Family TO Family
TOOLS FOR Rebuilding Foster Care

START

A Child Welfare Model for Drug-Affected Families

THE CHALLENGE OF DRUG ABUSE IN CHILD WELFARE, PART THREE

Table of Contents

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INTRODUCTION

The Annie E. Casey Foundation's Mission in Child Welfare

The Annie E. Casey Foundation was established in 1948 by Jim Casey, a founder of United Parcel Service, and his sister and brothers, who named the Foundation in honor of their mother. The primary mission of the Foundation is to foster public policies, human service reforms, and community supports that better meet the needs of vulnerable families.

The Foundation's work in child welfare is grounded in two fundamental convictions. First, there is no substitute for strong families to ensure that children grow up to be capable adults. Second, the ability of families to raise children is often inextricably linked to conditions in their communities.

The Foundation s goal in child welfare is to help neighborhoods build effective responses to families and children at risk of abuse or neglect. The Foundation believes that these community-centered responses can better protect children, support families, and strengthen communities.

Helping distressed neighborhoods become environments that foster strong, capable families is a complex challenge that will require transformation in many areas. Family foster care, the mainstay of all public child welfare systems, is in critical need of such transformation.

The Family to Family Initiative

With changes in policy, in the use of resources, and in program implementation, family foster care can respond to children's need for out-of-home placement and be a less expensive and often more appropriate choice than institutions or other group settings.

This reform by itself can yield important benefits for families and children, although it is only one part of a larger effort to address the overall well-being of children and families in need of child protective services.

Family to Family was designed in 1992 in consultation with national experts in child welfare. In keeping with the Annie E. Casey Foundation's guiding principles, the framework for the initiative is grounded in the belief that family foster care must take a more family-centered approach that is: (1) tailored to the individual needs of children and their families, (2) rooted in the child's community or neighborhood, (3) sensitive to cultural differences, and (4) able to serve many of the children now placed in group homes and institutions.

The Foundations's goal in child welfare is to help neighborhoods build effective responses to families and children at risk of abuse or neglect.

The ***Family to Family*** Initiative has encouraged states to reconceptualize, redesign, and reconstruct their foster care system to achieve the following new system-wide goals:

- ❒ To develop a network of family foster care that is more neighborhood-based, culturally sensitive, and located primarily in the communities where the children live;
- ❒ To assure that scarce family foster home resources are provided to all those children (and only to those children) who in fact must be removed from their homes;
- ❒ To reduce reliance on institutional or congregate care (in hospitals, psychiatric centers, correctional facilities, residential treatment programs, and group homes) by meeting the needs of many more of the children in those settings through family foster care;
- ❒ To increase the number and quality of foster families to meet projected needs;
- ❒ To reunite children with their families as soon as that can safely be accomplished, based on the family's and children's needs, not the system's time frames;
- ❒ To reduce the lengths of children's stay in out-of-home care; and
- ❒ To decrease the overall number of children coming into out-of-home care.

With these goals in mind, the Foundation selected and funded three states (Alabama, New Mexico, and Ohio) and five Georgia counties in August 1993, and two additional states (Maryland and Pennsylvania) in February 1994. Los Angeles County was awarded a planning grant in August 1996. States and counties funded through this Initiative were asked to develop family-centered, neighborhood-based family foster care systems within one or more local areas.

Communities targeted for the initiative were to be those with a history of placing large numbers of children out of their homes. The sites would then become the first phase of implementation of the newly conceptualized family foster care system throughout the state.

The Tools of *Family to Family*

All of us involved in ***Family to Family*** quickly became aware that new paradigms, policies, and organizational structures were not enough to both make and sustain substantive change in the way society protects children and supports families. New ways of actually doing the work needed to be put in place in the real world. During 1996, therefore, the Foundation and ***Family to Family*** grantees together developed a set of tools that we believe will help others build a neighborhood-based family foster care system. In our minds, such tools are indispensable elements of real change in child welfare.

The tools of ***Family to Family*** include the following:

- ❒ Ways to recruit, train, and support foster families;
- ❒ A decisionmaking model for placement in child protection;
- ❒ A model to recruit and support relative caregivers;
- ❒ New information system approaches and analytic methods;
- ❒ A self-evaluation model;
- ❒ Ways to build partnerships between public child welfare agencies and the communities they serve;
- ❒ New approaches to substance abuse treatment in a public child welfare setting;
- ❒ A model to confront burnout and build resilience among child protection staff;
- ❒ Communications planning in a public child protection environment;
- ❒ A model for partnerships between public and private agencies;
- ❒ Ways to link the world of child welfare agencies and correctional systems to support family resilience; and
- ❒ Proven models that move children home or to other permanent families.

New ways of actually doing the work needed to be put in place in the real world.

We hope that child welfare leaders and practitioners find one or more of these tools of use. We offer them with great respect to those who often receive few rewards for doing this most difficult work.

OVERVIEW

The START (Sobriety Treatment and Recovery Teams) approach evolved out of a promising network approach called ADAPT that began in 1989 in Toledo and from discussions among Cuyahoga County Department of Children and Family Services (CCDCFS) staff, Cuyahoga Drug Treatment Providers, Mental Health Providers, and Annie E. Casey Foundation staff and consultants.

The project is an attempt to integrate promising aspects of ADAPT, existing strengths of drug treatment providers and child welfare staff in Cuyahoga County, and results of current research on drug treatment for crack-addicted women. The START units are an attempt to meld 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. Where indicated, they can take custody and place children out of the home, working with the family on reunification or developing an alternate permanency plan for the children.

The Problem

For the past decade, child welfare services in Cuyahoga County have increasingly been challenged by an influx of referrals involving parental substance abuse. Currently, 75 percent of intakes involve drug abuse. A high percentage involve crack, which many workers believe to be a hopelessly addictive drug that leaves few possibilities for recovery.

In September and October 1996, 26 and 29 positive toxicology infants respectively were referred to CCDCFS through the county hotline (696-KIDS). In 1996, 11 infants born with a positive toxicology died while living at home: ten with parents, one with a grandparent. Seven of these deaths were classified as SIDS; two were from complications due to prematurity; and two were rollovers, where a parent rolled over on the child and smothered it. No infants born with positive toxicology died in foster care in 1996.

The substance abuse problem threatens the entire system. Child welfare workers are torn between wanting to believe the best about people and having to acknowledge that some parents are not able to keep their kids safe. They want to encourage bonds among family members, but sometimes they want to develop alternatives to the birth parents as primary caregivers. They don t want to place children unnecessarily, and they don t want to leave them in situations where they may get hurt. Workers are torn between feeling that drug addicts are hopeless and lawless individuals and realizing that all of us have problems and many people get past difficult periods.

Referring crack-addicted women to drug treatment without follow-up seems to be of very little help. More often than not, the woman does not follow through, continues to abuse substances, and is not able to parent her children adequately.

Workers feelings of helplessness about protecting children cause low morale and high turnover, making it even more difficult for the system to develop effective new approaches.

