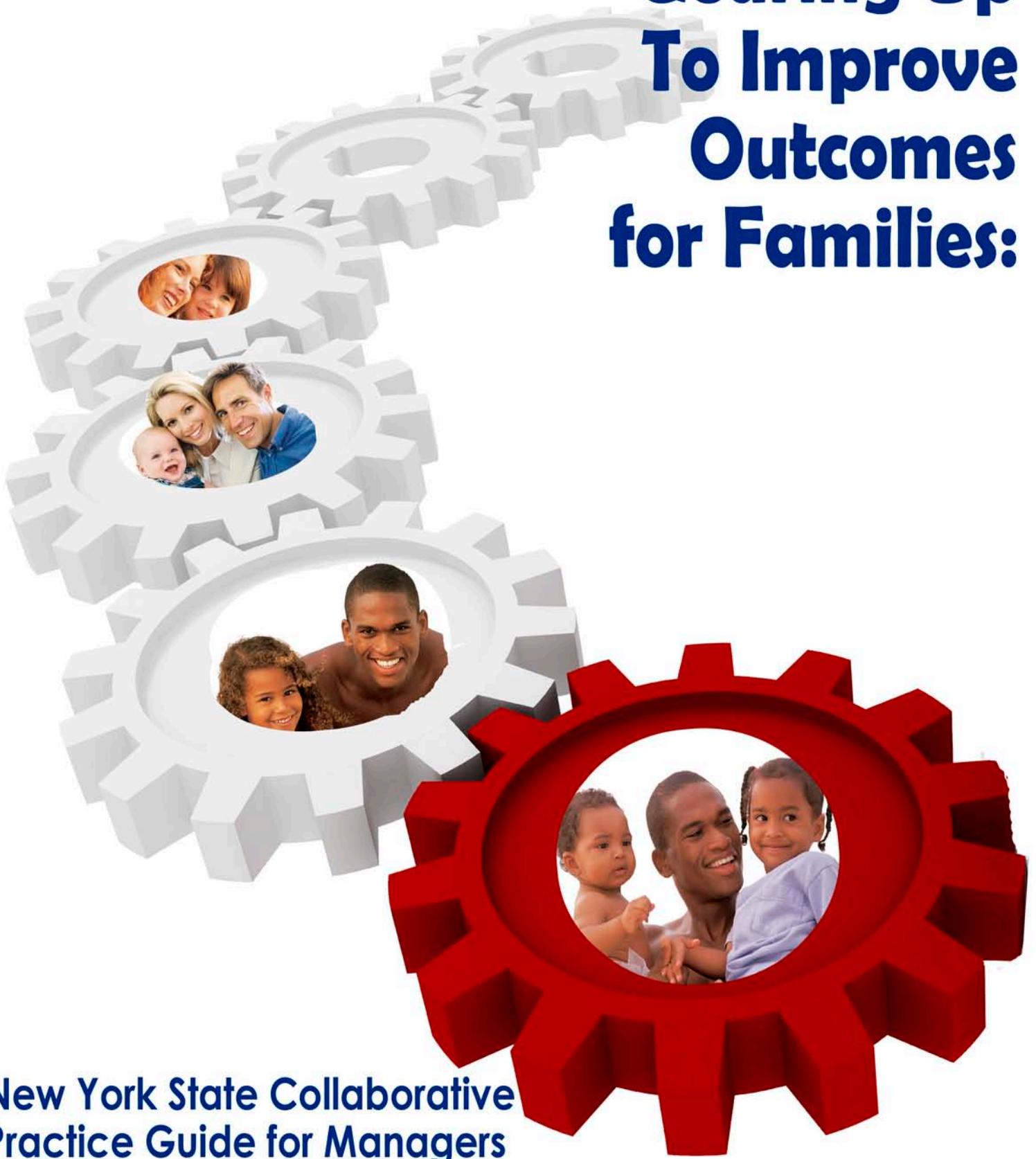


Gearing Up To Improve Outcomes for Families:



**New York State Collaborative
Practice Guide for Managers
and Supervisors in Child Welfare,
Chemical Dependency Services,
and Court Systems**

This Collaborative Practice Guide has been developed through the hard work of many professionals from the court, child welfare and chemical dependency systems in New York. This work occurred under the auspices of the In-Depth Technical Assistance (IDTA) Project sponsored by the National Center for Substance Abuse and Child Welfare (NCSACW), which was sponsored by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment and the Administration on Children, Youth and Families' Children's Bureau, Office on Child Abuse and Neglect. As part of New York's participation in this IDTA Project, NCSACW provided a lead consultant, Kari Earle. The IDTA core team extends sincere gratitude and thanks for the wisdom, perseverance, and guidance that Kari Earle provided as she facilitated, led and, occasionally, prodded our work.

This product is the result of two years' work. As with all collaborative work of this nature, leadership is critical. Thanks are due to the previous and current commissioners of the New York State Office of Children and Family Services (OCFS) and the New York State Office of Alcoholism and Substance Abuse Services (OASAS) and Chief Judge Judith S. Kaye of the New York State Unified Court System for promoting and supporting this work. Essential to the completion of this guide, and the accompanying work, is the dedication and time of the core team for this IDTA Project. As with many interagency partnerships, the composition of our group changed over time. The strength of any collaborative effort is its ability to continue through transition in its membership. Kudos are due to this group whose membership evolved over the duration of this work. Special thanks are extended to the members of the core team who committed themselves and their time amid busy schedules to complete this work. Core team members through the completion of this document include OASAS: Lureen McNeil, Sheila Roach, Maria Morris-Groves; OCA: Frank Jordan, Frank Woods, Christine Kiesel; Permanent Judicial Commission on Justice for Children: Azra Farrell; OCFS: Larry Pasti, Mary Ellen Ange, Shelley Murphy, Betsy Stevens; New York Public Welfare Association: Sheila Poole; New York City Administration for Children's Services: Monette Sachs, Andrea Reid, Nancy Chapman, Erika Tullberg; and New York State Association of Substance Abuse Providers: John Coppola.

It was important to the value of this document to include input from the broad spectrum of stakeholders in these three systems. Through both a statewide advisory group and workgroup committees many professionals committed time, energy and insights. Please see Appendix III for a complete list of those that contributed and for who thanks are due. Consumer input is valuable and this work included the voices of youth and parents who experienced these systems obtained through four focus groups. While anonymous, the core team expresses a special gratitude to those citizens who shared their experiences, recommendations and advice. Administrative support is necessary to compile and complete this guide. For that, the patience and skill of Pam Wood and Arden Blesser are appreciated, and without whose dedication, this would not have been possible.

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This guidebook, developed by the New York Partnership for Family Recovery with technical assistance provided by the National Center on Substance Abuse and Child Welfare (NCSACW), is based on the premise that when parents have substance use disorders, children can suffer from abuse and/or neglect. When this occurs, it is essential that the chemical dependency, child welfare and family court systems work together with families to achieve child safety, sustained parental recovery, and family well-being. This tool was created to serve as a desk reference for staff to assist in maximizing their effectiveness in working with families, and each other. It is only through collaboration and communication across systems as well as with families being served that we can offer families an opportunity to achieve long-term recovery.

This guide is designed specifically for the State of New York, and is modeled after a protocol developed by the New York City Administration for Children's Services (ACS) together with the New York State Office of Alcoholism and Substance Abuse Services (OASAS) as well as the national SAFERR (Screening and Assessment for Family Engagement, Retention and Recovery) model, which was released by the U.S. Department of Health and Human Services in May 2007*. Like SAFERR, this guide is based on three overarching principles:

- The co-occurrence of child maltreatment and substance use disorders demands urgency, and the highest standards of practice from everyone charged with assuring child safety and promoting family well-being.
- Success is possible and feasible. Staff in each system has the desire and potential to change individual lives and create responsible public policies.
- Family members must be active partners and participants in addressing these problems.

This guide highlights the opportunities for the caseworkers, chemical dependency counselors, and court personnel that work with families to coordinate their efforts in order to —

- Establish local cross-system teams to share information and coordinate case planning and service delivery to improve the ability of families to succeed;
- Develop tools and strategies to incorporate into daily practice protocols;
- Provide courts with information to facilitate timely and informed decisions regarding child safety and permanency; and
- Employ jointly defined mechanisms for problem-solving and success-sharing.

