

THROUGH THE EYES OF THE CHILD:
CJI-AOD TOOL KIT

Catch the Vision!

**20 Recommended Practices
to Help Families in the
Child Protection Court System with Alcohol and
Other Drug Issues**

Document Guide

Executive Summary

Pages 3-5

Purpose of the Children’s Justice Initiative (CJI)
Need for Improved Practices
Purpose of the Tool Kit
Focus on Cultural Considerations
Principles in Practice
How to Use the Tool Kit

Matrix of Recommended Practices

Pages 7-14

1. [Out-stationed Specialists/Co-located Staff](#)
2. [Intensive Case Management/Service Coordinator](#)
3. [Parent Partners/Mentors/Recovery Specialists](#)
4. [Shared Family Care](#)
5. [Family Recovery Programs](#)
6. [Wellbriety \(Culture is Healing\)](#)
7. [Family Group Decision Making](#)
8. [Motivational Interviewing](#)
9. [Comprehensive Family Assessment](#)
10. [Integrated Case Plan with Extended Case Monitoring](#)
11. [Incentives and Rewards](#)
12. [Intensive Family Preservation Services](#)
13. [Family Dependency Treatment Court](#)
14. [Individualized Services for Children/Early Intervention Programs](#)
15. [Focus Groups for Fathers](#)
16. [Father Specific Case Planning and Agency Cross Training](#)
17. [Brochures for Fathers](#)
18. [Support Groups](#)
19. [Interagency Communication Protocols](#)
20. [“Father Friendly” Agency Checklist](#)

Detailed Descriptions of Practices and Resources

Pages 12-41

Appendix A: Workgroup Participants

Pages 42-46

Appendix B: Data Sources and Citations

Pages 47-53

(Note: This document will be updated periodically to incorporate new information as needed. Current version: August 2006, located on the CJI-AOD website at <http://www.mncourts.gov>)

Executive Summary

Introduction

This Tool Kit is a project of the Children’s Justice Initiative (CJI) Alcohol and Other Drug (AOD) workgroup, and has been developed with technical assistance from the National Center for Substance Abuse and Child Welfare (NCSACW).

Purpose of the Children’s Justice Initiative (CJI)

The Children’s Justice Initiative is a collaborative venture between the Minnesota Supreme Court and the Minnesota Department of Human Services (DHS), developed to work more effectively with key stakeholders in each county to improve the processing of child protection cases and the outcomes for abused and neglected children. Recognizing that alcohol and other drug problems are a significant impediment to the realization of successful outcomes for families involved in child protection cases, the CJI-AOD workgroup was formed to address these concerns.

Need for Improved Practices

Losing custody of a child due to unsafe conditions often serves to motivate parents to seek treatment for their alcohol and other drug problems. This, in turn, provides a window of opportunity for the involved systems to capitalize on this motivation to engage and retain the parent(s) in the treatment and recovery process. In most cases, this is most effectively accomplished through the use of collaborative best practices that facilitate cross-system communication and planning on behalf of the **entire** family, utilizing a strength-based, family-centered approach that uses specific strategies that have proven results in positive outcomes. From a family’s point of view, improved outcomes are important for personal growth, healthy emotional development, and positive sustained relationships. For social service systems, the improved outcomes can result in reduced future child safety concerns and treatment recidivism, as well as a reduction in broader community consequences related to capacity, resources and cost.

Purpose of Tool Kit

This summary of recommended practices and protocols in this Tool Kit is intended to assist front-line practitioners as well as the managers and supervisors who set policy in the child welfare, chemical health, and juvenile protection court systems. These best practices will help to ensure that, in a fair and timely manner, abused and neglected children involved in the child protection system have safe, stable, permanent families by improving parental and family recovery from alcohol or other drug problems.

This Tool Kit has identified 20 strategies that are expected to positively impact one or more of the following priority areas of focus in working with families:

- ◆ Engagement and Retention in Treatment and Care
- ◆ Cross-systems Communication
- ◆ Exit/Transition Strategies
- ◆ Services for Children
- ◆ Services for Fathers.

The recommendations in this Tool Kit are derived from multiple sources, including:

- ◆ A statewide best practice inquiry directed to counties and tribes
- ◆ Parent focus groups conducted throughout the state
- ◆ Subject matter experts serving on the individual CJI-AOD committees
- ◆ NCSACW database search
- ◆ Internet research on evidence-based practices.

Several themes and principles were evident in each of these sources, and are integrated into the Tool Kit, including:

- ◆ The systems working with parents and children need a vision requiring an overall approach that is collaborative, culturally competent, family-centered and strength-based.
- ◆ Parents unanimously agreed that their alcohol and/or other drug activity took over areas of reasoning when it came to caring for, and the safety of, their children. They agreed that intervention was warranted at the time of occurrence. However, it was the services and/or the way they were delivered that seemed to alienate parents from wanting, believing, and in some cases, succeeding in making improvements within limited permanency timeframes.
- ◆ Parents frequently noted that their encounters with the various social service systems discouraged them from admitting their need for recovery, or seeking the services needed for their families to become healthy.
- ◆ Many parents found themselves working through a seemingly endless, confusing and often conflicting stream of rules, requirements and paperwork.

- ◆ Parents continually questioned how a system that is designed to help families justifies separating them for the purpose of treatment and recovery.
- ◆ Fathers, in particular, expressed the need for reparation of the father-child relationship, inclusion in the intervention and recovery process, and acknowledgement from professionals that they are important in the lives of their child(ren).

Focus on Cultural Considerations

As the number of individuals seeking chemical and mental health treatment continues to increase, there has also been an increase in the populations of color and marginalized communities seeking professional help. This reflects significant changes in the ethnic diversity of the American population. These changes have increased concern about how traditional treatment systems can accommodate the needs of the general population, and also serve the needs of a growing diverse population as reported in the recent census data (U.S. Bureau of Census, 2000).