Our primary concern has been to improve our methods of keeping children safe. Because we believe that most children are safest, emotionally and physically, in contact with their birth families, we are searching for ways to increase birth family involvement and responsibility for children. At the same time we acknowledge that some, if not many, substance-abusing parents will never be able to assume total responsibility for their children. In general, when infants show positive toxicology results, we believe that placement is necessary to assure their protection. Removal of the child will always be based upon identified risk factors.

Our primary concern has been to improve our methods of keeping children safe.

GOALS

Our purposes in this program are to keep children safe; to develop a safe, nurturing, and stable living situation for them as rapidly and responsibly as possible; and to help their parents overcome their drug problems. Specific objectives are as follows:

To Keep Children Safe.

- ❒ To reduce the risk for children who are not removed from their own homes
- ❒ To reduce the number of referrals to Child Protective Services of children who are not in custody

To Develop a Safe, Nurturing, and Stable Living Situation for These Children as Rapidly and Responsibly as Possible.

- ❒ To reduce the time that children remain in public agency custody before achieving permanency
- ❒ To reduce the number of subsequent removals from the family and thus the re-entry rate to custody within one year of program completion

To Help Drug-Addicted Parents Overcome Their Drug Problems.

- ❒ To increase the percentage of substance-addicted parents who enter treatment
- ❒ To increase treatment program retention rates after one and six months
- ❒ To increase abstinence rates after one and six months
- ❒ To decrease absenteeism from scheduled treatment sessions
- ❒ To increase program completion rates

BASIC TENETS AND PHILOSOPHY OF START

Those involved with the ADAPT Project spent much time clarifying their basic values and assumptions about their work and were pleased with the foundation they developed. In the development of START, we further clarified and supplemented those tenets as follows.

1. We acknowledge that addiction is a disease, which requires total abstinence. We support the recovery philosophy and understand that relapse may occur, requiring modified and/or intensified services.
2. We believe that the neglect and abuse of children is often associated with addiction. The possibility of losing custody of a child is often the key to bringing a parent into treatment.
3. We understand that since the other needs of the parent are often rooted in addiction, the initial focus of services should be on assessment and treatment of the addiction.
4. We believe that a sober, supportive living environment is critical to the recovery process.
5. We are aware that no one agency has the resources and expertise to respond adequately to the needs of the parent who is addicted and who has abused or neglected children.
6. We are committed to modifying agency policies or procedures to support a family s participation in its treatment plan with all service providers.
7. We commit ourselves to a family team approach to work cooperatively, together with the parents and the children, to develop and implement treatment/ case plans to meet each family member s individual needs.
8. We believe that keeping the parents and children closely connected is an essential factor in enhancing or preserving their relationship.
9. When a child must be removed from his family for protection, we believe the child has the right to frequent family visits during the parent s treatment.
10. We agree to work cooperatively toward reuniting the family and child as quickly as the child s protection can be assured.
11. We believe that both the family and the child have the right to continuity of health care services.
12. We are committed to creative approaches to child care, improving parenting skills, building family support systems, etc. for those who are willing to enter treatment.

In formulating our basic tenets, we also became aware of possible conflicts in the 12-step recovery and family preservation philosophies. We believe those approaches are compatible. The confusion centers on whether the sobriety of the parent, the safety of the child, and/or the preservation of the birth family should take precedence. Some people believe that support for parents in learning to take care of their children before their drug problems are completely resolved is in conflict with the 12-step model. We believe that a concern for the family can be successfully integrated with the 12-step approach. Details of the integration are shown in Appendix A.

METHODS

Governance

The Director of CCDCFS has the ultimate responsibility for the project. We have a two-tiered advisory group. The chief administrator and supervisors meet with the treatment providers monthly. The supervisors, workers, and advisors also meet monthly with the direct service workers from the treatment programs.

The other tier is a line-level group of staff workers directly serving families from all systems. This group meets at least monthly to discuss families and to pool resources in developing and implementing creative plans for particularly challenging issues and situations.

Staffing

Introduction

We believe that the substance-abusing parents and families we are seeing require more expertise than is currently found in any one person, system, or informal support system. We have developed a network of individuals, programs, and skills that will benefit all members as well as the families being helped. Each START team consists of a child welfare social worker and an advocate. Most of the advocates have achieved at least two years of recovery from substance abuse, many of them from crack addiction. Other partners include drug treatment people, relatives, and informal support persons.

This partnership gives social workers the opportunity to enhance their teamwork skills and skills regarding substance abuse through interactions with advocates who have experience with crack, the recovery process, and life in challenging communities. They also can learn from drug treatment providers who specialize in these areas.

Most advocates have had experiences similar to those of the families they are serving, and know what it is like to be involved with the child welfare system as a client. Advocates help other staff and clients to understand the resources they have used to get sober and stay in recovery. Drug treatment people have the opportunity to better understand child welfare methods for involving the whole family and developing a support system in the neighborhood.

Relatives and informal support people are encouraged in their role as key resources for both children and parents.

Roles of START Team Members

One of our biggest challenges is to keep the role flexibility we need to best serve individual families without losing the clarity of role that we need to function smoothly. Roles at this time are very flexible. We expect them to continue to evolve as we learn.

1. Child Welfare Staff

Child Welfare Supervisor: Two supervisors were selected in mid-August 1996. A change in one supervisor was made in May 1997. A job description for this position is shown in Appendix B. Materials used in hiring are shown in Appendix C.

Child Welfare Social Worker: Social workers have primary responsibility for risk assessments, safety planning, overall case planning, court filings, and testimony. These workers were selected through routine internal transfer procedures. A job description for this position is shown in Appendix D. We tried to find social workers with strong family-centered practice skills who could team with the advocates effectively without getting protective about roles. We also looked for people with attitudes and beliefs that will allow them to hold clients accountable but not be blameful or overly pessimistic.

Child Welfare Advocates: Most of the advocates are in recovery from substance abuse, many from abuse of crack. Most have been recruited from past child welfare caseloads. For those who qualify, the JOBS program subsidizes salaries for six months after hiring. Some issues worth considering in hiring advocates are shown in Appendix E. Job descriptions are shown in Appendix F.

Preference was given to recovering crack addicts and to past child welfare clients. We view them as resources in engaging drug-affected parents, serving as successful role models for them, and in assessing each client s current potential for relapse.

We believe that advocates are in an excellent position to share information both with clients and staff regarding risks for relapse, and may pick up on these factors before social workers do. This allows for a better intervention to protect children. It also teaches social workers to better identify the subtle signs of approaching relapse and how to intervene.

Advocates are able to talk straight with parents and have credibility that social workers often cannot achieve. They are more likely to recognize a client s manipulation because of their own experience with the same problems. This allows them to confront clients supportively and clearly at a level that is hard for social workers to attain.

The intention is to have social workers and advocates be full partners in serving clients, and to divide basic responsibilities so that the partners tasks for any given week depend upon the number of clients they have, the needs of the clients, and the particular strengths of individual social worker-advocate team members.

We struggled with this job title. Some drug treatment providers in particular have been concerned that the term advocates will encourage siding with the parent against treatment providers, and could decrease concern for child protection.