As the three systems worked to develop this guide, the shared language became an issue that took our time and energy so we could understand each other. One of the major areas where shared language is important is how to describe those families and individuals whose use of alcohol or other drugs/illegal substances has created problems or a need for treatment or intervention/prevention. We use the term substance use disorder (SUD) to refer to individuals whose use of alcohol or drugs requires treatment. This term underscores the understanding that a substance use disorder is a condition that requires treatment with other interventions rather than an act of volition by the individuals. Other terms used in this document include chemical dependency provider, treatment provider, addiction, substance abuse, and alcohol and other drugs (AOD).

**Young, N. K., Nakashian, M., Yeh, S., & Amatetti, S. Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR). DHHS Pub. No. (SMA) 07-4261. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2007. This publication can be accessed electronically through the following Internet World Wide Web connection <http://www.ncsacw.samhsa.gov>. For additional free copies of this document, please call SAMHSA's National Clearinghouse for Alcohol and Drug Information at 1-800-729-6686 or the National Clearinghouse on Child Abuse and Neglect at 1-800-394-3366.*

Purpose

The priority outcome of this initiative is to achieve child safety, permanency and well-being by supporting sustainable family recovery and reducing the need for court intervention. New York State has undertaken to create a holistic approach to working with families by bringing key systems into collaboration. Each of these systems and their partners recognize the need to work more effectively with families, to treat the parent for multiple problems, to foster long-term recovery, and to create comprehensive service plans with the family’s input. These systems and their representatives are committed to work together in the best interest of the child by supporting the entire family in a strength-based manner that promotes success.

The Adoption and Safe Families Act (ASFA) has heightened the urgency of achieving successful collaboration among systems working with families, particularly when children are placed outside the home due to child neglect. ASFA creates a presumption that if children are not able to be safely returned to their home after placement outside the child’s home for 15 months out of the past 22 months, DSS must petition to terminate the parent’s rights. ASFA requires that children achieve permanency swiftly. Parents whose children have entered the child welfare system as a result of their substance use disorder have unique challenges requiring prompt assessment, engagement and treatment. Treatment providers, child welfare workers and the courts must work collaboratively and with a clear understanding of the other systems in order to effectively support families.

The New York Partnership for Family Recovery seeks to provide guidelines and best practices to assist child welfare agencies, treatment providers and court officials working with families at the intersection of these three systems. These guidelines are designed to help parents and families engage in services to obtain treatment and maintain long-term recovery, while keeping their children safe. As adapted by various counties and cities, this document will be recommended for use in all future initiatives to improve outcomes for children and families by providing a model for cross-systems collaboration.

Goals & Objectives

- To establish a set of core values and principles that will guide the implementation of collaborative policies and practices.
- To provide practice guidance for local jurisdictions in the areas of: family engagement, screening and assessment, cross-system referrals, information sharing and service coordination, discharge planning and aftercare.
- To work with families affected by substance use disorders to support long-term recovery, reach better outcomes, reduce recidivism, and break the cycle of multigenerational involvement in the child welfare, family court and treatment systems.
- To identify opportunities throughout the course of a family’s multisystem involvement to improve engagement, assessment, referral and service coordination, and to identify and respond to any alcohol and other drug issues that may arise after the abuse/neglect petitions are filed with the court.
- To address the service needs of children impacted by parental substance use disorders as an essential part of a family’s comprehensive service plan.

Priority Populations

This initiative focuses on families affected with substance use disorders that are involved with child welfare, chemical dependency and court systems. These families often have histories of repeated involvement in one or more systems and may be the most extensive and expensive users of system resources.

“Family” in this context is defined broadly to include, for instance, adolescents in congregate care, multigenerational households, and other less traditional constellations.

Many of these families present with a history of intergenerational issues including substance use disorders, mental health diagnoses, physical disabilities, domestic violence and parenting deficits that are rooted in the parents’ own childhood experiences. It is recognized that all families fall on a continuum of need, development, and progress, and that services must be targeted to all family members, no matter what point they fall along that complex continuum.

Lead Systems

New York State’s

- Office of Alcoholism and Substance Abuse Services (OASAS)
- Office of Children and Family Services (OCFS)*
- Office of Court Administration (OCA)

Key Collaborative Partners

- New York City’s Administration for Children’s Services (ACS)
- New York State Office of Temporary and Disability Assistance (OTDA)
- New York Public Welfare Association (represents county departments of social services)
- Association of Substance Abuse Providers (ASAP)
- State and local agencies involved in the provision of services to families, including but not limited to: mental health, domestic violence, education, maternal and child health, child care, domestic violence, parenting, corrections, welfare, housing

Family & Youth Input

Focus groups with parents and youth that had been involved in all three systems were conducted in April 2007 to obtain their perspective on how current delivery of services in New York State can be improved. A summary of these focus groups can be found at <http://www.oasas.state.ny.us/special/index.cfm#>.

What Worked?

- Being treated with respect and compassion
- Peer support and mentoring
- Increased contact with and accountability to the courts, coupled with positive support
- Integrating treatment with wraparound support services
- Structure and consistency

* New York has a state-supervised, county-administered child welfare system. Child welfare services are provided by the county departments of social services, St. Regis Mohawk Tribe, and, in New York City, the Administration for Children’s Services.

- Case Management and Advocacy that helps families and youth navigate and understand the system, as well as access resources
- The Family Treatment Court approach (multi-agency team, increased judicial oversight, increased support)

What Needs Improvement?

- Need more of the following services and support:
 - Recovery mentors and family advocates
 - Integrated case planning
 - Case management
 - Family-centered treatment
 - Marriage and family counseling
- Treating families with dignity - including children
- Giving youth a voice throughout the process
- Supporting children in maintaining family connections during out-of-home placement
- Consistent staffing of counselors and caseworkers
- Training caseworkers and service providers on motivational techniques, the use of proven engagement and retention strategies, and best practices for handling relapse.

Goals & Objectives

- To deliver prevention, treatment, and recovery services to SUD-affected families as a part of a comprehensive service plan that may include trauma-informed services, parenting skills classes, mental and physical health assessments and services, interventions for domestic violence victims and child witnesses, housing and education assistance, employment readiness, and advocacy in responding to criminal justice issues.
- To ensure that appropriate resources are available to support families in their recovery from the effects of substance use disorders and other identified challenges. This can be accomplished through providing immediate and effective engagement, assessment, referrals to treatment, service delivery and coordination.

Joint Accountability for Shared Outcomes

Prioritizing the safety and well-being of children in each system’s policies and practices.

Supporting the safety and well-being of children by providing parents with comprehensive service plans that include treatment and support for recovery from substance use disorders, as well as addressing any other issues that might interfere with parenting.

Partnering to uphold the safety of the child(ren) in the event of parental relapse, by educating child welfare staff about the dynamics of relapse and providing information to assist in timely and appropriate interventions with the families that promote child safety and well-being.

Learning the dynamics of each system, how to work within each system’s established parameters, and how to utilize those structures to ensure that children are safe and that the parent’s treatment needs are fully met. (While each system is an equal partner with respect to the expertise and knowledge it contributes to the family’s treatment, case management and discharge plan, we acknowledge that the relative power and authority of each system is not equal.)

Information Sharing & Service Coordination

All systems agree to communicate and share pertinent and reliable information about family members in a purposeful and respectful manner that complies with Social Services Law, CASAC regulations, 42 CFR Part 2 (the federal law regarding confidentiality of alcohol and drug use patients), Health Insurance Portability and Accountability Act (HIPAA) and relevant court rules.

Each system will maintain updated key contact information to facilitate timely referrals, ongoing communication, service coordination, changes in case status and discharge planning across systems and between state, city, county, and local entities and providers throughout the life of a case.

Counselors and caseworkers will collaborate to work with and support the family by coordinating appointment schedules and developing service plan/treatment plan goals, to avoid creating unnecessary barriers to the family’s success.

Family-Centered Service Delivery

All systems will:

1. Support and facilitate family visits, if appropriate, when the parent/caretaker is incarcerated or in residential treatment. Visiting fosters and sustains the parent-child relationship, which is critical to a child's physical, emotional and psychological development and can also enhance the recovery of the parent. (If a parent or child expresses reservations about visiting, these issues will be explored separately with the parent, child and the appropriate service agencies.)
2. Work together to provide safety and permanency for children who have been neglected or abused, and advocate that they receive timely and appropriate therapeutic interventions of sufficient quality and duration to facilitate healing.
3. Coordinate services for families with co-occurring substance use disorders and domestic violence problems so that all necessary precautions are taken to protect the survivor. Treatment for the traumatic effects of domestic violence on survivors, including child witnesses, must be sufficient to maximize recovery. Abusive partners will be held accountable for their actions.