With these significant changes in population, varying approaches are needed in the treatment delivery systems to address cultural differences among consumers. Practitioners need to provide culturally competent services. This Tool Kit outlines strategies to help facilitate and develop culturally competent agencies and individual providers. Resources and information that will increase and enhance the ability to provide culturally competent services are woven throughout the strategies of this Tool Kit.

Principles in Practice

There is a need to work collaboratively across systems to achieve the goal of sustained safety and stability for children and their families through the recovery process. Strength-based practice should acknowledge deficits, but also focus on identifying family competence and strive to re-create the circumstances that allow competence to flourish. Collaboration between the various “systems” and families increases the likelihood of finding solutions. Choices made by families are more likely to be implemented than those made without collaboration and support. In large part, success is a result of respectful interactions that are derived from recognizing family competence, and their ability to make good choices and respond accordingly. Strength-based, family-centered practice as well as successful cross-system collaboration is sustained through:

- ◆ Respect
- ◆ Honesty
- ◆ Fairness and equity
- ◆ Solution-focused mutual accountability
- ◆ Clear and transparent communication
- ◆ Active mobilization of resources to remove barriers
- ◆ Celebration of successes, however small.

How to Use the Tool Kit

This Tool Kit is designed to be user-friendly in both paper and electronic formats. A summary and brief explanation of the 20 recommended practices appears in the matrix on pp. 5-11. For the paper version, the page numbers are noted where more detail can be found on a particular practice. For the electronic version, the underlined title of each practice is “hyperlinked” to the area in the document where more detailed information can be found. Simply move the cursor over the title and press the “Control” button on the keyboard while clicking on the title. To navigate from the detail back to the matrix, move the cursor over “back to matrix” in the header and click while holding down the “control” button. This allows you movement from section to section. To access a referenced Internet resource, click directly on the link provided, or cut and paste the link into the browser. Do not forget to check out the additional resources available in the Appendices.

Matrix of Recommended Practices for Priority Areas

<p style="text-align: center;">Recommended Practice</p> <p style="text-align: center;">Click on a title below for a detailed description of the recommended practice or intervention.</p>	Engagement and Retention	Cross-System Communication	Exit/Transition Strategies	Services for Children	Services for Fathers
<p><u>CULTURAL COMPETENCY INTEGRATED INTO ALL STRATEGIES</u> (pp. 15-17)</p> <p>The need for provision of culturally competent services has increased as more diverse populations enter county systems requiring help and services. This increased need also pertains to gender, age, sexual orientation, religious and spiritual orientation. In general, the focus of culturally competent services emphasizes the ethnic, racial and cultural needs of the service recipient because traditional services (chemical and mental health) historically did not address these needs. Culture is not simply determined by ethnicity and a particular set of beliefs, norms and values, but also involves the historical circumstances leading to a group’s economic, social and political status in the social structure. Culture also involves the circumstances and experiences associated with developing certain norms, beliefs and values making these factors critical to the psychological well-being of a group or its members. As people develop different responses to their life circumstances based on their culture, service providers are realizing that cultural competence is an important component in providing both ethical and effective chemical and mental health services.</p>	X	X	X	X	X

<p style="text-align: center;">Recommended Practice</p> <p style="text-align: center;">Click on a title below for a detailed description of the recommended practice or intervention.</p>	Engagement and Retention	Cross-System Communication	Exit/Transition Strategies	Services for Children	Services for Fathers
<p>1. OUT-STATIONED SPECIALISTS/CO-LOCATED STAFF (pp. 13-15) Identify child protection (CP) workers who specialize in working with cases where alcohol or other drug (AOD) addictions are present. A second option is to have all child protection workers skilled in working with families where AOD addictions are present. Specialized skill-based training should be developed to teach CP workers how to work with families dealing with AOD addictions. These workers would receive training in simultaneously addressing CP issues and AOD addiction. This strategy includes 1) staff located in schools, child welfare agencies and courts, and 2) chemical health specialists in schools.</p>	X	X		X	X
<p>2. INTENSIVE CASE MANAGEMENT/SERVICE COORDINATOR (p. 20) A service coordinator establishes linkages to medical, social, mental health and crisis services, as well as coordinates court services. The service coordinator is a liaison to resources and providers working with a family. In partnership with a parent mentor, the service coordinator organizes services and related issues regarding transportation, employment, education, housing, medical concerns and legal problems. A service coordinator and a parent mentor are assigned to each family, coordinating efforts to get parents in treatment and provide the needed linkages among providers. The case management position facilitates the often complicated and confusing court process involved with child protection, and the parent mentor can provide a friendly non-judgmental support system for the parent(s).</p>	X	X	X	X	X

<p style="text-align: center;">Recommended Practice</p> <p style="text-align: center;">Click on a title below for a detailed description of the recommended practice or intervention.</p>	Engagement and Retention	Cross-System Communication	Exit/Transition Strategies	Services for Children	Services for Fathers
<p>3. PARENT PARTNERS/MENTORS/RECOVERY SPECIALISTS (pp. 21-22) Parent partners are parents helping other parents successfully navigate the child protection system. Parent partners have previous child protection (CP) experience as consumers, are firmly established in their own recovery, and are willing to offer their experience and lessons learned to improve outcomes for other families. They provide outreach and support to parents involved with CP by offering help in understanding the process, encouraging parents to deal with their situation honestly, and facilitating parent success by building a safe, trusting relationship. They serve as guides for parents working to enter and/or maintain recovery. Parent partners help to educate the family on child welfare system concerns, documents, requirements and procedures. They also provide consultation and feedback to CP staff to improve services, develop parent-friendly materials, and share their experiences with community members and other organizations.</p> <p>Recovery specialists facilitate immediate access to services by assisting the parent/family in navigating the resources available and removing barriers related to culture, transportation, finances and treatment availability. By reducing the time it takes to access treatment, the length of time in out-of-home placement can also be reduced.</p>	X	X	X	X	X
<p>4. SHARED FAMILY CARE (p. 23) Shared family care (SFC) or whole family foster care is designed to prevent out-of-home placement. SFC allows the entire family to be placed together in a supervised setting while the parent(s) work on AOD issues, receive support in parenting, and children learn how to interact with sober and safe parent(s).</p>	X			X	X

