START

Sobriety Treatment and Recovery Teams

Cuyahoga County Department of Child and Family Services

Executive Summary

The Problem

Child welfare services in Cuyahoga County have increasingly been challenged by an influx of referrals involving parental substance abuse; drug abuse is a factor in 75% of all intakes, a high percentage involving crack cocaine. In September and October, 1996, 26 and 29 infants were referred to CCDCFS through the 696-KIDS Hotline who showed a positive toxicology screening for any drug at the time of birth. In 1996, 11 infants born with a positive toxicology died while living at home. No infants born with a positive toxicology died in foster care in 1996.

The START Units are an attempt to meld together what we know about addiction services treatment, good child welfare practice and family preservation practice into a model that can work with the special needs of these families. These units have all of the responsibility that regular Intake and Social Workers have. They provide in-home services and ongoing protective services. When indicated, they can take custody and place children, working with the family on reunification or developing an alternative permanency plan for the children. START began operation in March, 1997.

Tenets and Philosophy

We acknowledge that addiction is a disease which requires abstinence. We support the recovery philosophy and understand that relapse may occur, requiring modified and/or intensified services. We believe that the neglect and abuse of children is often associated with addiction. The potential for losing custody of their child is often the key to bringing the parent into treatment. We understand that since the other needs of the parent are often rooted in the addiction, the initial focus of services should be directed toward assessment and treatment of the addiction. We believe that a sober, supportive living environment is critical to the recovery process. We are aware that no one agency contains all the resources and expertise to respond adequately to the needs of the parent who is addicted and who has abused or neglected their children. We commit to modifying agency policies or procedures which may impede the family's cooperation with all service providers and we commit to consulting with both family and other service providers in all significant decision making. We commit ourselves to work cooperatively

together, and to consult on important decisions with each other and with the parents, to develop and implement plans to meet each family member's individual needs. We believe that keeping the parents and children closely connected is an essential factor to enhance or preserve their relationship. We believe that when a child must be removed from his family for protection, the child has the right to frequent visits with the family during the parent's treatment. We agree to work cooperatively toward a goal of reunification of the family and child as quickly as the child's protection can be assured. If the parent does not achieve sobriety, we agree the child deserves a safe and permanent home; therefore, consideration will be given to filing for permanent custody. We believe that both the family and the child have the right to continuity of health care services. We commit to creative approaches to child care, improving parenting skills, building family support systems, etc. for those who are willing to enter treatment.

Goals

Our purposes in this program are to: 1) keep children safe; 2) develop a safe, nurturing and stable a living situation for them as rapidly and responsibly as possible; and 3) help their parents overcome their drug problems. Specific objectives are developed for each of these goals, all of which are based on a set of tenets and values developed and agreed upon as the foundation of the work. Included are an acknowledgment of the disease concept of addiction, and that abuse and neglect is often associated. Development of cooperative work among child welfare, alcohol and other drug (AOD) treatment, other human service programs and the family is basic to meet the goals.

Focus

We are focusing our effor1s on women in Cuyahoga County who deliver babies at five area hospitals and who show a positive toxicology screening for any drug. We accept a maximum of 150 clients at anyone time in the treatment group, and include women and families who do not have a current case with CCDCFS. It should be noted that although the child remains the primary focus, the START program also views the mother as a client. The intense level of treatment and oversight with the mother is an impor1ant distinction as compared with the view of general child welfare cases.

Staffing

START has two supervisors overseeing five teams each, for a total of ten teams. Each START team consists of a child welfare social worker and an advocate. Each team handles a maximum

of 15 families at a time. Most of the advocates are people who have at least two years of recovery from substance abuse, many of them in recovery from crack addiction. Roles for the supervisor, social worker and advocate are generally defined, with enough flexibility to allow for best service to the families. Other partners in this network include drug treatment providers, healthcare providers, housing providers, neighbors, friends, relatives and other informal support persons.