In our recruiting efforts, we developed a pool of 96 potential advocates, and 10 were ultimately hired. We were concerned that, of these 96, 15 had past felony convictions. We realize that people who have histories of extensive drug use are likely to have convictions, but we were not able to hire those applicants except in one case where a waiver was obtained.

The remaining pool was to receive eight days of job readiness training from the Cuyahoga County JOBS Program. We were able to hire advocates with cars, driver s licenses, and insurance, so that they would be readily available to their clients.

Advocates have the opportunity to enhance their helping and teamwork skills.

2. Drug Treatment Providers

Drug treatment providers are expected to focus on a family-centered approach, including extended family members and foster parents, friends, and interested individuals. They must address enabling issues and must have the capacity to respond to issues surrounding adolescence and teen pregnancy.

Child welfare staff members are in full partnership with drug treatment staff from four programs: Recovery Resources, Miracle Village, Iwo San, and university hospitals. These programs offer a very wide range of drug treatment services, including pretreatment, inpatient, outpatient, and follow-up

Roles at this time are very flexible. We expect them to continue to evolve as we learn.

services. Drug treatment providers provide chemical dependency treatment to addicted individuals, of course, but they also take the lead in the treatment issues with the family, assist the social worker-advocate team in the protection of children, become a member of the family team, share information with the family team members, participate in the development of the family s case plan, and adopt a family system model.

3. Health Care Providers *(Hospital staff who refer, and medical personnel who care for the health needs of both parents and children.)*
Medical clinic workers in particular are members of the family team. They take the lead in medical treatment issues, assist in child protection, and share information about family medical needs and the family s follow-up with treatment on a regular basis.

Mental health care providers are involved as necessary.

4. Housing Providers
In the vast majority of cases, ongoing sobriety will require sober housing. Our goal is for housing providers to be members of the family team, assist the family team members in obtaining safe, sober housing, and share information with family team members. We have not identified providers who deal exclusively with housing as yet.

Four barriers are currently challenging our ability to prepare for this need: Few landlords are willing to accept vouchers; there is not enough available housing in general; homes that are available often do not meet housing standards; and we have not yet been able to identify someone in the housing bureaucracy to help us work through these issues.

5. Extended Family, Neighbors, Friends, and Other Support Systems
We recognize that everyone needs support, and that human services system resources are not enough to provide the necessary quality or quantity of support. We see all START staff people working closely to help clients identify and build stronger, clearer, more productive relationships with their families, friends, and neighbors. We encourage the START staff to rely heavily on these informal supports for monitoring children s safety, providing emergency care in some cases ongoing care and in all situations, offering support and monitoring families welfare after formal service provision has ended.

Training
The START Project involves training for all categories of helpers except the informal support network. Table 1 shows topics covered for all staff and the general time frame of the training.

TABLE 1
Training

Training Topic and Number of Days	Content	General Time Frame
Act I 7 half-day sessions	CWLA drug treatment basics	Before Feb. I for social workers, after for advocates
Advanced Act 4 half-days	Case focused consultation on drug-related issues	Before Feb. I for social workers, after for advocates
Core Training for Social Workers 15 days	Risk assessment Case planning Time management Conflict management Family preservation Worker liability	Before Feb. I for social workers

(continued)

TABLE 1 *(continued)*
Training

Training Topic and Number of Days	Content	General Time Frame
Core Training for Advocates 15 days	Overview of CCDCFS, professionalism in CW Practice	After Feb. 1 for advocates
Case Planning, Risk Assessment 1 day	Case management and decisionmaking	Before Feb. 1 for social workers, after for advocates
Strength-based Assessment 2 days	Eliciting and identifying strengths	Before Feb. 1 for social workers, after for advocates
Domestic Violence 1 day	Methods for helping abusers and those they abuse	Before Feb. 1 for social workers, after for advocates
Team Building/Partnering 2-3 days	Defining vision, mission, goals, strengths, and roles	First week in February for all workers
Relapse Prevention/Boundaries, Family Support/ Walking the Talk	Drug treatment techniques for child welfare workers	Third week in February for all workers
Cultural Diversity 4 days	Understanding cultural factors, our own, and others	Fourth week in February for all workers
Paraphernalia	What drugs and drug-related supplies look like	First week in March for all workers
Safety 2 days	Methods for addressing risks for workers and families	Third week in May for advocates
Motivational Interviewing 2 days	Methods for enhancing motivation in reluctant clients	First week in October for all workers

Population to Be Served

We are focusing our efforts on women in Cuyahoga County who deliver babies at five area hospitals and who show a positive toxicology screening for any drug. We expect 150 clients in the treatment group the first year and 150 in the control group. We will include women and families who do not have a current case with CCDCFS.

Caseloads

START teams now have 13 families per team, with a maximum of 15. Drug treatment caseloads will vary according to types and amounts of services each team provides.

The intention is to have social workers and advocates be full partners in serving clients.

Referral

A social worker, nurse, or physician reports cases. The hospital provides CCDCFS with medical information on the infant s health status and other pertinent information including the need for medical follow-up. A written summary is prepared and provided to the CCDCFS representative at the time of discharge for children requiring foster home placement.

CCDCFS staff members assess the family situation and provide 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. For cases where the mother or other children are active with CCDCFS, the agency facilitates or completes discharge within 24 hours of receiving the hospital report. Active cases

TABLE 2
Initial Roles in Accepting and Engaging Mothers During the Regular Workweek

Hotline	Intake	START
Makes referral within one hour of call	Receives referral	Gets notified that referral is coming, within one hour
Schedules mother with intake	Assigns worker	Assigns worker
Flags referral as START	Visits mother at hospital or home within 24 hours	Visits mother, often with intake worker
	Goes to home and sees children	Contacts drug treatment provider and other providers
	Finds out about other support available	Attends joint conference with supervisor
	Does risk assessment and develops safety plan	Within 48-72 hours sees that a drug assessment occurs
	Holds a joint conference including supervisor	START worker takes the mother to first appointment with providers and follows up with them to clarify plans
	Within 48 hours makes a decision if the infant can go home	Provides initial services as needed
	If placed, holds staffing for intake, START, and providers	Receives record from intake within 10 days
	Does investigation within 10 days. Reviews history and conducts crime check.	Responsible for risk assessment and safety planning
	Gives record to START	Talks with other providers at least weekly
		Organizes monthly face-to-face team meetings

include open cases, or those closed within three months prior to the date of report. START does not take cases that are currently active elsewhere in the agency.

For cases not active with CCDCFS at the time of the referral, discharge is facilitated or completed by CCDCFS within 48 hours. Infants are discharged from the hospital to a CCDCFS representative or designee or to the mother as CCDCFS determines.

This protocol is in effect seven days a week, 24 hours a day.

Table 2 shows roles and responsibilities for child welfare intake workers, investigative workers, and the START social worker/advocate pairs during the initial phase of entry into the program.

During the weekend, slightly different procedures are used, as described in Table 3.

TABLE 3
Intake and Engagement Procedures for Weekends

Hotline	Intake	START
Goes out within 24 hours	Attends Monday morning staff meeting	Supervisor is notified Monday morning, attends staffing
Schedules Monday morning staff meeting	Does investigation within 10 days	
Takes intake role, does risk assessment and safety plan	Reviews history and conducts crime check	
Develops a written proposal to present at staff meeting		

In the vast majority of cases, ongoing sobriety will require sober housing.