<p style="text-align: center;">Recommended Practice</p> <p style="text-align: center;">Click on a title below for a detailed description of the recommended practice or intervention.</p>	<p style="text-align: center;">Engagement and Retention</p>	<p style="text-align: center;">Cross-System Communication</p>	<p style="text-align: center;">Exit/Transition Strategies</p>	<p style="text-align: center;">Services for Children</p>	<p style="text-align: center;">Services for Fathers</p>
<p>5. FAMILY RECOVERY PROGRAMS (pp. 23-24) Residential treatment that accommodates the entire family is recommended. Research has found that women who experience AOD treatment in a family-centered setting with their children have improved retention in treatment, psychosocial functioning, parenting attitudes and self-esteem. Family counseling, structured joint parent-child activities, therapeutic services for children, life skills training, parent training, education on child development, and parenting which is culturally appropriate are key components of this model.</p>	X		X	X	X
<p>6. WELLBRIETY (CULTURE IS HEALING) (p. 26) Wellbriety teaches that honoring culture prevents chemical dependency and other dysfunctional behaviors. Elements of sobriety, recovery and community healing, which are often treated separately, are welcomed into the great Circle of Wellbriety. Recovery, treatment, intervention and prevention are not separate and unrelated parts of healing in the Wellbriety Movement; they are doors that a person can walk through to enter their own healing process (source: www.whitebison.org)</p>	X		X		X
<p>7. FAMILY GROUP DECISION MAKING (p. 27-28) Family Group Decision Making (FGDM) gathers family members, professionals, and others closely involved in children's lives to discuss a family's strengths, concerns and resources to develop a safety plan. FGDM should include AOD professionals when the family has AOD issues.</p>	X	X	X	X	X

<p align="center">Recommended Practice</p> <p align="center">Click on a title below for a detailed description of the recommended practice or intervention.</p>	<p align="center">Engagement and Retention</p>	<p align="center">Cross-System Communication</p>	<p align="center">Exit/Transition Strategies</p>	<p align="center">Services for Children</p>	<p align="center">Services for Fathers</p>
<p>8. MOTIVATIONAL INTERVIEWING (p. 29) Motivational interviewing is a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence. Utilizing motivational interviewing develops skills and awareness to better engage parents in the treatment and recovery process. This method facilitates a client’s self motivation which leads to compliance within the child protection system.</p>	X				
<p>9. COMPREHENSIVE FAMILY ASSESSMENT (pp. 30-32) Comprehensive Family Assessment leading to an integrated case plan is a strategy designed to reduce barriers and maximize resources to effectively deliver services to children, parents, and foster parents based on identified needs.</p>	X	X	X	X	X
<p>10. INTEGRATED CASE PLAN WITH EXTENDED CASE MONITORING (pp. 33-35) Integrated case management puts clients at the center and gives them an active voice in shaping services that will support them in directing their lives, using a team approach to implement service plans. In this approach, each person is a member of the team, and there is a case manager that works with the team to develop, implement, review and evaluate an integrated service plan. Extended case monitoring means extending to parents the opportunity for continued support of the child protection and formal AOD service systems to enhance the chances of successful recovery through periodic voluntary access to systems support as the parent finds it necessary, or through “case monitoring” under Minn. Stat. § 260C.201, subd.1(e).</p>	X	X	X	X	X

<p style="text-align: center;">Recommended Practice</p> <p style="text-align: center;">Click on a title below for a detailed description of the recommended practice or intervention.</p>	Engagement and Retention	Cross-System Communication	Exit/Transition Strategies	Services for Children	Services for Fathers
<p>11. INCENTIVES AND REWARDS (p. 36) Behavioral and psychosocial techniques are important components of effective therapies. According to a new study, cocaine and methamphetamine users stayed in treatment, and off drugs longer, when they were given small rewards in exchange for compliance and sobriety.</p>	X				
<p>12. INTENSIVE FAMILY PRESERVATION SERVICES (p. 37) Intensive family preservation services are short-term, intensive, in-home crisis intervention services that teach skills and provide supports for families when children are in imminent risk of out-of-home placement.</p>			X	X	X
<p>13. FAMILY DEPENDENCY TREATMENT COURT (p. 38) A Family Dependency Treatment Court (FDTC) is a court-based collaborative program that quickly identifies and assesses parental AOD issues. The FDTC develops comprehensive multi-disciplinary case plans for families, ensures intensive case monitoring, provides for frequent reviews of orders, and closely monitors case plan compliance and progress in treatment.</p>	X	X	X	X	X
<p>14. INDIVIDUALIZED SERVICES FOR CHILDREN/EARLY INTERVENTION PROGRAMS (p. 39) All children should receive developmentally appropriate interventions to address their individual needs based on a comprehensive assessment. Services should be designed to promote resiliency in the face of the child’s vulnerability, e.g., Attention</p>	X		X	X	

<p align="center">Recommended Practice</p> <p align="center">Click on a title below for a detailed description of the recommended practice or intervention.</p>	<p align="center">Engagement and Retention</p>	<p align="center">Cross-System Communication</p>	<p align="center">Exit/Transition Strategies</p>	<p align="center">Services for Children</p>	<p align="center">Services for Fathers</p>
<p>Deficit/Hyperactivity Disorder (ADHD), and ongoing risk factors in the family, school and community. Services should include assisting the child in adapting behavior and adjustment to a new setting, i.e., helping the child move from a dysfunctional family into a more functional one.</p>					
<p>15. FOCUS GROUPS FOR FATHERS (p. 40-41) CP and AOD service providers should have a strategy to improve their service delivery to fathers. This could include convening focus groups with fathers in recovery who have experience with the child protection system to identify barriers in the system, and to elicit recommendations for constructively engaging fathers in the process.</p>	X				X
<p>16. FATHER-SPECIFIC CASE PLANNING AND AGENCY CROSS-TRAINING (pp. 42-43) Case planning should address the father’s needs in the same way that it addresses the mother’s. Cross-system training on interacting with fathers who have chemical health issues should include: father education in early childhood development; creating father friendly services; engaging and retaining fathers in services; highlighting the differences in maternal and paternal parenting styles, helping mothers and fathers to understand them, and understanding the role of mothers as gatekeepers.</p>	X	X	X		X
<p>17. BROCHURES FOR FATHERS (p. 44) A comprehensive <i>Know Your Rights and Responsibilities</i> brochure for fathers involved with families with AOD issues should be developed and widely distributed.</p>	X				X