Cross-Systems Training

Cross-systems training will be provided for staff from the lead systems and their partners that:

- Teaches these shared values and supports their integration into policy and practice;
- Builds respect and operational knowledge that fosters a seamless system of care for families;
- Imparts practical guidance for dealing with differences of opinion without damaging the collaborative process.

Interactions With the Families We Mutually Serve Will Be:

Strength-based – services and interventions should build on the strengths and competencies of all family members, who must be empowered to actively participate in the service and treatment plan design.

Needs-driven - service and treatment plans should reflect the unique needs identified by the family seeking assistance and those working with them.

Family-centered – as understood by the three systems is a term wherein the family, as defined by its own members, is consistently regarded as having primary responsibility for nurturing and protecting its children unless child safety concerns require outside intervention.

Culturally competent – services will be delivered with an understanding of and respect for the individual culture of the family, as well as the family's ethnic, cultural, social and environmental context.

Community-based – recognizing that families are best served in their own communities, both traditional and non-traditional resources of the community will be utilized to fully support the family's recovery.

Comprehensive – families require coordinated services that address multiple and complex needs related to substance use disorders, mental health, family reunification, housing, employment, education, health, and other challenges.

Key Guiding Principles

Once a person's appropriate level of care has been identified, a referral to an appropriate service provider should be made in a timely manner.

All families should be screened for a SUD by the child welfare worker. This screening can be conducted informally, through informal observation or discussion with family members, or formally using a screening tool, with consent. Whenever possible, this screening should be done before a petition is filed in family court.

Upon determination that a family member is likely to have an SUD, a referral should be made to an OASAS-certified program for a comprehensive assessment and level-of-care determination. (In the case of co-located CASACs at DSS offices, the on-site CASAC can conduct an in-depth exploration of chemical dependency issues and then make a referral to an OASAS-certified program for a level of care determination.) At the same time, a safety plan for the child should be made.

CASACs are mandated child abuse reporters and must report any suspected child abuse or maltreatment to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR). Specifically, when a child, parent, or other person legally responsible for a child is before a mandated reporter acting in his or her professional capacity and the mandated reporter is presented with a reasonable cause to suspect child abuse or maltreatment, that information must be reported to the SCR.

Because the focus is on family well-being, caseworkers should not limit their screenings to the identified parent, but should also explore substance use by other household members. When appropriate, other family members who indicate a possible SUD should be encouraged to also participate in an assessment process with a treatment provider that can provide culturally and developmentally appropriate treatment and supportive services.

The child welfare worker and the treatment provider should invite the parent to sign release forms authorizing the disclosure of information among systems (in accordance with 42 CFR Part 2 and HIPAA) as early as possible in the process, to allow for sharing of information and case coordination.

Based on the results of the assessment and level-of-care determination, a referral will be made to an appropriate program, taking into consideration existing family issues and child welfare mandates.

Upon admission to a program, an individualized treatment plan will be developed that addresses the clinical needs of the client, along with family and child issues, and requirements from child welfare, family court, and other involved systems.

Child welfare workers, treatment providers, and family court should work collaboratively to share information about screening and assessments, clinical diagnoses, recommendations for care, and other relevant facts utilizing release-of-information forms that conform with HIPAA and 42 CFR Part 2.

Families involved in the temporary assistance program must have screenings and assessment conducted by a CASAC through the county department of social services (or the Human Resources Administration in New York City). This assessment is mandatory for adults to remain eligible for temporary assistance benefits.

Child Welfare Worker/ Treatment Provider Guidelines

SCREENING-ASSESSMENT-REFERRAL

Family Court Guidelines

After the filing of a neglect petition, where alcohol and drug use is alleged and/or subsequently identified, the court may order or attempt to persuade the respondent or other household member to participate in a screening and assessment for a substance use disorder, in order to assist the family in accessing and engaging in treatment.

When families and agencies appear before the court, judges or magistrates should ensure that appropriate screening and assessments have been conducted to include diagnosis and level of care determination and next scheduled visits in their deliberations. Attorneys for parents play a key role in advocating for timely assessments and in encouraging their clients to participate in the assessment process. The assessment results and their implications for services should be discussed in the courtroom or by a court conference with all interested parties as soon as possible after the assessment results are available. A separate calendared appearance may be necessary.

Family Treatment Court Guidelines

Historically, there has been a lack of coordination among the courts, treatment providers and child welfare systems when dealing with substance use disorders in families. With the implementation of Family Treatment Courts (FTC) and Model Courts, these systems have begun to work collaboratively, resulting in earlier linkages to treatment and better retention rates. Family Treatment Court resource coordinators/case managers are Credentialed Alcoholism and Substance Abuse Counselors (CASACs) who may conduct screening upon the filing of a neglect or abuse petition and with the consent of the parties or upon order of the court. The Family Treatment Court resource coordinator, DSS caseworker and treatment provider should not share specific information with one another unless they are authorized to do so by the client through a signed release or a court order. To do so without proper authority may result in the violation of the confidentiality requirements of Social Services Law, HIPPA or 42 CFR Part 2.

Special Considerations

- Since communication is key to successful collaboration, the case plan must include the authority to exchange information among systems via releases or a court order. Therefore, if a client fails to engage in treatment for a substance use disorder, the provider can promptly notify the child welfare worker and family court.
- All three systems need to ensure that the appropriate releases are signed so that information can be shared regarding the families' progress.
- Referral to a child welfare agency (Family Rehabilitative Program (FRP) with ACS) must take place when working with families with children in order to ensure that child safety is maintained.
- Substance use disorders need to be viewed in the context of how addiction affects the ability of parents to care for their children or poses specific risks for child maltreatment. It is important to note that pursuant to Social Services Law §422 and 422-a, DSS may not disclose information regarding unfounded child abuse and maltreatment reports to the State Central Register or reports that are still under investigation unless ordered to do so by a court.

Key Guiding Principles

Child welfare services, chemical dependency treatment providers and the court system need to collaborate to develop a comprehensive plan to help the families. Localities should form collaborations that include all three systems, along with community-based providers, to engage family members in prevention, treatment, and recovery services — particularly when substance use is suspected but not indicated in the court case. The ability to leverage opportunities that exist in other systems is an important tool in engaging family members in chemical dependency services. This multisystem collaboration can result in several benefits, including:

- Ensuring that a broad range of knowledge and expertise is available to address problems, thereby increasing the likelihood that services will be comprehensive and that families will engage and remain in them.
- Increasing the exchange of accurate information (if authorized to do so by the client or a court order) and timely coordination of services, as a result of increased understanding of one another's services and procedures.
- Developing a broader understanding of the needs of the family in regards to substance use disorder prevention, treatment and recovery services, as well as other preventive services, thus enhancing the team's ability to match services to family needs.

Individual system goals, mandates, and services should be woven into a single and comprehensive services plan that is clear to families and service providers. If unified case plans are not feasible, it is important that plans be developed in a coordinated manner that give clear and consistent guidance and direction to families.

Family members should be actively engaged in creating their plans. Families often have resources in the form of relatives, friends, churches, or other support networks that can participate in creating plans and in ensuring that families are able to comply with their plans. Families should be welcomed as full participants in multidisciplinary team meetings during which decisions about case plans will be made, and should have opportunities to express the needs of their family throughout the process.

Child Welfare Worker Guidelines

Factors of importance to local social services district case plans include:

- A permanency plan for the child(ren)
- Child safety
- Reunification services to be provided to the family as part of helping parents retain or regain custody, including chemical dependency services
- A visitation schedule for the parent(s) and child(ren)

Department of social services case plans should outline all individual and family goals and services that will be provided to assist parents and children. The department of social services will conduct statutorily required Family Assessment and Service Plans (FASPs) reviews that include family members and all service providers involved with the family. At these meetings, families should have an active voice in the development of their service plans and should feel comfortable expressing their needs and the needs of their family. All involved agencies should share information regarding the family's progress and treatment goals and objectives.