Safety

No matter how much START enhances our capacity to serve drug-affected families, we will not allow a child to remain in a situation where the risks are high. At the same time, risk factors do exist in all families referred to CCDCFS. Some additional assumptions about safety are as follows:

Severity of Risks for Infants

START is predicated on the assumption that infants are vulnerable and are the most likely population to die. We must not underestimate this in assessing risk. Mothers who have delivered more than one baby with a positive toxicology result are to be considered VERY high risk, both for the newborn and for other children at home.

Role of Child Welfare in Keeping Children Safe

Our policies about our role include the following:

1. A hotline call regarding a newborn with a positive toxicology result whose mother is still in the hospital must be given priority to ensure that the investigation begins immediately. Mothers can and should be visited in the hospital. Homes can often be visited prior to the mother s return.
2. In some families, solid investigative findings suggesting significant and multiple strengths might be incorporated into a solid and reliable safety plan that would allow children to remain at home. Any plan must be monitored frequently until risk can be reduced by more substantial long-term service initiatives.

3. Time frames for safety plans are to be IMMEDIATE. These are not case plans, addressing underlying causes for the child abuse and neglect, but short-term band-aids, intended to address symptoms only.
4. Every safety plan must include a strategy for how and under what circumstances support people and professional providers will alert CCDCFS if they have concerns.
5. If a decision is made to allow a child to remain in the home on a safety plan signed by the chief, as defined in procedures set up in November 1995, this decision must be timely and meaningful.
6. Many SIDS deaths occur with babies who sleep in the parents bed. We must be certain that adequate sleeping facilities are available before we leave infants in the home.
7. We must review and emphasize the seriousness of our role as managers when we sign a document such as a safety plan. This signature means review, agreement and ownership of the plan.
8. We must also carefully consider the amount of monitoring by our staff that is necessary once a child is placed again in the home.

We recognize that everyone needs support.

Roles of Other Service Providers Regarding Safety of Children

We know that we cannot rely on verbal statements of clients that they are in treatment, in therapy, or otherwise engaged in a risk-reducing activity. We should independently verify contact with providers, including details of participation. Medical providers must be integrally involved with any plans for these infants. Special needs must be considered when deciding whether or not a mother can take care of her child.

We rely upon our drug treatment partners to use frequent random urinalysis as one of the biggest motivators for parents to stay clean, and for giving START workers accurate information about actual drug use. Urinalysis can also prevent the types of You re using / No, I m not, arguments that can strain worker-parent relationships and take valuable time away from development of new, positive lifestyles.

The Role of Informal Support People in Insuring Children's Safety

We know we need to solicit and encourage participation of relatives and other natural support people. At the same time, we must carefully assess their capacity to serve as reliable, dependable anchors for both short- and long-term safety plans. Any support person who is relied upon to reduce risk must sign each safety plan.

Sending a Consistent Message to All Clients

We are committed to giving our clients one consistent message regarding their drug use.

Here is a summary of the message we wish to convey:

> Your urinalysis indicated your current involvement with drugs. We know that however many mothers care about their children, neglect and abuse of children are often associated with drug use. We believe that addiction is a disease that requires total abstinence. In order for you to retain custody of your child now, you must immediately enter a drug treatment program, attend it regularly and participate actively in its programs. We will support you in your efforts to achieve sobriety with a START team including a social worker and a client advocate who will work directly with you and also help your friends and family to be supportive.
>
> After treatment is completed and you have achieved sobriety, we expect you to continue to participate in support arrangements such as Twelve-Step Groups.
>
> We wish you the very best in your efforts to recover, and to be a good mother to your child. We expect, with

help and understanding, that you will succeed. We also want you to understand now, at the beginning, that permanent custody of your child will depend on this success. You must stop your drug use if you are going to have responsibility for your child.

Comprehensive Assessment and Treatment Planning

We have spent a good deal of time discussing our need for a comprehensive, integrated assessment process that will encompass all life domains, with appropriate emphasis on child safety and factors related to addiction. We want a process that can be learned by workers and advocates with relatively limited experience. We want it to involve input from the parent. We wish to capture strengths and resources as well as problem areas, and to be respectful of and relevant to cultural differences. We also want our assessment to be helpful in motivating parents and in treatment planning. We also want it to be standardized across workers.

We have not yet found one that meets all of the above criteria. For now, we are using the standard CCDCFS assessment process. We will continue to search.

Ongoing Services and Monitoring

We face many challenges in implementation as we try to make our practices match our ideals. Several aspects of service delivery are particularly important to us.

Accessibility

START team members make at least one home visit per week, per family. Families have access to their START workers or a CCDCFS crisis team 24 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 is provided as necessary.

Drug assessment and treatment are available within 72 hours of intake.

Flexibility

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 assigning tasks so that either the advocate or the social worker is able to perform many of them while retaining enough clarity about their roles that they don t spend enormous amounts of time negotiating.

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.

Coordination

START pairs keep in contact with the Drug Treatment Provider at least weekly by phone and in monthly face-to-face meetings. 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.

Case Closure

Case closure remains a risk assessment-based decision. At the same time, issues here are extremely complex and we expect we will continue to struggle to make perfect

Any plan must be monitored frequently until risk can be reduced by more substantial long-term service initiatives.

We are committed... to giving our clients one consistent message regarding their drug use.

decisions where none may be possible. One of the ways we are addressing this issue is to define poles that would make decisions easy at, say, six months.

For example:

A situation that would easily lead us to support case closure with the infant at home: The mother has been using drugs for only six months. Her extended family is nearby, stable, and reliable. She is in sober housing. She attended every one of her drug treatment sessions, and has passed every urinalysis. She is finished with treatment and is regularly attending AA. Her only child is now healthy and thriving.

At the other end of the spectrum, a situation that would easily lead us toward permanent removal of the infant might be: The mother has been on crack for ten years. She has been arrested many times for prostitution and theft. She has had three previous babies with a positive toxicology result. None of the children are in her custody. She has no stable relatives or friends. She has not attended any of her drug treatment sessions, or visited the baby since its birth. We do not know where she is. The baby is in a loving foster home with foster parents who wish to adopt her.

Our current challenge is to map out more scenarios between these poles, and to develop additional decisionmaking guidelines for both temporary and permanent custody of children.

EVALUATION

The START evaluation strategy incorporates the use of multiple sources of data and diverse analytic techniques. The evaluation focuses on examining the impact of START on three evaluation domains: cross system program management, START program implementation and operations, and child welfare and substance abuse treatment outcomes. We use existing child welfare program data whenever possible to track outcomes such as progress toward permanency. In addition, we developed new program monitoring forms that track the implementation of START, as well as client referrals, progress through treatment, and program interactions between the START team, and chemically dependent clients through the life of the project.

