timeframe for the child...this presents a conflict...if the issue of substance use continues to impact the children and parenting, it becomes an issue for DHS...How do you get that across to the providers? We're not trying to get 'their guy', we're trying to make sure (substance use) doesn't affect behavior with children..."

Given the new timeframes to find permanency for the child, another layer is added to this issue of relapse. One worker said "the system is set-up so a parent cannot relapse many times and still plan for the well-being of their child..." Since most substance abuse providers see relapse as part of the disease, this can present a challenge to those doing this work. One quote expresses this clearly: "How do you balance child welfare work and substance abuse work relative to helping the person

get the treatment necessary?" Another supervisor said he sees no inherent conflict with the new law, and sees the new law helping with permanency for children. He said he "doesn't see a conflict with the new law because the 15 months is not cut in stone...if a parent is making significant progress, the courts are sensitive to that...if they are not, the children shouldn't be left in limbo..." One therapist who works often with DHS cases said the new timeframe has changed the way she does her work. "With DHS clients, therapy has to be more directive due to the timeline...the therapist cannot just let the client determine the pace...it is a hard shift...you have to find a middle ground..."

Substance abuse providers said all of the agencies provide relapse prevention planning. However, the question of who is responsible for monitoring the plan is a major issue. Substance abuse providers said they "do not have the resources" to expand aftercare services. One provider said: "There should be a process in place to know what happens if a person relapses..." Another provider summed up the topic: "We try to raise awareness that abstinence is a goal – that it is a disease of relapse, and that a client's actions are the best indicators of recovery and that there is no guarantee that a person is sober".

6. What are the most significant barriers to services?

> "When children are still at home and one or both parents are struggling with substance abuse issues, what do you do with the children when the parents are getting treatment? ... foster care might be an option but is that the best way to deal with the situation? Do we have to break up families to get treatment? If a mom loses custody, for example, and she loses Medicaid, there's no way to pay for treatment...The biggest issue is the need to look at how to support treatment and still keep kids safe..."

All the respondents were able to identify barriers to services. Many answers revolved around a lack of resources, either in terms of specific places for treatment (such as residential), or a lack of providers trained in substance abuse and mental health (dual diagnosis). Some areas lacked qualified substance abuse providers in general. In certain areas, there was either no testing resources or the funding for testing had "fallen through." One supervisor said relying on self-reporting alone has not been effective; the lack of testing resources has created a barrier to effective services. In another area of the state, random testing is routinely done, and is relied upon often during the treatment process. One worker said, "readily available services aren't out there", and there is a "lack of awareness" of the increase in drug abuse. Another respondent stated a lack of variety in terms of treatment modalities. "The types of services in this state are all based on the disease- paradigm...this sets some people up for failure...there are other ways to treat substance abuse that should be explored...there are many ways to treat an illness..." Funding was cited by

several people as the most significant barrier to services, although one respondent said this could sometimes be used as an excuse.

The lack of residential services was described by many as a very significant problem, especially when the client has to travel far from home to get one of the few beds that are available. Intensive outpatient treatment is particularly difficult for someone who is homeless. Additionally, when the client returns to a home environment that is not supportive of treatment, success can be compromised. The lack of gender specific treatment programs for women was also cited as a barrier.

Client readiness and motivation to change were also indicated as major barriers to services. One worker said "client motivation is the biggest factor...we are not able to do much if motivation is not there...if the person is highly motivated, success can be possible...there can be a 'drinking culture' that is hard to break..." Denial and minimization proved to be another barrier to services. One supervisor said "many of the court battles are whether or not there is even a substance abuse problem...and evaluations from different sources can say different things..." In addition, several workers wondered about the effectiveness of court-ordered services in the long run. One supervisor wondered "Is the client buying into the treatment, or just doing it to get their kids back?" Lack of childcare, transportation, and effective coordination and collaboration were cited as barriers. One supervisor said "entrenched attitudes" also create barriers, and seemingly different "motivations and goals" can segregate services.