<p style="text-align: center;">Recommended Practice</p> <p style="text-align: center;">Click on a title below for a detailed description of the recommended practice or intervention.</p>	Engagement and Retention	Cross-System Communication	Exit/Transition Strategies	Services for Children	Services for Fathers
<p>18. SUPPORT GROUPS (p. 45) An integral component of service delivery should be support groups for fathers with opportunities for child interaction.</p>	X		X		X
<p>19. INTERAGENCY COMMUNICATION PROTOCOLS (p. 46) While there are excellent reasons to guard clients’ confidentiality, there are also important reasons for sharing information among programs that are working together to serve clients. These include the need to assure a full assessment and understanding of client needs, monitoring progress on case goals among varied service providers, assuring that agencies are not working at cross purposes, such as making conflicting demands of clients or undermining each other’s efforts, and making efficient use of resources to avoid duplication of efforts.</p>		X			
<p>20. “FATHER FRIENDLY” AGENCY CHECKLIST (p. 47) Agencies and treatment providers should have checklists when working with men who have chemical health issues. Checklists can:</p> <ul style="list-style-type: none"> ◆ Help to identify a father’s legal status, and assist them with establishing paternity ◆ Provide guidelines and support for staff ◆ Help conduct a father-friendly environmental assessment. 	X			X	X

Culturally Competent Services (Overview)

Integrated into all Strategies

Culture is defined as the integrated patterns of human behavior that include thoughts, speech, actions, customs, beliefs, social norms, and material traits of a racial, religious, or social group. This is applicable to the clinical practice as well as the organizational practice of an agency. Culturally competent services may serve as a means of integrating culture with the process of healing. The culturally competent system is defined as **a set of congruent practice skills, attitudes, policies, and structures which come together in a system, agency or among professionals to work effectively in cross- cultural situations. It is simply the state of being capable of functioning in the context of cultural differences** (Cross, Bazron, Dennis, Issacs, 1989). Best practice suggests that these competencies should give an organization and/or practitioners the capabilities, knowledge, skills, and attitudes that can deter negative outcomes for children and families, ranging from barriers to access, or misdiagnosis to inappropriate or harmful treatment (Pumariega et al, 1998).

There are five points that Terry Cross has identified as components of a culturally competent system or person, including:

- ◆ Values diversity
- ◆ Has the capacity for cultural assessment
- ◆ Is conscious of the dynamics inherent when cultures interact
- ◆ Has institutionalized cultural knowledge
- ◆ Has developed adaptation to diversity.

The guidelines suggested by the Georgetown University Center for Cultural Competence are in harmony with clinical/therapeutic best practices, including paying careful attention to cultural context of the client. Service providers and others must not see cultural competency as a separate entity to be included in the service delivery system, but inclusive of the entire service system. Recovery and rehabilitation are more likely to occur where systems, providers and services have, and utilize, knowledge and skills that are culturally competent and compatible with the backgrounds of consumers from the under-served/under-represented racial/ethnic groups, their families and communities (WICHE, 1999; Guiding Principles).

Culturally Competent Services (Overview)

To create a meaningful framework for therapeutic interventions, the provider should:

- ◆ Identify historical knowledge/awareness of the identified cultural group
- ◆ Have knowledge of past and recent events that affect the culture and the individual
- ◆ Have knowledge of beliefs and customs and how they affect behaviors and choices
- ◆ Show sensitivity to issues and cultural expectations affecting the group's past and present
- ◆ Have knowledge regarding cultural variation from established norms
- ◆ Possess skill and knowledge to assess individual strengths and weaknesses from within a culturally specific perspective
- ◆ Provide technical expertise in the application/modification of standard practices to the individual within cultural parameters
- ◆ Demonstrate technical knowledge and skills in the application of strategies and techniques that are culturally specific
- ◆ Show awareness of one's own limits of cultural competence, and show willingness to refer or consult with persons who are culturally competent.

(Adapted from Saafir, R., *Cultural Competence in Therapy and Counseling*, 1993)

Additional considerations for systems of care developed by the child welfare supervisor on culture and diversity, Ohio Welfare Training Program. These can be incorporated into the framework for delivery of services with the following guidelines:

- ◆ The ability to recognize the effects of the provider's culture on values, beliefs, thoughts, actions and communication
- ◆ The ability to recognize how the provider's "cultural lens" affects world view perceptions and its impact on the interpretation of other cultures
- ◆ The ability to learn about another culture from the people who know it best, particularly the members of that cultural group, and the willingness to be open to cultural change
- ◆ An understanding that achieving cultural competence requires becoming life-long learners; one can never become complacent in fully understanding culture
- ◆ The ability to recognize how cultural differences may affect perception, communication, and the ability to interact with people whose cultural backgrounds are different

Culturally Competent Services (Overview)

- ◆ An understanding of how cultural “blindness” and bias contribute to racism, prejudice and discrimination
- ◆ The ability to transcend cultural differences to establish trusting and meaningful relationships with persons from other cultures
- ◆ The ability to integrate cultural concepts appropriately into the chemical and mental health arenas to enhance and strengthen children/families within their own cultural contexts; and to provide children/families with opportunities to develop appropriate functional life skills to help them adapt to their situations and environments.