Treatment Provider Guidelines

A referral to Chemical Dependency Services may come from a child welfare agency or the family court. Chemical Dependency Prevention and Treatment providers should be mindful of the Adoption and Safe Family Act (see Appendices, I. Glossary of Terms for additional information) timetables. Treatment planning should include a discussion of those timetables when possible.

Treatment plans should be based on prior screening and assessment, as well as information obtained from the court and child welfare system. All information should be obtained with the appropriately signed releases or by court order and should include the following:

- Problem areas to be addressed, including but not limited to substance use, family relationships, medical care, and educational and employment needs;
- Goals of the treatment process (e.g., abstinence from the use of alcohol or drugs and improved parenting skills);
- Objectives and strategies to reach the treatment goals (e.g., develop social network with individuals who do not use substances and successfully complete evidence-based parenting classes);
- People responsible for actions such as making referrals, attending treatment sessions, and preparing follow-up reports;
- Time frame within which certain activities should occur; and,
- Expected benefits for the individual participating in the treatment experience.

Treatment plans are to be developed and reviewed with each client, on a regular basis. As the treatment plan is reviewed and revised, the chemical dependency providers must be current with updated information from the child welfare and court systems.

Family Court Guidelines

Family Court orders typically incorporate the service plan designed by the child welfare services agency, turning the child welfare case plan into a court order that complies with ASFA requirements and reflects the needs of both the respondent and the family. AOD treatment provisions in Family Court orders typically require the respondent to comply with treatment recommendations. All the agencies involved with a family should review the court order with the respondent to ensure that the Family Court's expectations of the respondent(s) are clear. In addition to the above, **Family Treatment Court** contracts should be thoroughly explained and reviewed with each respondent and his or her counsel to make sure that they fully understand all the service plan requirements.

Special Considerations

Caseworkers and service providers should receive training on chemical dependency and its effect on families, the Stages of Change model of recovery as well as motivational interviewing or client engagement. This training should be part of cross systems training that also includes sensitivity training regarding parental privacy rights.

Treatment providers should receive training on the Adoption and Safe Families time frames and the child's need for permanency.

Personnel in all three systems need training related to collaboration, confidentiality and parental rights, as well as knowledge of evidence-based practices for working with families at the intersection of the three systems.

Background & Key Guiding Principles

Cross-systems communication and the exchange of privileged client information often presents a challenge to collaborative practice, and is typically seen as a significant barrier, due to myriad federal and state confidentiality regulations.

Systems should work together to develop consensus regarding the nature and type of information required to support informed decision-making and make agreements about how shared information will be used. It is important to note that no agreement may overrule the statutory-mandated roles of an agency or court. For example, DSS cannot agree to disregard information pertaining to child safety. Child welfare staff and the courts legitimately need information about family members' participation in services in order to make informed decisions about child safety and permanency. This needs to be balanced with a family's privacy rights, and the treatment provider's responsibility to guard against the unauthorized release of sensitive information regarding its clients. Finally, no agency should share information with another unless authorized to do so by a release from the client, or a court order, or as required by state or federal law.

Accessing information systems offers opportunities for service providers to reduce the duplication of reporting requirements. This is an important area for the collaboration to explore and support.

General Practice Guidelines

When developing collaborative guidelines, confidentiality regulations and privacy rights should be taken into account early in the process, leaving ample time to develop forms that comply with regulations and respond to the needs of families and of each collaborative partner.

Counselors and caseworkers should work collaboratively with family members to obtain the necessary consents to exchange information about screening, assessments, and service provision as early in the life of the case as possible in order to facilitate timely referrals to treatment and supportive services, so that child permanency can be achieved sooner rather than later. Court staff should also be included in these releases. If a client refuses to consent to information sharing, a court order may be sought.

Lead systems should develop, approve and use multi-agency release of information and consent forms that enable the sharing of information about a parent/caretaker or adolescent in a purposeful and respectful manner that maintains compliance with Social Services Law, CASAC Regulations, 42 CFR Part 2, HIPAA and relevant court rules.

As soon as appropriate releases and confidentiality forms are signed, the systems can work together to ensure that all family members receive the help they need.

Child Welfare & the Courts Need to Know:

After a referral is made:

- Referral status: e.g., referral accepted; appointment kept or missed; admission approved, pending or denied; next scheduled appointment
- Assessment summary or recommendations
- Diagnosis
- Level of care determination
- Services to be provided
- Urinalysis results

During the course of treatment:

- Progress and attendance in treatment
- Compliance with program, including urinalysis results
- Identification of co-occurring issues

- Significant changes: address, level of care, diagnosis, household composition, etc.
- Observations of parent-child relationship
- Discharge status and aftercare plans/needs

Treatment Providers Need to Know:

Upon referral of a parent or child from CPS:

- Reason for the referral and whether SUD issues were indicated in the petition
- Results of screening and assessments done previously
- Case plan goals for all family members
- Confirmation that release of information forms are signed or court order obtained
- Previous history regarding alcohol and other drugs use
- Previous history of child welfare involvement
- Composition of family/household, including children that might have been permanently removed
- Client identifying information for benefits (SSN, Medicaid)
- Status of children and visiting schedule
- Contact information of caseworker/planner/supervisor

Throughout the treatment process:

- Parent/Respondent court dates
- Service Plan Review (SPR) dates
- Information on child custody issues
- Results of any court or CPS-conducted urine tests
- Ongoing status related to child or visiting arrangements as well as schedules
- Status of court case, including closing of court case

In order to improve communication and information sharing, it is crucial that localities assess their information system resources and improve structures for sharing information across systems in ways that will not be detrimental to the client/respondent. The process of information sharing should be reviewed by all parties to be sure that each system is collaboratively meeting the needs of the family.

Forms must be designed to be used for both parents and youth with child welfare and substance use disorder issues.

Obtaining a parent's or guardian ad litem's consent is an important and necessary step to engage the youth and family in chemical dependency treatment.

Special Considerations

Key Guiding Principles

Nationally, parental substance abuse has been identified as an underlying factor in as high as 80 percent of child abuse/neglect cases. However, Family Court judges note that in many cases, it is not included in the allegations contained in the neglect petition. Even if there is a strong suspicion of parental substance abuse, the parent's attorney will often advise against making any admission of alcohol or drug abuse, due to a concern that this information may be used against the respondent in a proceeding to terminate parental rights. This has the effect of impeding the ability to expediently identify the underlying issues that bring these families to the attention of the court and the child welfare system. Left unidentified, these problems will most likely be unresolved, and may lead to repeat neglect, causing a profoundly negative trajectory in the developmental life of the child(ren).

Timely and coordinated prevention and treatment services will foster family stability and self-sufficiency, and promote long-term recovery. Families involved with the Family Court, child welfare and chemical dependency systems have complex needs that require a coordinated response. Children from families impacted by a substance use disorder have a higher risk for attachment disruptions, psychological trauma and medical issues such as ADD, ADHD, Fetal Alcohol Spectrum Disorder - all of which may significantly affect academic and social adjustment.

Once a local collaborative has agreed on their mutual values, goals and principles, and developed a mechanism for sharing information, they must determine if the community has the necessary resources to support the collaborative. They also should always be open to adding the necessary community-based organizations and other systems to improve the services to the families that they serve. It is within these networks that training among the systems, collaborative agreements, and the pooling of resources should take place. It is important that localities collaborate to engage every entity working with each family member, including treatment providers, law guardians, attorneys and case managers.

Practice Guidelines

New York estimates that up to 70 percent of clients/respondents within the court and chemical dependency systems are also receiving temporary assistance. This creates an opportunity to utilize the leverage that the local DSS possesses through temporary assistance to engage parents for treatment.

There are several points of intersection where families can be engaged in services. Community collaborations networks should work to develop agreements to engage clients/respondents at these points:

Referral for preventive services: When the child has not been removed and the client/respondent cooperates voluntarily with preventive services, there is an opportunity to address other issues (such as, chemical dependency, mental health, domestic violence) in a holistic way without court intervention.

Child removal or placement outside of the home: If a child has been placed outside of the care of his or her parents as a result of abuse or neglect, both the family court and the local DSS will be a part of the collaboration network.

Ongoing family reassessment, service provision, and court permanency hearings throughout the child welfare case: Parents or caretakers who are suspected but have not had substance abuse identified can be engaged through community service providers who are part of the collaboration, or by the judicial officer or attorney for parent or child.