Substance abuse providers cited many of the same barriers: transportation, childcare, funding, lack of residential services, and lack of dual diagnosis services. Additionally, they cited “a poor relationship with DHS” regarding some cases, a lack of accurate assessment (including identification), and a lack of support services. All agencies stated they have waiting lists, and are also faced with a difficult employment market at present. “Recruiting and retaining qualified staff is hard,” especially in certain areas of the state. Unfortunately, this exacerbates the problem of a waiting list. However, respondents did share some practical ways that help in breaking down the barriers.

7. What practices appear to be most effective?

> "Collaboration works best when there is respect, education, and communication...a respect for each others' roles, and an understanding of the different perspectives...we need to be able to 'agree to disagree' at times...we don't have to be at odds...we can work together..."

The responses to this question all revolved around the need for increased respect, education, and communication. Consistently, workers from various areas of child welfare said that things work best in a case if people understand each others' roles, realize their can be different perspectives, yet maintain the common goal of helping the family.

Many respondents said "networking or team meetings" are a good way to reinforce identified goals, and to make sure everyone involved in the case is "on the same page". One worker did say these meetings can be difficult, as well, but at least issues get discussed openly. Another supervisor said: "The provider we work best with is very child focused within the family...the relationship she has with the family allows her to be open with DHS and with all other parties..." Another worker said she has joint sessions with the substance abuse provider on occasion, and this helps build a relationship as well. She stated "regular communication, regular team meetings, and sending test results to the therapist" are all ways to build collaboration.

In addition to frequent contact and communication, one worker said there has to be "a personal touch". She said "getting to know the person and their job" is important, and would like to "get together with substance abuse providers to get to know them as people and understand their roles". Another worker said frequent contact helps to "compare observations... and work together to clarify what's really happening..." One worker said that since her town is small, she has gotten to know many of the providers by attending workshops together, etc., and that makes a positive difference. One supervisor shared any "training or opportunities to network would be great...like the Domestic Violence Training...they have been very beneficial..." Despite their differences, it is interesting to note mostly all child welfare respondents reported a "good working relationship with substance providers". The answers were often qualified, with specifics as to what has been working well and what has not.

Substance abuse providers had similar practices for increasing effectiveness: getting to know each other as individuals, being included in team meetings with DHS, having regular communication and coordination, providing training for each other, and a willingness to negotiate. One provider said, "when we both have the same understanding of the process" things have worked well. Another person said effectiveness "varies very much individual to individual...and region to region..."

One substance abuse provider summarized: “The more I try to understand them and show them what we do...it works better...like inviting them to do a training...” When asked about priority status, one provider said DHS and substance abuse providers need to “sit down and do protocols” to make it happen. Another said priority status is a hard issue, because all cases are priorities. Additionally, providers were clear that philosophical differences need to be talked about, along with “histories that never leave”. Developing strategies to work on projects together, building local collaborations, and possibly “job swapping” for brief periods of time were all suggested as ways to increase effectiveness between the two disciplines. One woman strongly stated: “we are not each other’s enemy...”, and another said it’s “hard to get to the same point, but we both have the same goals, although the focus is different...”

8. What additional training would be most helpful?

> “…we need some kind of training that helps child welfare and substance abuse understand each other’s perspectives…”

Most of the responses to this question involved the need to understand each other’s roles and perspectives better. The majority of the respondents requested more “Cross-Disciplinary Training,” stating “training offered in the context of Cross-Disciplinary helps in understanding the concepts of another discipline better…it’s all a mindset…” One supervisor said: "There’s been a lot of progress in recognizing that the issues of substance abuse, child welfare, and domestic violence are systemic…perhaps a similar training between substance abuse and child welfare would help with perceptions of each other’s roles…and the fact that we always run into the question of “Who’s the client?” One person said she wanted to emphasize “increasing collaboration is a huge issue that needs attention…” Better training on the impact of substance abuse on children was also a need expressed by respondents.

In addition, several respondents compared the use of on-site domestic violence consultations to the area of substance abuse. One supervisor said: “Having expertise (on domestic violence) at our fingertips has worked well…I would love to have a substance abuse person who also understands child welfare issues right in the office…we need to have more exposure to each other…and develop common consensus…how can we understand each other better?...it’s hard because substance abuse providers are scattered…” This theme was echoed by many of the respondents.