Training

The 8T ART Project involves training for all categories of helpers except the informal support network. The working assumption is that all child welfare staff, including the Advocates, have the basic training required of all child welfare staff in Cuyahoga County, including Core Training, Case Planning, Risk Assessment, Professionalism in CW practice, and other such required training. In addition, specific training was provided in the following areas: 1) ADD treatment basics, 2) eliciting and identifying strengths, 3) team building and partnering, 4) relapse prevention and other strategies of family support, 5) methods for assessing risks for workers and families, and 6) Motivational Interviewing.

Intake

Cases are reported by a social worker, nurse or physician. The hospital provides CCDCFS with medical information regarding the infant's health status and other pertinent information including the need for medical follow-up. CCDCFS staff assesses the family situation and provides recommendations to the hospital for discharge of the infant to parents based on safety considerations, or CCDCFS pursues custody and removes the infant directly from the hospital. Specific roles and responsibilities are developed for Child Welfare Intake Workers, Investigative workers, and the START social worker/advocate pairs during the initial phase of entry into the program.

Duration of Services

It is difficult to assess how long START will continue to be involved with each family. A conservative estimate of this would be 12 months (the median length of time for out-of-home placement in Cuyahoga County). However, the literature suggests that involvement of this population with child welfare agencies is much longer, around 26 months. Assuming that START will reduce the time that women remain involved with the system, the evaluation team has approximated this time will be about 18 months. This suggests that during the first year of

implementation START will serve 150 women and their families. Beginning in Year 2 we would expect to see some clients' involvement with START terminated with new families replacing them in the START program. This scenario would result in an estimated 200 clients served by the START program during the first two years of the program and 300 clients by the end of Year three.

Services Provided

Families have access to their START workers or a CCDCFS crisis team twenty four hours a day, seven days a week, to provide maximum accessibility and assurance of child safety. If a crisis occurs, families can call a hotline number, and their START worker or their worker's supervisor will be contacted. As much as possible, services are provided where people need them, in the home or neighborhood. Transportation and other emergency assistance is provided as necessary. Other basic needs are also provided for as needed.

Drug assessment and treatment is available within 72 hours of intake. The START staff makes the referral, using agreed-upon protocols, and they take the client to at least the first three treatment appointments in order to help establish the relationship between the client and the provider.

Case plans address all of the safety needs of the child and family, the treatment needs for the parent, and the other service needs that will support the parent's ability to succeed in treatment and be able to keep the child safe. One of our biggest challenges is to leave ourselves the flexibility to provide what families most need, without setting staff up for unrealistic expectations and failure. Another of our biggest challenges is having flexibility so that either the advocate or the social worker is able to perform many tasks, while retaining enough clarity about their roles that they don't spend enormous amounts of time negotiating or overlapping. At the same time, we also recognize that social workers are legally mandated to assume full responsibility for some tasks, such as case planning and signing complaints. At present, few boundaries have been set around services to be provided by child welfare staff, their partners in other systems, and informal supports.

START pairs keep in ongoing contact with the Drug Treatment Provider at least weekly by phone, and monthly, face to face. The Treatment Provider is expected to notify the START team immediately if the parent misses any appointments. The START team is committed to

meeting with the parent within 24 hours. If drug treatment stops, there is a face-to-face meeting. We will also hold a six-month case plan review as long as the case is active. See Attachment "H" for more detail regarding the individual services available from START service providers.

There is a full array of drug treatment services, including but not limited to, residential and outpatient treatment, aftercare, family education and treatment, parenting and nutrition services, support meetings, group and individual counseling, sober housing, relapse prevention and treatment, detoxification, well-baby care, self esteem building, cultural/social activities, and play therapy. In addition, services include such things as child care, transportation, medical services, crisis services, job services, concrete services, and child safety-the number one priority.

Closure of Services

Case closure remains a risk assessment-based decision. At the same time, these issues are extremely complex and we expect we will continue to struggle to make perfect decisions where none may be possible. One of the ways we are addressing this issue is to define "poles" that would make decisions easier at, say, six month intervals. The situations at the extreme ends of the pole appear simple to identify. Our current challenge is to map out more scenarios between these poles, and to develop additional decision making guidelines for both temporary and permanent custody of children.