Case closure and treatment completion: Families with chemical dependency issues should be referred for aftercare services and family support services, which allows them to be supported and re-engaged, if needed, in the event of relapse.

Localities should seek to form collaborations that include DSS, Court, chemical dependency systems, treatment providers, legal professionals, CASA and community-based providers for the purpose of engaging clients in treatment, particularly when substance abuse is suspected but not indicated in the court case. In each locality where systems are coming together to collaborate around child welfare and substance abuse issues, there should be a focused effort to identify how cases flow through each system, and where cases intersect between the systems, to identify points where the clients can be engaged and encouraged to be assessed for chemical dependency treatment, if appropriate.

Key Guiding Principles

A coordinated service plan that includes ongoing connection to community-based service providers is essential to sustainable family recovery. These connections can offer long-term support to parents and children after official system requirements end. All systems involved need to develop and implement policies that support the transition from the completion of treatment to self-sufficiency. Cross systems discharge planning should focus on the family members in recovery, family dynamics, and family values. It should help families identify and build upon their unique strengths, successfully face their challenges, and make positive choices. Discharge planning must be a joint effort with defined expectations that are made clear to parents and child(ren) by the systems involved.

Practice Guidelines

Discharge Planning begins from the moment the family enters one of the three systems and should include the following types of supports to long-term recovery:

- A plan for family reunification or child permanency with child safety a key component;
- Connection to a recovery community to provide sober supports;
- Connection to all necessary community-based services;
- Supportive and safe parenting skills training;
- Alcohol and other drugs education and prevention services for children;
- Services to promote healthy development of the family throughout the reunification process, including ongoing case management services for children;
- Linkage of child(ren) to necessary medical, mental health and social services, as well as evidence-based prevention/early intervention programs to address identifiable risk and protective factors.

Cross-systems discharge planning should begin early in the treatment/Intervention/judicial process, and be continually reviewed and updated until treatment is completed or the case is closed. It is recommended that:

- Family intervention services are considered a priority in the discharge process within the cross-systems collaboration;
- After treatment completion, the family's status is closely monitored to assure that the appropriate aftercare/recovery services needed to sustain parental recovery and child safety and well-being are provided;
- A plan to provide community-based supportive services is established that can meet the ongoing medical, mental health and social services needs of the family;
- Cross-systems training is provided to enhance the skills of the staff involved in the discharge planning process.

Special Considerations

Cross-training and collaborative network and resource development support a well-designed discharge planning process, so that continuity of care is maintained, family bonds are strengthened, and recidivism is reduced.

Background & Guiding Principles

Families affected by substance use disorders present a multitude of risk factors that need to be addressed as part of the plan for long-term recovery. Youth from families affected by substance use disorders frequently have serious emotional and behavioral problems which manifest as a range of high risk behaviors including alcohol and other drug use. In 2003-04, 1.4 million children aged 12 -17 in foster care were classified as needing drug treatment; yet 87 percent of these youngsters did not receive it (*NSDUH Report 24, 2006*).

Children of substance abusers require early and sustained interventions to avoid high lifetime rates of substance use disorders and related health problems (NSDUH Report 24, 2005). These problems must be identified before they can be addressed. The lack of understanding of the clinical effects that result from parental substance use disorders, disrupted attachments and environmental instability contributes to the failure to provide services to children.

Screening & Assessment

Children and adolescents from families affected by a substance use disorder should receive a comprehensive assessment to include;

- Physical Health
- Emotional Health
- Behavioral Health (Mental Health and Chemical Use)
- Educational

Young children should be referred to Early Intervention programs for screening assessment and treatment. Adolescents should be referred for comprehensive assessments to an appropriate professional who can make referrals for services. Pre-teens and adolescents should also be referred to evidence-based alcohol and other drugs prevention or treatment programs to help them identify, express and cope with feelings regarding parental substance use disorder and assist them in cultivating healthy relationships and life skills.

Case Management

Collaboration should include mechanisms to ensure ongoing case management for youth who have identified prevention, intervention, treatment or other service needs, to ensure referral, engagement and appropriate duration of service is achieved.

AOD Prevention & Treatment

Extensive efforts have focused on addressing parental substance use disorders within the families that we serve. However, in spite of research which clearly shows that children of parents with SUDs are at greater risk for delinquency, teen pregnancy, school drop out and violence, little has been done to address these risks until problem behaviors emerge. Efforts to decrease chemical dependency and improve outcomes for youth must focus on ensuring the integration of existing community and school-based resources, and ensuring that each child of parents with SUDs receives prevention and treatment services.

The OASAS prevention framework supports safe and healthy environments. In OASAS, prevention is seen as a proactive, research-based, data driven process utilizing proven strategies and programs to reduce or prevent alcohol and other drug abuse among individuals, families, and communities. The risk and protective focused framework is grounded in a public health approach, using evidence-based predictors of problem behaviors to achieve positive outcomes. Research has shown that if certain risk and protective factors are present, a predictable outcome will result. Understanding and identifying risk and protective factors helps providers and communities prevent problem behaviors and promote healthy development

AOD Prevention & Treatment

among children, adolescents, and young adults. This approach allows providers to select the most appropriate evidence-based programs and strategies to help their populations effectively reduce or avoid substance use and abuse, by focusing their resources on reducing those risk factors specific to their community.

Collaboration among the systems should include identification of mechanisms to ensure ongoing case management for youth who have a significant need for prevention/intervention services, to ensure continuity as well as appropriate ongoing services to address their identified risk and protective factors as well as the need for interventions, if appropriate.

Local collaborations can be strengthened by each system being clear about language and identifying which programs or services are effective to achieve which outcomes. For example, “prevention services” means something different to the chemical dependency system than “preventive services” means to the child welfare system. Yet, some practices or evidence-based programs have been identified that work in each system to achieve its outcomes.

OASAS certifies treatment programs in three levels of care: Chemical Dependency Outpatient Services, Chemical Dependency Inpatient Services, and Chemical Dependency Residential Services. In addition, OASAS is in the process of implementing Residential Rehabilitation Services for Youth (RRSY) as a foundation for our system of care for adolescents.

Within the Chemical Dependency Residential Services are Intensive Residential Services (long-term/traditional therapeutic community model) and Community Residence (halfway house model). Both of these service models have programs that allow young children to enter treatment with their parents.

In order for an individual to receive treatment services, he or she must have a DSM IV Diagnosis for Substance Use Disorder. If an individual does not meet this diagnostic criterion but has experienced problems related to the use of alcohol or other drugs, the individual or family should be referred to OASAS Prevention Services.

Additional Resources

A listing of prevention providers in each region can be found at <http://www.oasas.state.ny.us/prevention/index.cfm#>. In addition, providers and system representatives can use the following links to find women and children treatment programs and adolescent treatment programs <http://www.oasas.state.ny.us/special/index.cfm#> and other treatment programs <http://www.oasas.state.ny.us/treatment/index.cfm#> throughout New York. Assistance in finding and selecting appropriate evidence-based programs is available at OCFS’s Effective Practices website at http://www.ocfs.state.ny.us/main/sppd/eff_practices/.

Background

Nationally, parental substance abuse has been identified as an underlying factor in as high as 80 percent of child abuse/neglect cases. However, Family Court judges note that in many cases, it is not included in the allegations contained in the neglect petition. Even if there is an allegation of parental substance abuse, the parent's attorney will often advise against making any admission of alcohol or drug abuse, due to a concern that this information may be used against the respondent in a later proceeding to terminate parental rights. This has the effect of impeding the identification and treatment of the underlying issues that bring families to the attention of the court and the child welfare system. Left unidentified, these problems will most likely remain unresolved, may lead to additional acts of neglect, and may cause a profoundly negative trajectory in the developmental life of the child(ren).

Points of Intersection & Opportunities

There are several points of intersection where families can be engaged in services. Community collaborations should work to engage the client/respondents at these points:

Temporary assistance - There are estimates that up to 70 percent of clients/respondents within the court and chemical dependency systems are also receiving temporary assistance. This creates an opportunity to utilize the leverage that temporary assistance services possess to engage parents for treatment.

Child removal from the home - If it is ascertained that the client is receiving temporary assistance payments, and if a county departments of social services or NYC Human Resource Administration is part of the collaboration with agreements and processes in place, then the client can be assessed and referred to treatment, if appropriate.