This overview is not exhaustive of what a culturally competent service/system entails, but only serves as a guide on how to begin, develop and be able to provide culturally competent services. Each cultural group has its own set of cultural nuances that providers need to be aware of in order to be able to provide services. Research continues to provide guidance on conducting culturally specific and appropriate assessments, screenings, tests and measurements, and identifying culture bound syndromes and other strategies that will assist in providing culturally competent services to improve outcomes. [\(back to matrix\)](#)

Out-stationed Specialists/Co-located Staff

LOUISVILLE, KY. The Clark-funded Community Partnership for Protection of Children (CPPC) site, UJIMA, has an AOD case manager co-located with CPS staff. Some of the duties performed by this position are assessments, screenings, and referrals to appropriate treatment services. It may be determined through an initial screening that a client may not need services for AOD treatment, but may require other social services help. This assessment outcome is communicated to the referral sources and follow-up case management or monitoring is provided as prescribed.

If a client is referred to treatment, a treatment plan is developed to assist the client and family. The AOD case manager helps the client with issues regarding maintaining abstinence, child care, housing (transitional and permanent), transportation, employment, vocational rehabilitation, medical concerns and legal problems. The AOD case manager collaborates with other service providers in meeting client and family needs. The case manager provides advocacy for the client (e.g., attending family court sessions to facilitate reunification of parent(s) and child(ren) once the client is viewed as stable) and will report to the referring agency if the client is noncompliant with the treatment or service plan. The AOD case manager maintains involvement until the client no longer seeks services or is no longer compliant.

The AOD case manager at UJIMA participates in outreach undertakings and events within the community, such as health fairs and other types of forums. Staff is also available to consult with faith-based or other social service entities to include AOD related curriculum in their endeavors to reach others affected by AOD. Staff will also collaborate with other CPPC components such as a domestic violence prevention and community resources team to help in their efforts. The case manager provides education and consultation in the areas of AOD treatment and recovery to all UJIMA staff and community members who desire it.

The AOD case manager will also facilitate any referrals for family members to services when warranted. The staff encourages clients and family members who are affected by addiction to seek support through Alcoholics Anonymous, Narcotics Anonymous (NA), ALANON, or NARANON as recovery is an ongoing process. The staff also promotes any positive activity that supports the emotional, spiritual, physical and mental well-being of clients and family - church, exercise and education. For instance, UJIMA features an on-site program for 6-12 year-olds that helps children understand dynamics of addiction and recovery, and lets them know they are not alone. The program is called Children of Addicted Parents Program (CAPP) and runs concurrently with NA meetings at UJIMA. Contact: **Barbara Carter; Neighborhood Place UJIMA; (502) 595-5643; Keith Vandever, CADC; CPPC; Neighborhood Place UJIMA;** e-mail: kvandeve@sevencounties.org

Out-stationed Specialists/Co-located Staff (continued)

References and Other Models

CONTRA COSTA COUNTY, CALIF. Out Stationed Workers at Child Protective Services (CPS) Office

Contra Costa employs early intervention outreach specialist (EIOS) workers who are housed at each of the regional child welfare offices. The EIOS worker serves as the liaison between the Divisions of Children and Family Services and Community Substance Abuse Services and the local treatment agency network. The EIOS worker provides outreach and support services for substance-abusing parents involved with CPS. Initial contact between the EIOS worker and the client is usually made at the emergency removal hearing and sometimes at the adjudication hearing. Referrals are made through the CPS worker by faxing a copy of the court petition to the EIOS worker the day prior to the emergency removal hearing. The EIOS worker goes to court the day of the detention hearing to talk with the parents concerning the AOD treatment and legal child welfare timelines. Parents are linked directly from court to AOD treatment via the county AOD access line.

MERCED COUNTY, CALIF. Out-stationed Worker at Child Welfare Services (CWS) Office

Merced County's Department of Mental Health has out-stationed an AOD counselor/social worker at the child welfare office. The AOD counselor is available for on-site consultation and to accompany CWS workers to home visits. The AOD counselor holds a master's degree in social work that helps facilitate cross-disciplinary communication. On specific cases that may be AOD involved, the CWS staff invites the AOD counselor. The AOD counselor is prepared to conduct immediate screening and assessments of child welfare clients. The AOD counselor is also part of the Methamphetamine Lab Response Team, which goes out to homes suspected of producing methamphetamine. Having the AOD counselor on the response team means s/he is involved from the beginning of the case and throughout the court proceedings.

Child Welfare Worker Assigned to Residential Treatment Centers

Another model involves the county assigning one child welfare worker to all the parents having child welfare cases and receiving treatment in a particular residential treatment site. The CWS worker can work more closely with the AOD treatment staff on joint treatment plans with the CWS-AOD involved families.

http://www.ncsacw.samhsa.gov/files/Virginia_Compndium.pdf

<http://cffutures.org/OntarioCD/SUMMARY%20OF%20COUNTY%20PROJECTS.htm>

[\(back to matrix\)](#)

Intensive Case Management/Service Coordinator

Models and Other Considerations

Intensive Case Management

With the effort to collaborate and blend service delivery to families, case management becomes more than just seeing that the case plan gets written and implemented. Case management done in a collaborative and intensive manner greatly improves success in treatment and post-treatment maintenance (McLellan, 1999; Greenfield, 1997). With intensive case management, individuals and families receive more, and a wider variety of, services while in treatment than do clients without intensive case management; this can result in improved outcomes. Use of AOD can be reduced significantly. Clients are more likely to show improvement in employment, family relationships, emotional and health functioning, as well as legal status. A new title for case management might be “service coordination.” This title more accurately reflects the roles and responsibilities of someone in this relationship with a family. Helping providers to coordinate services that are complementary and appropriate is a difficult task. It takes someone who can help bridge the differences among the various systems, and phase the services so that they are not all being delivered at the same time.