Another training need identified is to learn more about drug abuse, focusing on prescription drugs. One worker said: “The drug problem is so big now…years ago, alcohol use was so common, now it’s different…there needs to be an increase in

public awareness and worker training re: how to identify and treat this issue…" Another worker said in her region "prescription drug use is the major reason for kids coming into care", and a training by a pharmacist on "some of the facts around commonly used prescription drugs would be most helpful, facts such as what are they, what are they normally used for, addiction rates, etc.,…"

Similarly, other respondents said they saw a need to increase their "own knowledge" of what to look for in drug use cases. One worker recommended training to "increase my own knowledge of what to look for…the clues…and better interviewing and assessment questions…and more training on the process of a substance abuse evaluation…such as what can an evaluation actually answer?" One worker said the State Police had recently done training on identifying drug paraphernalia, and it was extremely helpful. One supervisor summed it up by saying: "We can always use more training on drug use...we've had some parents die...and methadone clinics are a tricky issue...and increasing our understanding of treatment options for drug addicts would be helpful..." Another supervisor said "Caseworkers from DHS need to learn more about substance abuse…how we can be more involved in the process to make it more successful for the client…" This person also stressed "joint treatment planning" as a key to successful collaboration.

Some of the responses included the need for "dual diagnosis" providers, as many clients have mental health needs as well. One worker said "it's more difficult to work with people who are using addiction to help with trauma…we need to see mental health needs addressed more…" One supervisor said training around creating a "better link between the reality of what child welfare workers need to do and the timeframes…Is what we are expecting realistic?" Another said, "more training for caseworkers on the impact of substance abuse from a clinical perspective…and in determining progress in a case…How do you determine progress?" A few respondents also said they'd like to see substance abuse providers know more about the "family systems" approach when doing their work.

FINDINGS RELATED TO DOMESTIC VIOLENCE AND SUBSTANCE ABUSE

The following is a summary of the responses to the telephone surveys with persons working in the field of domestic violence.

1. How is substance abuse screened for in domestic violence cases?

> *"Give the woman choices – find out if she wants help."*

In most cases no formal screening and assessment is conducted for substance abuse. Each of the service providers spoke of self-identification/self-diagnosis/self-disclosure as the primary method utilized to determine the presence of substance abuse. Others mentioned various forms of informal evaluation sighting a broad spectrum of approaches from "one check-off place asking if there were drugs or alcohol involved on a police report, to a substance abuse survey utilized in batterers' groups, to smelling the alcohol or "recognizing odd behavior" in clients, to "asking straight out", or "going on intuition."

The answers to this question varied according to the domestic violence program arena. Most of the respondents mentioned the short length of time with the client as a barrier to doing formal screenings or assessments. One advocate mentioned that on the hotline the best that can be done is to listen for cues such as slurred speech, while in the shelter there would be time in daily interactions to do "a little bit of screening" asking if the client uses, if there is a substance abuse problem, if the client is working a program. More extensive assessment can be done if the client is in transitional housing due to the longer term of stay.

In the case of the batterer, screening and assessment is also most often informal, but may be identified through arrest paperwork, through probation officers, or through urine screening ordered by the probation officer, or drug or alcohol tests that can be called for by the police at any time during the probation period, or through discussions or surveys in batterers' intervention groups.

When asked, "What percentage of your cases involve substance abuse?" respondents cited 28% on the part of the victim. Abusers were seen as having substance abuse issues in 45% of the cases, and substance abuse issues occurred in both the victim and the abuser in 26% of the cases.

2. What type of referral process is utilized?

"Many times substance abuse goes hand-in-hand with domestic violence, but it is not the cause."

The two responses most often given by the domestic violence advocates were first to offer resources and choices if the victim asks for them, and second work on a safety plan with the client about her own substance abuse or substance abuse on the part of the batterer.

If the client asks for information and resources for the batterer it would be offered along with information for the client stating alcohol/drug abuse is not responsible for the domestic violence occurring in the home. The client would also be advised she has no power to change the abuser. Discussions would take place with the client about her own substance abuse and safety planning in case of relapse on her part.