Referral for preventive services - When the child has not been removed and the client/respondent is referred to preventive services, there is an opportunity to address issues such as substance use disorders, mental health, and domestic violence in a holistic way.

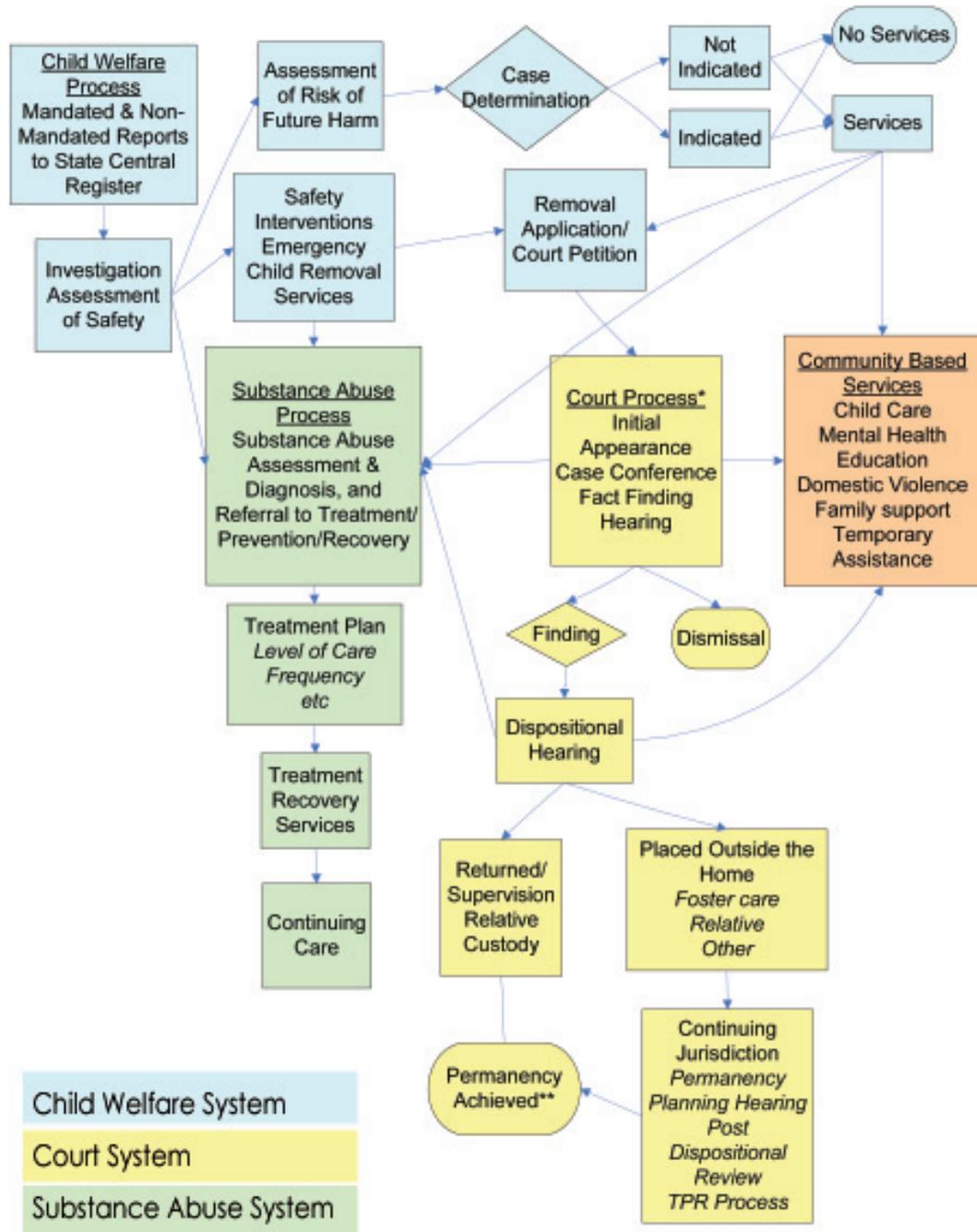
Ongoing family reassessment, service provision, and court permanency hearings throughout the child welfare case - Parents or caretakers who have not had substance use disorders identified early in the case may be referred for assessment at any time by service providers who learn new information.

Case closure and Treatment completion - Families with substance use disorders should be referred for aftercare services and family support services, which allow them to be supported and re-engaged, if needed, in the event of relapse.

Practice Guidelines

Localities should seek to form collaborations that include DSS, court, chemical dependency systems, and community-based providers for the purpose of engaging clients in treatment, particularly when substance abuse is suspected but not indicated in the court case. In each locality where systems are coming together to collaborate around child welfare and substance abuse issues, there should be a focused effort to identify how cases flow through each system, and where cases intersect among the systems, to identify points where the clients can be engaged and encouraged to be assessed for chemical dependency treatment, if appropriate.

The chart below visually represents how the three systems and other providers intersect and how referrals are made across systems. It is designed to help agencies develop a comprehensive and collaborative process that will provide the most effective services for the families we serve.



* Family Treatment Courts are being established in the Family Courts to address cases where a substance abuse disorder is a factor in a neglect proceeding. Please see the full report for additional information.

** Permanency may be achieved by: reunification, permanent custody with a relative, guardianship, adoption or another alternate permanent planned living arrangement.

APPENDICES

Appendix I

Glossary of Terms

ACS – New York City’s Administration for Children’s Services

Alcohol and drug services – includes the broad continuum of programs and strategies designed to prevent and treat substance abuse and dependence and to lessen adverse consequences associated with substance use.

AOD - Alcohol and Other Drugs.

ASFA - Adoption and Safe Families Act is federal law, enacted in 1997. ASFA made changes in a wide range of policies established under the Adoption Assistance and Child Welfare Act to improve the safety of children, to promote adoption and other permanent homes for children, and to support families, including a presumption that a child in foster care for 15 months out of the past 22 months must be safely returned home or freed for adoption by filing to terminate the parent’s rights. NYS enacted a statute implementing the federal ASFA, which was further amended in 2000. A comprehensive “permanency bill” was signed into law in NYS in 2005.

aftercare or continuing care – the immediate period after an intensive period of substance abuse treatment, designed to support an individual’s recovery through provision of formal supports such as relapse prevention services. These supports are combined with informal community-based recovery supports, such as participation in 12-Step programs, church, or other activities that support the recovery process.

assessment in child welfare – broadly refers to gathering information that affects a child’s immediate safety, potential risk of future harm, and a family’s level of functioning and well-being based on its strengths and needs. The types of assessment in child welfare are:

safety assessment – evaluates immediate threats to the life or well-being of a child.

risk assessment – evaluates potential future threats to the life or well-being of a child in the context of existing protective factors.

family assessment – evaluates how well a family is functioning in several domains that affect child and family well-being, including needs and strengths of the family.

assessment for substance use disorder – broadly refers to a comprehensive bio-psycho-social interview conducted by an OASAS-certified treatment provider, CASAC or QHP

best practice part - the courtroom practice of a family court judge or court attorney referee that implements procedures and practices toward achieving better outcomes and changing behaviors in child welfare cases; usually tied to the implementation of the NCJFCJ’s Resource Guidelines and is frequently the result of collaborative design among the key child welfare stakeholders in that jurisdiction.

CASA – Court Appointed Special Advocate

CASAC - Credentialed Alcohol and Substance Abuse Counselor

case plan – an individualized plan of action based on a comprehensive assessment, with measurable goals and outcomes developed by a family and child welfare services worker to lessen risk to children and ensure their safety, permanency, and well-being.

child abuse – to cause substantial physical injury to a child, or place the child at risk of substantial physical injury that is likely to cause death or protracted impairment of the child’s physical or emotional health.

child neglect – to cause impairment or risk of impairment to a child’s physical, mental or emotional condition by failing to provide a minimum degree of care.

Glossary of Terms

Examples of neglect are failing to meet a child’s basic needs, failing to supervise a child, inflicting harm to a child, and/or the misuse of drugs or alcohol to the extent that the person loses control of his or her actions when caring for a child.

child protective services (CPS) – the division within child welfare services that is responsible for investigating reports of child abuse and neglect and determining whether a child is in need of protection.

child welfare services (CWS) –the broad continuum of programs and strategies designed to protect children from child abuse and neglect and to strengthen families.

community-based recovery support – informal support available to an individual that helps that individual to maintain recovery from a substance use disorder. This support frequently involves participation in 12- Step programs, but may also include supportive friends, family, church, sports activities, hobbies, or other activities that reinforce the individual’s recovery, either directly or indirectly.