The first goal of the evaluation was to establish clarity concerning the aims of the START program and to specify how the program was expected to achieve the desired outcomes. Exhibit 1 specifies program concepts and components. Expected practice changes and their impact on families and children are specified in Exhibit 2. The START evaluation measures both the nature of the intervention (program operations) and its effectiveness (outcome evaluation). In the sections below, for each evaluation domain we specify evaluation questions that have been posed by Cuyahoga County Division of Children and Family Services (CCDCFS) staff and other members of the evaluation team. These questions form the basis for our quasi-experimental evaluation design. Finally, we provide a strategy for collecting and analyzing the data needed to answer these questions.

EXHIBIT 1
START Program Design

Program Concepts	Program Components
Form new partnerships	Specialized training in team-building and cross-agency issues
	Form social worker/family advocate team
	Intense collaboration with treatment providers
	Cross-agency coordination of services
Provide individual/strength-based tailoring of assistance for all clients using a holistic approach	Specialized training in motivational interviewing, relapse prevention
	Increased personal contact and accessibility between social worker/ family advocate team and client

EXHIBIT 2

Expected Practice Changes as a Result of START Implementation

Practice Changes	Impact on the Way Services Are Provided to Clients
Family advocate who is a recovering addict works with the client	Advocate relates to experiences of the clients
START team and treatment providers jointly plan and work the case	Drug assessment and treatment are quickly available
START team takes client to first treatment appointments	Treatment worker notifies START team if client misses treatment
START team works with other agencies to provide additional needed services	Family receives other services such as medical, housing assistance
Child welfare intake workers treat all positive toxicity referrals as emergencies	Mother is quickly identified for services, receives needed support, and is held more accountable
	Intake and START teams have joint meeting with mother during first week
START team visits client weekly	Ongoing support is provided to mother and timely intervention is possible

The START evaluation strategy incorporates the use of multiple sources of data and diverse analytic techniques.

Program Operations Documentation

In the first phase of the evaluation we document START implementation. There are two START units. Each unit consists of a supervisor, five social workers, and five family advocates. The program accepts positive toxicology babies referred to DCFS through the Hotline and seeks to incorporate the following structural features to achieve its aims:

- ❒ Intense personal contact between the START team and client
- ❒ Contact between the START team and the treatment provider
- ❒ Interaction between the START team, the treatment providers, and the client
- ❒ Cross-system coordination of treatment plan and the provision of ancillary support services
- ❒ Inclusion of a family advocate who is in recovery as a member of the START team
- ❒ Intense training for all members of the START team

We will measure the nature of the START program by collecting program operations implementation data. Exhibit 3 summarizes the measures we are using to determine whether the program is successfully implementing the structural features summarized above. We will collect these operations data from several sources: existing program data already collected by the department, focus groups with program staff and with staff from collaborating programs, interviews with START and DCFS administrators and administrators from collaborating programs, and new START data collection forms.

EXHIBIT 3

Program Operations Measures and Other Needed Data

Program Characteristic	Data Items/ Potential Measures	Sources of Data
Increased personal contact between team and client and/or other household members	1. Frequency and nature of contacts with client 2. Frequency and nature of contacts with other household members 3. Timeliness of first contact with client 4. Safety plan requirements specified adequately and on schedule	START contacts form
Increased collaboration between START team and treatment providers	1. Frequency and nature of contacts 2. Timeliness of crisis notification 3. Attendance at joint conferences and staff meetings 4. Length of wait for treatment services	START contacts form
Cross-system collaboration	1. Conference participants 2. Quantity and type of services used by client: e.g. child care services, health services, mental health services, housing, other services 3. Standard service package vs. individualized needs met	Focus groups CYCIS data* START contacts form
Teaming of social worker with family advocate	1. Able to recruit family advocates with desired characteristics: time in recovery, past child welfare involvement, JOBS eligible 2. Specialized training completed by social workers, family advocates, treatment staff 3. Nature of social worker and family advocate interactions 4. Caseload characteristics	Personnel recruitment data; Post-training assessment form START administrative data Focus groups
Client characteristics	1. Positive toxicity infant (yes/no) 2. Family history of DCFS involvement 3. Previous positive-toxicity infant 4. Previous treatment episodes 5. Protective factors from risk assessment 6. Risk factors from risk assessment 7. Incidence of other special circumstances (e.g. homelessness, illness) 8. Substance of choice	START tracking form Risk assessment CYCIS data*

*CYCIS data = Child and Youth Centered Information System

We will select 150 child welfare clients into the control group.

Outcomes

To assess the effectiveness of the START program we will compare clients who are served by START to others in the traditional CCDHS child welfare programs on relevant outcomes (Exhibit 4). For example, we can compare the length of time to permanency for START participants to that of all children who enter out-of-home care during the specified time period. Our comparisons will be based upon entry cohorts into the START program and entry cohorts for comparable time periods of a control group and all other CCDHS clients.

We will select 150 child welfare clients into the control group. The control group will be selected from all Hotline referrals received between February 1, 1996 and December 31, 1996 and meet the following criteria: there was a positive-toxicity infant and a case was opened by DCFS.

The evaluation committee elected to use a retrospective control group for these reasons: (1) a group of clients who became involved with DCFS before START was implemented is a true comparison between START practice and usual DCFS practice, and (2) there will be no change in the way workers treat cases in the comparison group. The committee recognizes that there are disadvantages to this approach; data collection may be more difficult due to incomplete case records.

We will use data being collected by the Alcohol, Drug, Addiction Services board to summarize the treatment experiences of the control group women. These data contain information on services received by clients in Cuyahoga County in all agencies that receive Medicaid funding. This information will then be compared with the data obtained from case record abstracts of child welfare records.

The capacity of the evaluation to detect differences in outcomes between the START program groups and the control group is dependent on the number of clients in each group. Early in the program planning and evaluation process, we will determine the timing of client flow into START. Preliminary data suggest that there are approximately 30 positive-toxicity-infant referrals each month. Since total combined caseload for the START units is capped at 150 cases (15 cases per SW-FA pair), it will take at least five months to fill the caseloads of the START units.

It is difficult to assess how long START will continue to be involved with each family. A conservative estimate is 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 estimated the time at about 18 months. This suggests that during the first year of implementation START will serve 150 women and their families. Beginning in Year Two we would expect to see termination of some clients involvement and 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.

START program planners have identified several outcomes of interest. The proposed sources of data for measuring each of these outcomes are summarized in Exhibit 5. We will use existing DCFS program data files for some of these outcomes: time to permanency and reduced referrals on families whose children are not in custody. START program files and control group data files will provide information on other outcomes such as contact with mothers. Finally, information on treatment participation and retention in treatment will come from a variety of sources. For START program participants, we will work with the treatment agencies to use information in their participant files. For control group members, the source of data may vary.