Service Coordinator

The service coordinator position requires extensive training and cross training. They can be child protection workers that are cross trained in AOD or AOD professionals cross trained in child protection issues. Rule 25 training is also helpful for the service coordinator. Thorough and current knowledge of county and regional resources is necessary. Specific software can be used to access appropriate resources, and to facilitate communication among all providers. Interns from college and university programs can be used as assistants for service coordinators. Smaller counties with fewer resources and training opportunities can organize together to meet individual county needs and responsibilities. The court’s support of this effort is critical; the service coordinators and parent mentors should be seen as authoritative members of the team working with the families. Cultural competency needs to be an integral part of training for the service coordinator. Whenever possible, the service coordinator should be considered for gender and similar cultural experiences.

Grants through federal and state agencies, as well as private foundations, could be used for program training, pilots, delivery systems, and evaluation (i.e., Robert Wood Johnson, SAMSHA, Department of Corrections, Department of Health, Center for Substance Abuse Treatment). University programs could be involved for ongoing gathering and analysis of data. There are also grant opportunities available to create software to coordinate service linkages.

[\(back to matrix\)](#)

Parent Partners/Recovery Mentors/Recovery Specialists

Models

Sacramento STARS (Specialized Treatment and Recovery Services) Program

The STARS workers maintain a supportive and monitoring relationship with the client, having a special emphasis upon engagement and retention in treatment, and providing a liaison function among the court, CPS, and AOD treatment. The court and CPS workers are provided reports concerning the client's treatment progress and drug test results, and the judge imposes rewards and progressive sanctions in response to the client's progress. More intensive court monitoring is offered to clients who have difficulty complying with requisite court orders. The full continuum of community-based AOD treatments are utilized within this program, with assessment and treatment matching standards aligned with the California Alcohol and Drug Services Division's existing system of care.

The Illinois Alcohol and Other Drug Abuse (AODA) Demonstration

In AODA, parents in substance-affected families receive recovery coach services in addition to traditional child welfare and AOD treatment services. The recovery coach liaison is stationed in juvenile court to facilitate and expedite an initial engagement session immediately following the AODA assessment. Recovery coaches will often transport parents to the initial intake appointment to ensure attendance and treatment accessibility. Recovery coaches maintain regular contact with the AODA treatment agency and child welfare worker by arranging interagency staffing, attending administrative case reviews, and being available for court appearances. Recovery coaches ensure that a comprehensive range of assessments, in addition to the AODA assessment, are completed. Recovery coaches assist parents in obtaining entitlement or other program resources for which the family is eligible, and in meeting responsibilities and mandates associated with the benefits. The parent and the recovery coach mutually develop a plan to prioritize issues identified in the clinical assessment, benefit determination, and other assessments. Recovery coaches make home visits and visits to AODA treatment agencies. They are assigned to a parent, throughout and beyond the treatment process, to ensure that parents are actively engaged in aftercare and recovery support activities. Recovery coaches have access to random urine toxicology testing to monitor a parent's compliance with program requirements. In addition to monthly progress reports, recovery coaches prepare a Permanency Assessment and Recommendation Report for the caseworker. This report assesses the parent's progress in treatment and recovery. It also provides a recommendation regarding the safety of the child, should custody be returned to the parent.

Collaboration with other providers, particularly between the treatment center's plan and the case worker's plan should occur as outlined in Michigan's protocol: http://www.ncsacw.samhsa.gov/files/Michigan_Protocol.pdf

Parent Partners/Recovery Mentors/Recovery Specialists (continued)

Model and Other Considerations

Parent Partners

Involving parent partners in the CPS system can result in improvements in materials, environment, policies and procedures to enhance engagement of parents. Parent partners can also increase understanding and provide a genuine offer of support and services to the parent. Cross system collaboration must include each system embracing the value of parent involvement, and treating parent partners as equals. A clear communication protocol with the assigned parent partner is critical to a smooth progression in implementation of the program and for ongoing sustainability. The parent partner acts as a coach on how the bureaucracy works and on data privacy law/policy/procedures. The parent partner helps to address concerns, and provides general support for questions and challenges the parent may have. Parent partners who are from similar racial/ethnic backgrounds as the parent client can improve engagement, understanding, and reduce the adversarial experience for parents. Parent partners can also help ensure that professionals work to develop client-centered relationships and provide culturally competent services. A parent partner model should:

- ◆ Allow the mentor to be available, not only while in the child protection system, but also as a resource to assist in transition outside the system.
- ◆ Require the mentor to be in recovery for at least two years. It is not essential that they have direct experience with the child protection system – but it is preferred.

Recommended Resources Required for Implementation:

- ◆ Brochure or fact sheet for parents explaining the parent partner model and giving hotline information, if a hotline exists
- ◆ Personal case vignettes from parent partners about their own CPS/recovery experience
- ◆ Parent hotline: A hotline for parents that provides a resource to connect with a parent partner
- ◆ Development of a selection process, including:
 - ◆ Position description
 - ◆ Application and hiring process for paid parent partners
 - ◆ Volunteer agreement for non-paid parent partners
 - ◆ Parent partner release forms for Bureau of Criminal Apprehension criminal history and child abuse/neglect records
 - ◆ Letters of reference
- ◆ Parent Partner Confidentiality Agreement
- ◆ Communication protocol
- ◆ Identified CPS staff liaison.

Parent Partners/Recovery Mentors /Recovery Specialists should all have a chemical health assessor available at the time of Emergency Protective Care hearing to make the referral for the partner/mentor/specialist that will assist the parent.