The police stated regularly that they are "looking at arrest first, and only make referrals in the follow-up, not in the initial contact." "Substance abuse isn't really on the radar screen—it's not our primary mission. We document the condition only, and we might be willing to make a referral, but not much more."

Two batterers' intervention program directors stated they would offer referrals and resources if asked. One director mentioned that AA and NA are the most accessible and least expensive, and therefore are the ones to which he most often refers clients.

3. To what extent are substance abuse services available for situations involving domestic violence?

"Services are readily available with insurance—without can be a challenge."

Responses to this question varied according to geographic location, but all respondents sighted the need for insurance or the lack of money as the major concern when seeking substance abuse services.

Many spoke of the variety of 24 hour inpatient services available, but quickly mentioned the lack of beds, the long waiting lists, and the length of time it takes to get a return phone call from providers as problems.

Rural communities sighted transportation and lack of childcare as major issues. Clients have told advocates that accessing services in rural communities can add to their personal danger due to the fact that information "gets back to the abuser."

Advocates regularly sighted that many substance abuse providers have normal business hours, and that emergency services for after hours are not available.

Urban areas did not usually share the concern about transportation citing that services are most often "all on the bus lines" or available by taxi.

4.What criteria are used to determine progress in treatment?

> *"There is no monitoring in most cases because DV victims are not with us long enough."*

Domestic violence service providers regularly stated the difficulty in monitoring the progress of their clients due to the brief periods of time that clients spend on the hotline, in the shelter, at the outreach office or in support groups. Clients who become residents of transitional housing apartments allow for more follow-up and monitoring through self-reporting. Advocates did state that they would be willing to monitor progress if asked by clients.

Batterers' intervention group facilitators stated that accountability for the abuser only comes through the court, or through determining if they are working a program, or by recognizing their regular attendance at meetings.

Police openly stated that "we don't know about progress, and it's not really our job to monitor."

5. Are you or your agency involved in relapse planning?

The response to this question was no in almost all cases. Only two respondents said they would talk about it if the need arose, but said that most often they would "refer out."

Judges and prosecutors stated that there is often a standard order in domestic violence cases: no use or possession of alcohol submit to random testing and evaluation and treatment to the satisfaction of probation and parole. The question regarding relapse is often – do we revoke probation for any violation? How can you hold both the offender accountable and recognize that relapse is part of the disease.

6. What are the most significant barriers to services?

> "Please don't forget the rural women."

In virtually all cases the first barrier listed was the lack of money or the lack of insurance. Substance abuse providers surveyed concurred with this response, regularly, citing "the biggest single obstacle to people accessing appropriate care" as lack of insurance. Some mentioned that when clients would lose their children through the Department of Human Services that they then would also lose Medicaid, and would not be able to access substance abuse services without it. The expense of inpatient services was often mentioned as prohibitive for many clients, and therefore the most accessible services referred to would be AA, NA, or Al Anon.

Other barriers were attached specifically to rural communities and involved the above-mentioned but also cited transportation as a major barrier. Battered women often do not have access to a vehicle, and when they live in rural communities they are in remote situations often without a phone, close neighbors, or regional transportation. Clients in rural communities often fear accessing services because information may "get back to the abuser". Clients in these communities often are not aware of the resources that are available.

Other barriers mentioned often were lack of beds, and long waiting lists for in-patient services, lack of childcare, and lack of services where children can come along with the client making it untenable for clients to participate in long-term programs because they cannot provide for the care of their children.

Respondents regularly mentioned that the philosophical barriers between substance abuse providers and domestic violence advocates could cause miscommunications, or misunderstandings between providers. One advocate said, "If only we could create a brand new language which we developed and agreed upon together—words new to both of us with definitions agreed upon by all."

7. What practices appear to be the most effective?

> "There is always talk of collaboration—in reality it is not always playing out. Where it's working is when substance abuse providers have incorporated an understanding of domestic violence."