EXHIBIT 4
Goals and Outcome Measures

Reduce the risk for children when a chemically dependent mother is present

Increase percentage of CD mothers with whom DCFS still has contact at 6 months, 1 year

Reduce number of subsequent substantiated Child Abuse and Neglect (CAN) reports

Reduce risk factors present in the home

Increase protective factors present in the home

Reduce the time to permanency for children who must be removed from their families and placed in out-of-home care

Decrease length of time to permanency

Reduce number of subsequent removals

Decrease reentry rate to out-of-home placement within one year of discharge from START

Increase percentage of chemically dependent mothers who enter and complete treatment

Increase percentage of chemically dependent mothers who enter treatment

Increase percentage of chemically dependent mothers who move from pre-treatment to treatment

Increase treatment retention rate at 2 months and 6 months

Increase percentage of chemically dependent mothers who complete the required treatment program

EXHIBIT 5
Outcome Data Requirements

Measure	Data Elements Needed	Data Source
Goal: Reduce the risk for children with a chemically dependent mother		
Reduce subsequent substantiated CANs	❒ # referrals for abuse or neglect ❒ # substantiated	CANs system
Reduce risk factors in home	❒ risk factors present upon entering START ❒ risk factors present at specified intervals	Risk assessment instrument
Increase protective factors in home	❒ protective factors present upon entering START ❒ protective factors present at specified intervals	Risk assessment instrument
Increase long-term contact with mother	❒ frequency of contacts with mother	START contacts form

(continued)

Information on treatment participation and retention in treatment will come from a variety of sources.

EXHIBIT 5 *(continued)*
Outcome Data Requirements

Measure	Data Elements Needed	Data Source
Goal: Reduce the time to permanency for children who must be removed from their families and placed in out-of-home care		
Reduce length of time to permanency	❒ date of initial placement ❒ date placement ended ❒ placement type ❒ CYCIS case number	CYCIS
Reduce reentry rate within one year of discharge	❒ date placement episode ended ❒ date of reentry to care	CYCIS
Goal: Increase the percentage of clients who enter and complete recommended treatment		
Increase percentage of clients with complete assess-ment	❒ # clients referred for assessment ❒ # clients who complete assessment process	START contact form ADAS database (for measures on control group)
Increase percentage of clients who move from pre-treatment to treatment	❒ # of clients who enter pre-treatment phase by program ❒ # of clients who enter treatment program ❒ unique ID of clients	START contact form ADAS database (for measures on control group)
Increase treatment retention rate at: 2 months and 6 months	❒ # of clients who progress through various phases of treatment programs	START contact form ADAS database (for measures on control group)
Increase percentage of clients who complete treatment program	❒ # of clients who complete all phases of treatment program to which they were referred	START contact form ADAS database (for measures on control group)

Role of Self-Evaluation Process in START Evaluation

As members of a self-evaluation process, START program staff and administrators are collecting, analyzing, and using data for making program decisions. The role of the ***Family to Family***/START Self-Evaluation team is summarized in Exhibit 6. It is important to note that the self-evaluation group became active in planning the evaluation in the early phases of project planning and participated integrally in discussions about program design and implementation. As shown in Exhibit 6, the self-evaluation group s involvement remains substantial throughout the life of the project.

The self-evaluation group became active in... the early phases of project planning and participated integrally in discussions about program design and implementation.

EXHIBIT 6
Role of Self-Evaluation in START at Varying Phases of START Design and Implementation

Program Design Phase

Articulation of goals and related outcome measures to ensure that START can be evaluated.

Definition of ways to measure the form of services provided to ensure that program managers will know whether they are implementing START as planned.

Structured recording of decisions that influenced the evolution of the program design and are important to evaluation.

Facilitation of the cross-agency collaboration by identifying evaluation design issues that are important to the substance abuse treatment agencies. This included visits to the partner agencies to determine how they could support the data collection needed for tracking outcomes specific to substance abuse treatment.

Evaluation/Self-Evaluation Design Phase

Identification of skills and staff that are critical within the agency to using data to inform decisions and track program development and impact. This group became the self-evaluation team.

Design of the preliminary evaluation methodology identifying key decisionmaking points on which agency staff input is required.

Conduct evaluation decisionmaking meetings with agency director, deputy director, and program staff who will be involved with START to resolve critical evaluation issues that impact upon the agency s commitment to support the evaluation. These meetings are essential to establishing agency buy-in to collect data, using scarce resources to support data management and analysis efforts, and designing ways to use data in the monitoring and evaluation of the program. Examples of issues discussed include: program measures and the data needed to monitor them; design of new data collection forms that social workers and supervisors must complete; data collection protocols that require time and effort of the supervisors and social worker/family advocate teams; and reporting requirements that must be programmed by agency MIS staff.

Identification of existing sources of data that can be used to support the evaluation. These data sources included information from ADAS, DCFS, and the treatment agencies.

(continued)

EXHIBIT 6 *(continued)*

Role of Self-Evaluation in START at Varying Phases of START Design and Implementation

Program/Evaluation Implementation Phase

Identification and support for agency staff with responsibility for coordinating and implementing evaluation tasks.

Monitoring evaluation implementation and providing technical assistance as needed in areas that include data management, analysis, and report writing.

Assistance with providing continual and timely feedback to program administrators and staff on their successes in program implementation and early outcomes.

Feedback to program administrators and staff on barriers to program implementation using the data collected for the evaluation. This allows administrators to continually track whether they are serving the clients that they planned to serve, the form and cost of these services, and to implement program changes as needed.

APPENDICES

Appendix A

Ways to Integrate Twelve-Step and Family Support Approaches

We have already established our commitment to the short- and long-term emotional and physical safety of children as our top priority. We believe that we can succeed with some families despite a parent s initial involvement with drugs. The following are examples of ways of integrating 12-step and family-centered perspectives.

Building on Strengths

Both perspectives agree that people addicted to crack are going to have a very difficult, if not impossible, time serving as adequate parents, and that we need to help them either to get off drugs or relinquish responsibility for their kids. Both approaches agree that parents are most likely to get off crack if they have a sense that it is possible to do so. Everyone agrees that resources are so slim these days that we need to take advantage of all that we can find. Both would agree to the following premise:

Once the child s safety is assured, and the parent is addressing the drug problem, we will *build on her strengths* to help her achieve the goal of abstinence as quickly and completely as possible.

A Holistic Approach

Both perspectives agree that people who get off drugs will still have problems. Sometimes those problems increase the probability of relapse, but it s much easier to deal with them if the person is off drugs. Sometimes people won t get off drugs before they address other issues. A premise both could agree to is:

Once the child s safety is assured, and the parent is addressing the drug problem, *a holistic approach* will be used to help her solve other problems and increase the chances of lasting sobriety.

Individual Tailoring

Both perspectives can agree that people get in trouble for a variety of reasons. What they need in order to get off crack, and stay off, will vary as well, and it would be nice if all drug programs had the flexibility they would like to tailor their services for individuals. A premise both approaches can support is:

Once the parent has decided to address her drug problem, services will be used to increase her chances of success.

Decisionmaking Partnerships

Both approaches would agree that people habitually high on crack cannot adequately take care of their children. If they can t get off drugs, they shouldn t have sole responsibility for their kids. The goal is for people to be able to make responsible decisions.

This will take some shaping. People are more likely to go along with plans if they have some say in them. Decisions vary in their impact. Some are harmless, and we have nothing to lose by making them collaborative. A premise both approaches could support would be:

Once the parent has decided to address her drug problem, having some say in how she addresses it (and other problems) can enhance her motivation and her participation in the treatment. This can also help her begin to make other decisions. Part of our responsibility in helping clients to make good decisions is to provide them with clear information about the consequences of their drug use.