[\(back to matrix\)](#)

Shared Family Care

Models, Resources, and Other Considerations

In Shared Family Care (SFC), the entire family is temporarily placed in the home of a host family. The host family is trained to mentor and support the parents as they develop skills and supports necessary to care for their children and move toward independent living. SFC can be used for prevention - making it unnecessary to separate parents from their children; for reunification - providing a safe environment in which to reunite a family that has been separated; or to help parents make the decision to relinquish their parental rights. Several Shared Family Care programs exist in the United States:

http://aia.berkeley.edu/information_resources/shared_family_care.html

http://www.childrensrights.org/Policy/policy_resources_EX_fostercare_annualreport.htm

Resources for Counties:

- ◆ *Shared Family Care Handbook* (Family Partnership, n.d.) – describes how to set up a SFC program, lists mentor qualifications, matching process, etc. There are also forms that can be utilized.
- ◆ East Metro Women’s Center - a supportive housing program for homeless and low income families in Ramsey and Washington Counties at <http://www.emwc.org>
- ◆ Growing Home, St. Paul, Minn., previously operated a Shared Family Care for adults, but has been reorganized to serve adolescents only at http://www.growinghome.org/fs_about.html
- ◆ Incarnation House, Minneapolis, Minn., a transitional housing program that serves mothers with chemical abuse issues and their children at <http://www.waysidehouse.org>
- ◆ Jackson Street Village, St. Paul, Minn., a “health house” that provides supportive housing services to families experiencing chemical issues and homelessness at http://www.cermakrhoades.com/jackson_street_village.html
- ◆ Perspectives Family Center, St. Louis Park, Minn., provides supportive and transitional housing for parents who are homeless and have a diagnosable disability at <http://www.perspectives-family.org>
- ◆ *Assessing Shared Family Care Programs and Their Effectiveness*; Minnesota DHS report
- ◆ Jean Storlie, (651) 261-2179, e-mail: jmstorl@co.chisago.mn.us; Karlene Smith, (651) 213-0378, e-mail: kksmith@co.chisago.mn.us.

It is important to explore potential kinship SFC placements prior to non-relative placements. Foster families interested in taking in an entire family need to be identified, screened, licensed and trained on how to be a positive mentor for the parent(s). Families must be offered a culturally sensitive environment. SFC may be more cost-effective than placing children in foster care while the parent is receiving treatment. Funding could be accessed through Rule 25, by identifying SFC in the treatment plan (McBride, J., 2005).

[\(back to matrix\)](#)

Family Recovery Programs

Model and References

The Children's Defense Fund publication, *Healing the Whole Family: A Look at Family Care Programs*, reports on innovative residential programs for families struggling with AOD, domestic violence, homelessness and teen parenting. The report features 50 family care programs around the country that offer families supervised living arrangements and intensive services to support the parent(s), the child(ren), and the family unit in order to promote child safety and family stability. The elements consistently identified included:

- ◆ Comprehensive services that address the complex needs of parent(s), child(ren), and the family unit
- ◆ Longer treatment timelines and aftercare that allow genuine healing to take place as families uncover and address problems for the first time; practice new behaviors in a supportive setting; and ease back into the community
- ◆ Priority attention to children's safety
- ◆ An accepting, yet demanding treatment environment characterized by clear expectations and standards, as well as an understanding that relapses and setbacks are part of recovery
- ◆ Committed, skilled, and flexible staff who are able to address diverse and emerging needs
- ◆ Active peer support among residents while in the program, and as they transition back into the community.

To access report: http://www.childrendefense.org/childwelfare/abuse/healing_whole_family.aspx

With the enactment of Rule 31 in January 2005, treatment facilities are no longer confined to providing a particular level of care to their clients. The revised Rule gives providers more flexibility to address an individual's needs by considering housing and treatment as separate issues. For example, a client who does not need intensive treatment services, and is appropriate for outpatient treatment, may not necessarily have a safe place to live. Conversely, a person who needs to develop skills in independent living and community re-integration may have a safe place to live (DHS: Chemical Dependency Treatment – Rule 31). There were additional requirements added to the Rule for those facilities interested in serving both clients and their children: <http://www.revisor.leg.state.mn.us/arule/9530/6490.html>

Funding:

- ◆ Consolidated Chemical Dependency Treatment funds (CCDTF) - state administered funding consisting of federal, state, county and private funds
- ◆ County funds
- ◆ Private foundations
- ◆ Federal grants (see: <http://www.samhsa.gov/Grants/2006/ataglance.aspx>)
- ◆ Resource lists should be created for counties so they know who to contact at the state with questions about licensing, funding or implementing new services, as well as funding sources (public and private) that have supported family-focused residential treatment facilities.

Family Recovery Programs

Special Considerations

Other Resources:

- ◆ Lighthouse of the Sierra, Reno, Nev., (lead agency: STEP 2, Inc., Diaz Dixon, CEO, (775) 787-9411)
- ◆ Strengthening Families program, Creating Lasting Family Connections program, Focus on Families program.

Other Considerations:

- ◆ Training needs to be provided on the different models that have been used, funding sources and requirements for licensure under Rule 31; models currently in Minnesota include Journey Home and Wayside (Incarnation House)
- ◆ All professionals will need training on treatment modality once a treatment program is established.
- ◆ A multidisciplinary team of professionals is needed – chemical dependency counselors, case managers, medical staff, psychiatrists, therapists, child care workers, etc.
- ◆ Family is defined as the identified child(ren), siblings, and their caregivers in a CHIPS petition.
- ◆ “Four Clocks” coordination within CHIPS:
 - ◆ Family service plan (assessment)
 - ◆ Permanency hearing timeline
 - ◆ Treatment timeline
 - ◆ MFIP
- ◆ Match services to parents’ risk of chronic maltreatment and AOD
- ◆ Coordination of services and case planning is important to prevent duplication, not overwhelming families so they cannot be successful.