Domestic violence advocates universally spoke of the importance of communication and collaboration with substance abuse providers. When describing the substance abuse providers that are seen as most effective, advocates said, "They give

feedback," "They look at barriers," "They recognize childcare needs," "They understand domestic violence," "They treat the women with respect".

One shelter mentioned that they are doing regular domestic violence groups at one of the substance abuse treatment centers, and how well that has worked in building communication from one agency to another. Other advocates mentioned how effective it is when there are cross-referrals, direct communication, rapid response to phone calls and "more time to talk". Many respondents stated the need for "effective language" to address such philosophical differences in terminology as the on-going co-dependency diagnosis, and controversial interpretations of that term. Substance abuse providers cited the need for "clearing up the misunderstanding between 'powerless over alcohol' and accountability—our goal is to empower our clients too—just as DV advocates do." Substance abuse providers offered many thoughts similar to DV advocates on effective practices, stating how effective their work can be when "getting regular referrals from DV workers," having regular meetings on client progress, and showing each other professional respect One SA worker said, "The interaction or connection between substance abuse and family abuse is clear," which "reinforces the need for more teamwork" to enhance our practices.

In some treatment programs a major concern being addressed is childcare. Domestic violence advocates focus on the welfare of the women and children they serve and continually spoke of how important it is for substance abuse programs to recognize the need for either childcare, or money for childcare. Several advocates mentioned that only one treatment center allows women to bring their children with them when entering in-patient treatment.

AA, NA, and Al Anon were often mentioned as the most easily accessible services due to the lack of need for insurance, and no waiting lists.

8. What effective training have you attended in the last 3 years, and what additional training would be helpful?

> **"**Some of my best 'training' has come from conversations with substance abuse counselors in the hallways during breaks at training sessions**."**

Domestic violence service providers benefited most from attending training that addressed the signs and symptoms of substance abuse, taught the types of drugs and their effects on the body and on behavior, and gave a broader understanding of the dynamics of alcohol abuse, and self-medication, and the long-term effects of alcoholism and drug abuse.

Many advocates mentioned the benefits of attending the Cross-Disciplinary training, or the desire to attend the training. Several advocates mentioned the

effectiveness of becoming a Cross-Disciplinary trainer and participating in on-going workshops as a way to stay in regular communication with substance abuse providers, and as a steady reminder of the reasons for the different philosophical approaches to clients. A few advocates mentioned their desire to attend the training, but spoke of the prohibitive time commitment.

Judges and attorneys also wanted joint training, citing that it is important for judges, prosecutors and defense attorneys to understand these issues.

Suggestions for additional training included a request for an annual orientation to the latest findings and procedures in the substance abuse field, a workshop on "effective language across agencies would enhance our philosophical differences," "more on resources, would be helpful," and several advocates mentioned wanting training on PTSD and substance abuse, and the need for empowerment training for substance abuse counselors.

Many domestic violence workers felt that the most effective way to conduct training was more informal—taking time to talk with individuals from the substance abuse field or collaborating on a case. They also felt that conducting cross training, being invited to train at a substance abuse provider's office or inviting the provider to their office, was a positive experience. Substance abuse providers agreed on the best approaches. One said, "I think there should be semi-annual meetings of court, police, DV advocates, DHS, etc., doing panels and presentations to strengthen our sense of coalition."

Recommendations

At this point, the Project's recommendations comprise two broad categories. One area covers topics related to system issues while the other discusses the availability of services.

System Proposals

According to the data collected by the Project, there is not a formal or well-defined system of protocols or practices for situations involving child abuse/neglect and substance abuse or domestic violence and substance abuse. The process for identifying substance abuse and providing access to services is better developed for child welfare situations because that system is more clearly defined by state and federal law. Nonetheless, the Project found there was not a consistent method of addressing substance abuse issues. Even less clear was a process for identifying and evaluating substance abuse in situations involving domestic violence. Self-identification and self-referral for services is the rule rather than the exception. In fact, at times individuals facing domestic violence situations do not have any formal contact with an agency or services until they appear in court.