Specific Short-Term Goal Setting

Tension is strong between those in the drug treatment field who believe that immediate abstinence is the only option and those who focus on harm reduction. Everyone would most likely agree that abstinence is the most desirable goal and outcome. Not everyone will be able to do it. There is a difference between going cold turkey (the method of stopping) and teetotalling, or never using (the goal of stopping). Usually we lump them together, and it s unclear whether we re talking about the method or the goal. People often relapse on the road to recovery, but they may still arrive eventually.

For START, we believe everyone will agree that abstinence is a required goal for parents who have been addicts. We will use *specific short-term goal setting,* monitoring, and feedback as one method for helping them achieve this status.

Worker Selection and Training

Child welfare programs traditionally hire social workers. Many drug treatment programs use ex-addicts. We will use teams including both.

We will select and train workers to hold parents accountable and simultaneously support them in reaching goals of assuring child safety and achieving abstinence.

Appendix B

Job Description for START Supervisor

Usual Working Title of Position
Chemical Dependency Services Supervisor

Position No. and Title of Immediate Supervisor
Case Review/Chemical Dependency Services Senior Supervisor

Normal Working Hours (Explain unusual or rotating shift)
Flexible Schedule, On Call 24 Hours a Day, 7 Days a Week, Must Carry a Beeper

Job Description and Worker Characteristics

Percentage	Job Duties in Order of Importance
50%	Chemical Dependency Supervisor must become a registered candidate under the auspices of the Ohio Chemical Dependency Board. A registered candidate is required to have 40 hours of specific chemical dependency training and a year s supervision by a CCDC III. The agency will provide the supervisor, this training, and supervision in the first year in the chemical dependency unit. The supervisor must maintain a registered-candidate certification, attending 40 hours of training a year.
25%	Responsible for designing, implementing and continuing development of the Chemical Dependency Services Program.
15%	Supervise caseworkers and case aides assigned to the unit. Responsible to assign work, delegate case responsibilities, evaluate staff, communicate agency policies and procedures, regularly schedule conferences with staff and counsel on improvement, if needed.
	Responsible for reviewing and approving services provided to clients. Consult regularly with the chief of the department to update on unit s operations, plans and reports. Provide back-up support and home visits for caseworkers assigned to the unit. Attend all scheduled staff and treatment team meetings, as necessary.
	Approve summaries, letters, dictation, reports, correspondence, and monthly expense reports. Sign time sheet, monitor flex schedule of workers, approval for the use of ill and vacation time. Attend conferences, seminars, and in-service training programs.
10%	Represent the agency at meetings, conferences and workshops. Handle consumer complaints and attend court hearings as required by the agency.
	Become a member of the Family Preservation Task Force and/or any future advisory groups related to Family Preservation and Chemical Dependency Services.
	Perform other functionally related duties as required by this position.

Minimum Acceptable Characteristics

Knowledge of:

1. Risk assessment
2. Family systems theory
3. Child welfare practices and management
4. Employee training and development
5. Supervision
6. Interviewing
7. Group work & group process
8. Office practices and procedures
9. Counseling
10. Government structure
11. Juvenile court policy and procedures
12. Public/human relations
13. Manpower

Ability to:

14. Internalize chemical dependency concepts as they relate to family preservation
15. Communicate effectively both orally and in writing
16. Lead a group and actively involve all team members in the group process
17. Work effectively in a multicultural environment
18. Define problems, collect data, and draw valid conclusions
19. Gather, collate, and classify information
20. Do statistical analysis
21. Write routine business letters

Appendix C

Considerations Regarding Specific Screening Practices for START Supervisors

Possible questions to ask:

1. What are three ways you might describe a person who is addicted to drugs?
2. How do you think people get to be drug addicts?
3. What do you think people need in order to get off drugs?
4. How do you feel about working with people who are on crack?
5. What kinds of supports would be helpful to you in working with this group?
6. Have you ever supervised people who have been recovering drug addicts? If so, how did it go?
7. Have you ever supervised people who have been child welfare clients? If so, how was it?
8. What do you think recovering drug addicts and past child welfare clients might have to offer START clients?
9. What would your concerns be in working with them?
10. How might you deal with those concerns?

Possible role-playing exercises with applicants:

Advocate/Caseworker Dispute

The advocate and caseworker have been working with a family for one month. The mother in the family has been attending drug treatment about 75% of the time she is supposed to.

The mother has formed a very close relationship with the advocate. Last night the mother confided in the advocate that she has smoked crack a couple of times in the last few weeks and has no intention of giving it up completely.

This morning, the caseworker was at the house and the mother was very groggy and appeared to have been asleep on the couch with her infant crying in the other room.

The caseworker and advocate discussed their most recent visits and disagree. The caseworker feels the infant should be placed outside the home. The advocate believes the mother has the flu and that she is right on the verge of getting her act together. The advocate fears that the mother will just give up if her baby is removed.

The advocate and caseworker should be instructed to be committed to their positions but not totally closed to each other s point of view. The supervisor applicant s job is to help them come up with a plan that they all feel is okay.

Family Staffing

This role-playing exercise requires two people to play workers and the supervisor applicant to play the supervisor. More than two people can play workers.

One worker appears bored and distracted as another worker presents a family. She looks at her watch and goes through her papers. She begins completing her timesheets, looks around the room and goes through her purse or wallet. If the supervisor does not limit this

behavior, the worker escalates the distraction. She starts side conversations by borrowing a pen, stands up and looks around, cleans her notebook noisily. The supervisor s goal here should be to run an efficient meeting and to set limits appropriately with the distracting worker.

Community Relations

In this role-playing exercise, the supervisor applicant is supposed to calm down a frustrated referring worker from a hospital, and work together with her to come up with a plan to help the family and keep the infant safe.

The person playing the referring worker is excited about the new START program. She is a nurse who is trying to refer a woman on her unit who tested positive for crack and delivered an infant two days ago. She called the START unit directly right after the baby was born and was told that someone would come visit immediately. It didn t happen. Now, she has to get the woman out of the hospital and she is very frustrated and confused and angry. The START supervisor gets the call.

Lists of ideas to have supervisor applicants read and respond to:

1. Beliefs about the helping process: Do you agree or disagree?

❒ We often fail to tap into informal resources within the community, under-using a potential source of help.

❒ Some members of some communities view the entry of professionals as an intrusion from outside, something they had no part in developing.

❒ Having professionals enter a community and then leave can lead to changes that result in dependency, or in maintenance of the changes only when the professional is involved.

❒ When we view professionals as the only sources of expertise about helping, we can convey the message that regular people are inadequate and lack the capacity to really make it on their own.

❒ As people get the message that professionals do not believe they can succeed on their own, they can become less willing to try to improve their lives.

2. Here are some beliefs about the strengths of professionals. What do you think? Are there any you can add?

❒ Professionals have detailed knowledge of conceptual frameworks within which to assess and help resolve individual and family problems.

❒ They have a systematic orientation and can understand controlled observation.

❒ They know multitudes of techniques for problem-solving.

❒ They can usually write fairly well.

❒ They know the language that funding bodies use.