DSS – county department of social services

diagnosis of a substance use disorder – using criteria established by the American Psychological Association, Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV), to determine whether a person is classified as a substance user, substance abuser, or is substance dependent.

dispositional hearing – the stage of the family court process in which, after finding that a child is abused or neglected, the court determines whether the child should remain at home or be placed outside of the home, and whether to order the respondent(s) to engage in specific services under the supervision of DSS. The standard for this determination is what is in the best interest of the child.

drug testing - Tests conducted by agencies or the court to determine if there is a physical presence of alcohol or other drugs in the bloodstream.

family court - family court, present in every county in New York State, hears cases involving children and families, including adoption, child custody, visitation and support, neglect and abuse, persons in need of supervision (PINS), juvenile delinquency, family offenses (domestic violence) and paternity. The family court does not decide divorce, annulment or separation proceedings.

family treatment court - FTC is a specialized court that hears child neglect and abuse cases involving parents with substance abuse problems. The court is designed to not only break the cycle of addiction and neglect through monitored service delivery, but strives to shorten out-of-home placement through ongoing case monitoring and expedited, informed permanency planning.

fact-finding hearing – in child welfare proceedings, the trial stage at which the court determines whether allegations of child abuse or neglect are sustained by the evidence and, if so, are legally sufficient to support intervention on behalf of the child. This is followed by a dispositional hearing that defines the nature of such intervention.

model court - originally a designation that was attached to the pilot courts in New York City and Erie County through the National Council of Juvenile and Family Court Judges (NCJFCJ) Victim’s Act Model Court program. By accepting this designation, the courts agreed to implement the recommendations of the NCJFCJ’s Resource Guidelines outlining best court practice for child welfare cases and become a pilot site for other initiatives designed to achieve positive outcomes for children and families. Over time, this term has come to represent a part of court in other jurisdictions engaged in the same work and is often interchangeable with the term “best practice part” (see definition above) or “permanency part.”

network- grouping of community service providers comprised of representatives from the child welfare, court, chemical dependency, DSS, medical, mental health, domestic violence, educational/vocational and other human service systems.

Glossary of Terms

permanency goal – required for every child placed outside of his or her home in order to plan for the child’s stability, safety and well-being. A permanency goal may only be one of the following: return to parent; placement for adoption with the local DSS filing a petition for Termination of Parental Rights; legal guardianship; placement with a fit and willing relative; or placement in another planned permanent living arrangement that includes a significant connection to an adult who is willing to be a permanency resource for the child, including documentation of the compelling reason for determining that it would not be in the best interests of the child to have one of the other permanency goals.

permanency planning hearing – required by ASFA and New York State’s Permanency Law of 2005 for all children removed from their homes. The permanency hearing must be commenced initially within 8 months after a child is removed from his or her home, and subsequent permanency hearings are held every 6 months from the completion of the last permanency hearing. Every permanency hearing must be completed within 30 days of the date certain scheduled for a permanency hearing. When a child is freed for adoption, or a determination has been made that aggravated circumstances exist or that reasonable efforts are not required in a case, a permanency hearing is held within 30 days of the child being freed and completed again within 30 days.

QHP- qualified health professional as defined in statute, this refers to one of the following NYS licensed or credentialed professionals: physician, psychiatrist, psychologist, nurse, certified social worker, CASAC, nurse aid or physician assistant.

reasonable efforts – the reasonable efforts requirement of the federal law is designed so that families are provided with services to prevent child abuse and neglect and to reduce unnecessary disruption of families. Once children are placed outside the home, federal law requires reasonable efforts to be made toward a designated permanency goal. (See definition of permanency goal above.) The family court must determine whether the agency has made the required reasonable efforts. ASFA expanded reasonable efforts provisions by requiring that when a court determines that reasonable efforts to reunify are not required, a permanency planning hearing must be held within 30 days of such determination. Reasonable efforts also must be made to place the child in a timely manner in accordance with the permanency plan and to complete whatever steps are necessary to finalize the plan. Reasonable efforts have been determined to be equivalent to DSS’s diligent efforts required to prove permanent neglect.

recovery – the process by which an individual has learned to develop and maintain a lifestyle that is free from substance use, which enables individuals with substance abuse and dependency problems to return to full functioning.

relapse – to fall back into a previous problem behavior pattern; a return of a disease or illness after partial recovery from it.

removal hearing – the first court hearing in a child abuse or neglect case that occurs either immediately before or immediately after the child is removed from home on an emergency basis. It may be preceded by an ex parte order directing placement of the child, and in emergency cases may constitute the first judicial review of a child placed without prior court approval.

respondent – the person against whom a petition is filed in family court, and who responds to the petition. In a child abuse or neglect case, the respondent is a parent, guardian or person who is regularly in the home providing care for the child who causes or allows the abuse or neglect of a child. The respondent is known as the defendant in other types of courts.

screening for child abuse or neglect, or both – observations and questions leading to a determination that a child may have been the victim of abuse or neglect, or both. These observations or questions are centered on issues of physical or sexual abuse, deprivation, and neglect of child’s basic needs or well-being.

Glossary of Terms

screening for substance use disorders – a set of routinely administered observations and questions leading to a determination that a person has a potential substance use disorder. Screening is conducted by child welfare service staff as well as community-based providers, hospital staff, other health or local DSS eligibility staff, or may be a specialized service conducted by an alcohol or drug counselor.

substance use disorders – include the spectrums of substance abuse and dependence as defined by the diagnostic criteria of the American Psychological Association, Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV):

substance use – the consumption of legal or illegal, or both, psychoactive substances.

substance abuse – a pattern of substance use that results in at least one of four consequences: (1) failure to fulfill role obligations, (2) use placing one in danger (e.g., driving under the influence), (3) legal consequences, or (4) interpersonal/social problems.

substance dependence – a pattern of use resulting in at least three of seven dependence criteria as specified in the DSM-IV: (1) tolerance, (2) withdrawal, (3) unplanned use, (4) persistent desire or failure to reduce use, (5) spending a great deal of time using, (6) sacrificing activities to use, or (7) physical/psychological problems related to use.

termination of parental rights (TPR) hearing – a hearing or trial which may result in severance of all legal ties between child and parent. The burden of proof must be by clear and convincing evidence. ASFA requires that a termination of parental rights petition be filed, except in certain cases, when a child is in foster care for 15 months out of the most recent 22 months. There are several grounds for terminating parental rights. They include: 1) permanent neglect – when a parent fails to plan for the future of the child or maintain contact with the child for at least 12 consecutive months of the child’s placement or 15 out of 22 months despite the diligent efforts of DSS to assist the family; 2) abandonment – when a parent fails to have significant communication or contact with the child or agency, although able to do so, for a period of 6 months or more; 3) mental retardation or mental health – when a parent is significantly impaired and unable to safely care for a child now and in the foreseeable future due to mental retardation or mental health diagnosis; 4) severe and repeated abuse – when a parent commits one of a list of certain crimes against a child, or when a parent is found to have committed more than one act of child abuse in a five-year period. A petition seeking termination of parental rights must be based upon one of the following grounds (SSL §384-b): abandonment; permanent neglect (also FCA §614); mental illness; mental retardation; or severe or repeated abuse (also FCA §1012(j)).

treatment plan – an individualized plan of action based on a comprehensive assessment, with measurable goals and outcomes developed by a participant and substance abuse specialist to reduce or eliminate substance use and related adverse consequences.

preventive services - those supportive and rehabilitative services provided to children and families for the purpose of averting disruption of a family via placement of a child in foster care; or services enabling a child who has been placed in foster care to return to his family at an earlier time than would otherwise be possible; or reducing the likelihood that a child who has been discharged from foster care would return to such care.