In response to focus group questions and telephone surveys, many professionals indicated one of the key factors to effective and efficient substance abuse services is found in appropriate and reliable screening and evaluation. While on a case by case basis there are indications that screening and evaluation occurs, the Project did not find a common standard or process for substance abuse screening and evaluation. An accurate screening mechanism can lead to the early detection and treatment of substance abuse. At the same time, reliable evaluations determine what level of service is necessary and what type of intervention will be effective. The development of screening and evaluation tools is part of building a system of protocols and practices. The protocols will outline how a person is identified as having a problem and then referred for substance abuse services. The system will also include a process for determining how well someone is progressing in treatment, the development of a relapse prevention plan and the provision of aftercare services. The implementation of a plan that incorporated these elements would increase access to services and, hopefully, significantly improve accountability and outcomes.

However, the development and implementation of a formal system of practices and protocols should be preceded by a concerted effort to identify and resolve the philosophical issues, which influence professionals and the provision of services related to child welfare, domestic violence and substance abuse. While conducting this Project, it became evident there were noticeable philosophical differences that stood in the way of developing a more cohesive system. Several of the differences

are the result of confidentiality laws and statutory restrictions, but a number are related to perceptions regarding the practice of one discipline versus another.

For example, some child welfare professionals said substance abuse professionals were overly concerned with the well-being of adults who were receiving services instead of the children who were involved. On the other hand, substance abuse professionals claimed child welfare workers were overly punitive and did not fully understand the dynamics of family systems or the relapsing nature of substance abuse. Service providers in the domestic violence field expressed frustrations with substance abuse treatment modalities that "blame the victim" and stress co-dependency problems. They fear the public will come to see domestic violence as a problem that can be resolved by simply addressing substance abuse issues. From their perspective, perpetrators do not have a mental illness and they can control their behavior by making more educated choices. Conversely, substance abuse counselors believe substance abuse is a contributing factor to domestic violence and that successful interventions will help reduce violent behaviors.

State and federal requirements further exacerbate these conflicting perspectives. Consequently, it will be important to examine these statutory issues as well as the philosophical differences in order to develop more consistent protocols and practices.

Service Proposals

The development of a system of practices and protocols is dependent on having a variety of substance abuse services available. The data collected by the Project indicates that there are several gaps in services as well as barriers to existing services. These recommendations are similar to problems first raised in the report prepared by the Task Force on Substance Abuse the "Largest Hidden Tax: Substance Abuse in Maine". The 1998 report highlights several barriers to services including the lack of childcare, transportation and insurance. While a portion of these needs will be met by proceeds from the tobacco settlement, it appears that additional resources will be required. During the past decade, insurance companies and other funding sources have become more reluctant to support extended residential programs for substance abuse. It would be timely for the Office of Substance Abuse (OSA) to examine the demand for residential and emergency services in the context of this report.

Finally, based on the Project's data, client motivation is an important factor in improving the outcomes for substance abuse treatment. If a client is highly motivated to engage in treatment but is placed on a six-week waiting list, the opportunity for successful intervention may be lost for the immediate future. In order to sustain a client's motivation, services should be made available in a timely fashion.

1) The Department of Mental Health/Retardation and Substance Abuse Services and the Department of Human Services should develop and implement protocols and best practices for situations involving child abuse/neglect and substance abuse and domestic violence and substance abuse.

These protocols should take into consideration recent federal laws and confidentiality issues. The development and implementation of this system is a critical first step in defining expectations and identifying specific outcomes. Over time it will allow the Office of Substance Abuse to monitor the delivery of services and to identify gaps in services.

2) As part of developing practice protocols, the two departments should develop a system that provides reliable, clear and uniform methods for screening and evaluating substance abuse.

As noted earlier, our data showed that an important factor in the provision of substance abuse services is having effective screening and evaluation tools. A number of child welfare professionals indicated that at times they had difficulty understanding and relying on evaluations completed by substance abuse providers. They said the evaluations were often general and relied almost exclusively on self-reporting by the client. They express a need to have better tools to screen for substance abuse and to have reliable evaluations.