❒ They know people who make decisions about funding.

❒ They can educate natural helpers to assume more responsibilities, such as more training, mentoring, and direct help than they are already providing.

❒ They can make natural leaders aware of just how much they do know and encourage them to follow through on their beliefs.

❒ They can help natural helpers learn to provide training.

❒ They can work with natural helpers to adapt existing materials and develop new materials.

❒ They can help others learn to develop, fund, operate, and evaluate their own strategies.

❒ They can provide specialized services in very difficult problem areas.

❒ They can help others learn to develop, fund, operate, and evaluate their own social service models.

3. Some people believe these are strengths of natural helpers. What do you think? Can you add any?

❒ They understand the neighborhood.

❒ They usually understand their own culture and generally more about other cultures in the neighborhood than people who don t live there.

❒ They are usually more committed to resolving the issues because the challenges affect them personally.

❒ They usually have more trust and status within the neighborhood than most outsiders do.

❒ They may provide ongoing long-term support.

❒ They are more likely to hear about problems before they become so severe that intensive intervention is the only option.

❒ If they are paid for their work, it will help the economic status of the neighborhood.

❒ They may provide successful role models.

❒ They are often more familiar with the intricacies of public bureaucracies than many professionals, because their personal welfare has often depended upon this understanding.

❒ They know which strategies work and which do not within their neighborhoods.

❒ They often know the needs of the community.

❒ They have mastered the ability to function in conditions that are physically and emotionally scary to professionals, sometimes to the degree that the professionals refuse to enter the site or cannot function well.

❒ They are more likely to be available 24 hours a day to those they support. This can decrease the possibility of people being harmed.

❒ Natural helpers are more likely to provide support in the recipient s natural environment.

❒ They can support families who have been or would be unable or unwilling to receive services in more traditional settings.

❒ The use of natural helpers allows for more effective and comprehensive monitoring regarding client safety.

Appendix D

Job Description for START Social Worker

Usual Working Title of Position
Chemical Dependency Services Worker

Position No. and Title of Immediate Supervisor
Chemical Dependency Services Supervisor I

Normal Working Hours (Explain unusual or rotating shift)
From 8:30 a.m. to 4:30 p.m. Must be flexible on work hours

Job Description and Worker Characteristics

Percentage	Job Duties in Order of Importance	Minimum Acceptable Characteristics
	Chemical Dependency Unit workers must become registered candidates under the auspices of the Ohio Chemical Dependency Board. A registered candidate is required to have 40 hours of specific chemical dependency training and a year s supervision by a CCDC III. The Agency will provide the worker this training and supervision in the first year in the Chemical Dependency Unit. Workers must maintain a registered-candidate certification, attending 40 hours of training a year.	Knowledge of: 1. Risk assessment 2. Interviewing 3. Counseling 4. Family systems theory 5. Office practices and procedures 6. Sociology 7. Psychology 8. Community resources 9. Prior knowledge of chemical dependency treatment preferred, but not required 10. Chemical dependency concepts as they relate to family preservation concepts 11. Ways to deal with a large number of variables and to determine a specific course of action on the basis of need 12. Ways to interpret a variety of instructions in written, oral, picture, and/or scheduled form 13. Ways to complete routine forms 14. Business letter forms reflecting standard procedures 15. Gathering, collating, and classifying information about data, people, or things according to established methods 16. Handling sensitive telephone and face-to-face inquiries and contacts with public and government officials
90%	Assess and provide Intensive Chemical Dependency Services and Social Work Intervention for moderate to high-risk cases assigned. The Chemical Dependency Services and Educational Component is geared to reduce risk to children, to increase family functioning and integrity through immediate intervention that defuses the crisis and stabilizes the family. Chemical Dependency Services will include, but not be limited to, counseling, advocacy, case coordination, concrete services, development of echograms and genograms for families, protective services, substitute care, and out-of-town investigations. Re-evaluate and monitor client s progress. Be a part of the treatment team in order to continue, change, or terminate services. Prepare and complete all federal, state, and local reporting requirements and written documents for a Chemical Dependency Services caseload. Interface with needed resources, internal and external, to the agency on behalf of clients. This requires knowledge of agency and community resources availability. Chemical Dependency Unit Workers will spend a minimum of 1 1/2 hours a week in direct face-to-face contact with the family. This contact can occur 24 hours a day, 7 days a week, resulting in a flex schedule.	

Appendix E

Possible Considerations in Hiring START Advocates

1. We want people who are not blameful or (very) angry at either the system, themselves, or people with drug problems in general.
2. We do not want people who think that the particular way they got off drugs is the only way it can happen. We want people who will help others develop unique approaches for themselves.
3. We want people who feel okay about supervision and about social workers.
4. We want people who are pretty confident about, and committed to, staying clean.
5. We would like to find people who are able to think about some of the possible challenges they would face in this job, and who can come up with some ideas of how they would address them.
6. We want people who recognize how much they have to offer to this effort.

Possible questions to ask:

1. Why do you think people get on drugs?
2. What do you think they need to get off?
3. What is the most difficult experience you have had with The System? How did you handle it? (We are looking for productive problem-solving rather than blaming and attacking.)
4. What is the most difficult experience you have had with a teacher or a supervisor? How did you handle it?
5. What is the most difficult experience you have had with a social worker or caseworker? How did you handle it?
6. How confident are you that you will stay in recovery if you take on additional challenges and responsibilities? What will help you?
7. How committed are you to staying in recovery? What would you do if you felt your new job was threatening your ability to do it?
8. What would you do if you noticed that one of your co-workers was about to relapse, or had already done so?
9. What do you think would be the most challenging aspect of this job for you?
10. What do you think you have to offer this program?
11. Why do you want the job?
12. How do you feel about being on call all the time, and about going out to people s homes?

Appendix F

Job Description for START Advocate

Usual Working Title of Position
Family and Recovery Advocate

Position No. and Title of Immediate Supervisor
Social Service Supervisor I

Normal Working Hours (Explain unusual or rotating shift)

Job Description and Worker Characteristics

Percentage	Job Duties in Order of Importance
32 - 52%	Escorts and/or transports parent and/or child to substance abuse treatment sessions, medical, educational, social service, mental health appointments, and shopping centers.
15 - 35%	Interviews clients in home or office in order to determine progress. Assists social service worker and family to support recovery of parent. Arranges for needs
8 - 18%	of client by locating housing, food, clothing, and furniture as needed. Completes necessary forms.
11 - 21%	Converses with clients and general public on phone referrals to other agencies; provides information on community services and schedules appointments as needed for family or child services.
0 - 5%	Establishes, organizes and maintains case files for the unit and other statistical information.
0 - 5%	Completes correspondence, records, or reports; makes copies as needed.
	Attends committee meetings, staff meetings, agency training, and conferences. Performs other related duties as required.

Minimum Acceptable Characteristics

Knowledge of:

1. Safety practices
2. Public relations
3. Office practices and procedures
4. How to carry out instructions in written or oral form
5. Reading, copying, and recording figures
6. Interviewing
7. Dealing with problems involving several variables in a familiar context
8. Completing routine forms
9. Answering routine telephone inquiries from the public