Every county must have these Core Services available:

1. **Day care** - includes day care centers, family day care, group family day care, and school-age childcare activities.
2. **Homemaker Services** - includes assessing the need for, arranging for, providing and evaluating the provision of personal care, home management and incidental household tasks through the services of a trained homemaker.
3. **Parent training** - as group instruction in parent skills development and the developmental needs of the child and adolescent, for the purpose of strengthening parental functioning and parent/child relationships in order to avert a disruption in a family or help a child in foster care return home sooner than otherwise possible.
4. **Parent aide services** - are those services provided in the home and community that focus on the need of the parent for instruction and guidance and are designed to maintain and enhance parental functioning and family/parent role performance.
5. **Transportation services** - includes providing or arranging for transportation of the child and/or his family to and/or from services arranged as part of the child's service plan, except that transportation may not be provided as a preventive service for visitation of children in foster care with their parents, and may only be provided if such transportation cannot be arranged or provided by the child's family.
6. **Clinical services** - includes assessment, diagnosis, testing, psychotherapy, and specialized therapies provided by a person who has received a master's degree in social work, a licensed psychologist, a licensed psychiatrist or other recognized therapist in human services.
7. **Respite care** - and services for families in which a parent, legal guardian, caretaker or child has Acquired Immune Deficiency Syndrome (AIDS), HIV infection or HIV-related illness.
8. **Twenty-four-hour access to emergency services** - which means developing a plan for, arranging for or providing emergency services, including cash or the equivalent thereof, goods and shelter when a child is at risk of foster care and such services may prevent placement. The plan may include coordination with income maintenance staff or identification of service agencies within the social services district that provide 24-hour services such as a privately administered telephone hotline.
 - Emergency cash or goods as money or the equivalent thereof, food, clothing or other essential items that are provided to a child and his family in an emergency or acute problem situation in order to avert foster care placement.
 - Emergency shelter as providing or arranging for shelter where a child and his family who are in an emergency or acute problem situation reside in a site other than their own home in order to avert foster care placement.

Appendix II

Preventive Services

other services (Not required to be available but can be considered preventive services)

1. Housekeeper/chore services includes assessing the need for, arranging for, providing and evaluating the provision of light work or household tasks (including such activities as help in shopping, lawn care, simple household repairs and running errands), which families and individuals in their own homes are unable to perform because of illness, incapacity or absence of a caretaker relative, and which do not require the services of a trained homemaker.
2. Family planning services includes arranging for and providing social and educational services which include the distribution of printed material, group discussions and individual sessions to discuss family planning, educational and medical resources available in the community and or medical services, which include diagnosis, treatment, drugs, supplies and related counseling furnished or prescribed by or under the supervision of a physician.
3. Home management services assessing the need for, arranging for, providing and evaluating the provision of formal or informal instruction and training in management of household budgets, maintenance and care of the home, preparation of food, nutrition, consumer education, child rearing and health maintenance.
4. Day services to children include programs offering a combination of services including at least: social services, psychiatric, psychological, education and/or vocational services and health supervision, and also including, as appropriate, recreational and transportation services.
5. Housing services defined as rent subsidies, including payment of rent arrears, or any other assistance necessary to obtain adequate housing will be considered preventive services but will only be available to families of children already in foster care if such families satisfy the requirements.
6. Intensive, home-based, family preservation services are casework services and direct therapeutic services provided to families in order to reduce or avoid the need for foster care placements of children who are in imminent danger of such placements. Intensive, home-based, family preservation services may include arranging, on behalf of the families, housing assistance, child care, job training, education services, emergency cash grants and basic support needs.
7. Outreach activities are those activities designed to publicize the existence and availability of preventive services for parents, caretakers, and children who meet the criteria for the provision of preventive services and to advise such parents, caretakers and children of the availability of such services to meet their needs, alleviate the cause or condition that creates the risk of foster care placement and to assist the family to stay together.

New York Partnership for Family Recovery and Committee Members

Karen Ambrozik
NYS Drug Treatment Court

Mary Ellen Ange
NYS OCFS

Mary Aufleger
Office of Court Administration

Jennifer Baer
Monroe County Family Treatment Court

Melissa Baker
Administration for Children's Services

Linda Baldwin
Office of Court Administration

Bill Barnett
NYS OASAS

Mark Bertozzi
NYS DOH

Trista Borra
Office of Court Administration

Allison Campbell
NYS OMH

David Cardona
Albany County Family Court

Karen Carroll
Office of Court Administration

Nancy Chapman
Administration for Children's Services

Mary Collier
NYS OASAS

John Coppola
ASAP

Donna Crummell
Leake & Watts

Sky Peña Davis
Office of Court Administration

Michael A. Deas
Administration for Children's Services

Jacqueline DeCarlo
Lower Eastside Service Center

Kathleen R. DeCataldo
NYS Permanent Judicial Commission

Biana Delorenz
NYS Division of the Budget

Barbara DeMayo
NYC Family Court

Bruna DiBiasi
Office of Court Administration

Kari Earle
NCSACW

Evan Elkin
Vera Institute of Justice

Azra Farrell
Permanent Judicial Commission
On Justice for Children

Corrie Fierstein
NYS Division of the Budget

Nina Rose Fischer
North American Family Institute

Christa Foschio-Bebak
Office of Court Administration

Bill Fox
FLACRA

Allison Frantz Harte
Administration for Children's Services

Alexis Gadsden
Outreach Project

Ms. Randy Gottesma-Smolian
Network-Development

David Guyer
Oswego County Drug Treatment Courts

Brenda Harris-Collins
Queens Outreach

Paula Hennessy
NYS OCFS

Selina Higgins
Administration for Children's Services

Jim Isenberg
North American Family Institute

Frank Jordan
Office of Court Administration

Jerry Josepher
Catholic Guardian Society

Mayra Juliao-Nunez
Administration for Children's Services

Christine Kiesel
Office of Court Administration

Raymond Kimmelman
Administration for Children's Services

Honorable Judy Harris Kluger
Court Operations and Planning

Gaye LaSalle
Rockefeller College, University at Albany

Pat Lavin
NYS OASAS

Pat Lincourt
NYS OASAS

Mark Madden
NYS OTDA

Appendix III

Partnership for Family Recovery and Committee Members

Appendix III

Partnership for Family Recovery and Committee Members

Honorable Gerald E. Maney
Albany County Family Court

Cindy Heady Marsh
NYS Drug Treatment Court

Nancy Martin
Administration for Children's Services

Nancy Martinez
NYS OCFS

Robert Martinez
Administration for Children's Services

Elaine McCann
NYS Division of the Budget

Lureen McNeil
NYS OASAS

Maria Morris
NYS OASAS

Juliet Morton
Educational Alliance Pride

Shelley Murphy
NYS OCFS

Patsy Murray
NYS OCFS

Andrew Myerberg
Administration for Children's Services

Susan Ohanesian
Palladia, Inc.

Karen Orcutt
NYS Division of Budget

Emily Parise
NYC Family Treatment Court

Lawrence Pasti
NYS OCFS

Ronald Pawelczak
Monroe County Family Court

Michael Piazza
Putnam County Department of Social
Services

Susan Plaza
Odyssey House

Sheila Poole
Albany County Dept. for Children, Youth
& Families

Michelle Rafael
NYS OCFS

Pam Reger
Rockefeller College, University at Albany

Andrea Reid
Administration for Children's Services

Robert Resnick
NYS OCFS

Kelleena Richards
NYS OCFS

Sheila Roach
NYS OASAS

Elizabeth Roberts
Administration for Children's Services

Steve Rockman
Samaritan Village

Nicholas A. Roes
New Hope Manor

Julie Rosenbluth
Phoenix House

Maureen Rossi
Office of Court Administration

Cindy Roth
Office of Court Administration

Joanne Ruppel
NYS OCFS

Monette Sachs
Administration for Children's Services

Jim Scordo
CREDO

Junius Scott
Administration for Children & Families

Donald K. Smith
The Hope House

Tyler Spangenberg
CCSI

Betsy Stevens
NYS OCFS

Erica Tullberg
Administration for Children's Services

Kevin Valenchis
NYS Division of Budget

Justine Van Straaten
Center for Court Innovation

Darlene Ward
Office of Court Administration

Rue Zalia Watkins
Mental Health Association of New York

Naomi Weinstein
Phoenix House

Denise White-Smith
JBFCs-Mawthorne Cedar Knolls

Frank Woods
Office of Court Administration



**New York State
Office of Children & Family Services**

Capital View Office Park
52 Washington Street
Rensselaer, New York 12144

Visit our website at:
www.ocfs.state.ny.us

E-mail us at:
info@ocfs.state.ny.us

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childwelfare@oasas.state.ny.us



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