Almost all of the substance abuse providers reported they conducted substance abuse evaluations. However, they reported over fifteen (15) different methods of conducting evaluations, some of which were not even specific to substance abuse. Substance abuse providers pointed out that at times they received inappropriate referrals due to poor screening techniques.

3) In the development of best practices and protocols, Departments as well as service providers and professionals must address the program and philosophical differences that exist between the disciplines of child welfare, domestic violence and substance abuse.

The development and implementation of substance abuse protocols and best practices will be significantly enhanced if the philosophical differences can be resolved. Several of the participants in the focus groups and the telephone surveys said they would like to be part of a process that discussed these issues. Ultimately, these differences are confusing to the public and to persons who need services. Opportunities to coordinate services become limited and scarce resources are compromised.

4) Both Departments should support, improve and expand training programs which are cross disciplinary, stress integrated case management and increase skills in communication, coordination and collaboration.

The Project's data consistently showed professionals benefited from cross-disciplinary training and training that emphasized integrated methods of case management. Cross-disciplinary training is one approach that has helped bridge those philosophical differences between the disciplines of child welfare, substance abuse and domestic violence. A number of professionals said that cross-disciplinary training has changed the way they work with other agencies and has increased communication and collaboration. Furthermore, demonstration projects supported by the Children's Cabinet indicate that integrated case management programs help coordinate services and maximize resources. Training opportunities should be made available to health care professionals, law enforcement officials and members of the court system.

5) A comprehensive and coordinated system of aftercare and monitoring should be developed.

The overwhelming majority of substance abuse providers said they provided relapse prevention planning. However, there was very little agreement as to who was responsible for providing aftercare and monitoring services. A number of providers said they would offer the service if additional services were available. Child welfare professionals said parents or caregivers would experience a relapse and use drugs or alcohol. It was often unclear if the relapse created a situation of jeopardy for the child or if it was an isolated occurrence that would not require substantial intervention.

Given that substance abuse is seen as a relapsing condition, a better-defined system of aftercare and monitoring would help parents and care givers to access services before a serious relapse occurs.

6) Both Departments should review policies and programs related to in-patient and outpatient residential services and emergency services.

Service providers and professionals across the spectrum highlighted the need for more residential options including in-patient services and half-way houses. The once traditional twenty eight (28) day rehabilitation program is almost non-existent as most insurance companies will no longer authorize extended in-patient services. In many cases in-patient services are not covered beyond five (5) to seven (7) days. As a result, many service providers say it is difficult to find a safe and substance free place for clients placing them at risk of relapsing. In particular, domestic violence service providers noted the need for more emergency services.

7) Both Departments should develop a plan to address the multiple barriers to substance abuse services.

Almost three-quarters of substance abuse providers (72%) cited the "lack of insurance" when asked to identify barriers to effective substance abuse treatment in a written survey. The providers also pointed out the lack of client motivation (66%), transportation (63%), childcare (60%) and inadequate funds (51%) stood in the way of effective service delivery. These barriers pose a challenge to both clients and providers. Whether a service is available or effective becomes moot if the client is unable to pay, find transportation or secure childcare. Several providers in rural areas of the state commented on the lack of transportation and that services were often of too great a distance for their clients. As pointed out earlier, client motivation plays an important role in the treatment of substance abuse. If clients are unable to access services or are placed on waiting list, client motivation can be adversely affected. At this time, almost all service providers reported having waiting lists.

At least two topics were identified that warrant consideration but are not part of the Project's specific recommendation. The first item, staff recruitment and retention, was raised during a focus group with substance abuse providers. Several of the providers said that due to the tight job market, they have had difficulty recruiting and retaining qualified staff. This problem not only effects the quality of services but it also undermines collaboration and coordination efforts with other providers and agencies. At some point, this problem may speak to the capacity of substance abuse agencies to develop an on-going system of best practices and protocols. The Office of Substance Abuse may want to examine this issue in more detail.

The second topic related to the need for on-going substance abuse education and prevention programs in conjunction with local school systems. It was noted by respondents that waiting until substance becomes a problem results in interventions and treatments that are more difficult and costly. Education and prevention efforts could be very helpful in identifying substance abuse and reducing the need for child welfare services.