It is important to ensure that the family recovery program has culturally relevant programming and a diverse cross-disciplinary team. The facility itself should be welcoming, and open to accommodating different cultural needs. Program staff need to be culturally sensitive and respectful of the families in their care. [\(back to matrix\)](#)

Wellbriety (Culture is Healing)

<p>Model and References</p>	<p>White Bison, Inc. is an American Indian owned non-profit corporation founded by Don Coyhis in 1989. Its vision is to bring 100 American Indian communities to Wellbriety by the year 2010. White Bison provides programs and educational resources for native people. The Wellbriety movement's focus is not only to bring about sobriety, but also Wellbriety among native American people throughout the United States. It encourages people to recover their ancient traditions, teachings and ceremonies. Wellbriety means a balanced lifestyle emotionally, physically, mentally and spiritually.</p> <p>The Wellbriety movement includes a special emphasis on youth, as they are tomorrow's leaders. The Daughters of Tradition, Sons of Tradition, and the Youth Wellbriety Movement are prevention programs that provide native American youth with training and development. They also focus on healthy lifestyles and values, healthy relationships, and an appreciation for traditions and spirituality. Additional resources may be found at the White Bison Web site: http://www.whitebison.org Phone, (719) 548-1000, e-mail: info@whitebison.org.</p>
<p>Special Considerations</p>	<p>Recommended Resources Required for Implementation:</p> <ul style="list-style-type: none"> ◆ Medicine Wheel and 12 Steps training ◆ Firestarter training ◆ Daughters of Tradition training I and II ◆ Sons of Traditions training ◆ Adult Children of Alcoholics training ◆ Family Series: Families of Alcoholics training. <p style="text-align: right;">(back to matrix)</p>

Family Group Decision Making

Model, Other Considerations, and References

Through Family Group Decision Making (FGDM), also known as family group conferencing, family members are invited by professionals to participate in a meeting and planning process that identifies and focuses on the family's strengths as a way to resolve concerns about the child's safety. When AOD issues have been identified as a concern regarding the child's safety, an AOD professional is an integral part of the FGDM process. Based on the family's strengths and child's needs, the FGDM process is used to create plans to ensure the child's safety, and to strengthen and preserve the family. Since families are most knowledgeable about themselves and their children, the family itself is able to develop a plan that works best for them. FGDM reduces blame, improves relations, and creates a stronger coordination of resources and supports for the parents and children. It empowers families to make decisions about their future, and encourages parents to take responsibility for their past and future actions, taking ownership of the plans that were developed. This model affirms cultural diversity and uses ethnographic interviewing techniques which support the premise that the family is the expert on themselves; it is assumed that they are the most knowledgeable about what will work for them; and they have strengths/protective capacities that can be built upon.

The needs of the younger children need to be specifically expressed by someone on their behalf at the meeting since they are too young to participate or have a voice. Involvement of assessors and/or treatment providers will require specific data practice protocols. (The above considerations are addressed in *Navigating the Pathways: Lessons and Promising Practice in Linking Alcohol and Drug Services with Child Welfare*; USDHHS; SAMSA and CSAT, pp. 25-26). FGDM is currently funded in Minnesota through Title IV-B, subpart 2, of the Social Security Act.

Resources:

National Center on Family Group Decision Making: <http://www.americanhumane.org>

Resource Center for Family-focused Practice (UC Davis)

<http://humanservices.ucdavis.edu/resource/familygroup/index.asp>

Family Group Decision Making project: <http://social.chass.ncsu.edu/jpennell/fgdm/>

Family Group Decision Making

Two training formats on FGDM are available through the Minnesota Child Welfare Training System: a one-day orientation training and a five-day facilitator training. The one-day orientation provides participants information on the model, including the purposes, benefits and protocol variations. FGDM can be used either for placement resources and permanency planning, or for safety planning while preserving the child in the parents' care. Core values of this model should include:

- ◆ All families have strengths
- ◆ Families are experts on themselves
- ◆ Families deserve to be treated with dignity and respect
- ◆ Families can make well-informed decisions about keeping their children safe when supported.

Serious consideration of the use of FGDM should be given through assignment of an implementation team whose task is to develop a rollout plan. A plan should include:

- ◆ Staff resources
- ◆ Timeframes
- ◆ Primary decision points
- ◆ Meeting number projections
- ◆ Placement-related data with related AOD concerns
- ◆ Stakeholder and community providers' engagement and preparation
- ◆ Logistics for meeting events
- ◆ Documentation needs
- ◆ Data and outcome measures
- ◆ Written policy/protocols.

A representative from the AOD treatment provider community should be a team member at the planning stage, as well as developing a practice model with them as a member of the family team meeting process.

[\(back to matrix\)](#)

Motivational Interviewing

Considerations and References	<p>The Motivational Interviewing (MI) Web site, www.motivationalinterview.org, is a vast repository of MI information, including background information, applications to special populations such as criminal justice clients and medical patients, and the practice of MI in groups. The resource library includes bibliographies, articles and abstracts, treatment manuals, calendar of training events, and a directory of MI trainers.</p>
	<p>Motivational Interviewing techniques are important to learn and use within the basic knowledge set of Stages of Change related to addiction and recovery. Applying the principles of motivational interviewing provides new meaning to the interviewee's experience.</p>
	<p>Conduct cross-system training using the method of motivational interviewing to develop skills and awareness to better engage parents in the treatment and recovery process. (Reference: Hazelden video – The Clinical Innovators series, Carlo DiClemente on Stages of Change and Addiction).</p> <p>This training can be requested as a specialized curriculum offered through the Minnesota Child Welfare Training System for all county/tribal child protection social workers. Community and/or system stakeholders can attend by being placed on a waiting list and paying a \$50.00 fee. This interviewing method utilizes a strength-based approach that establishes the interviewer in a learning role, and the client/parent as the teacher/expert on themselves. This allows for cultural awareness and needs of the client to be articulated during the intervention.</p> <p style="text-align: right;">(back to matrix)</p>

Comprehensive Family Assessment

Recommended Resources

- ◆ Family Centered Assessment Guidebook: *The Art of Assessment*.
- ◆ Abbreviated version of the Family Centered Assessment Guidebook used by Ramsey County.
- ◆ Ramsey County case plan examples using the full and/or abbreviated version of the Family Centered Assessment Guidebook: *The Art of Assessment*.
- ◆ Seven Day Placement meeting format.
- ◆ Plan-Do-Study-Act (PDSA) worksheet.
- ◆ Child Assessment of Needs and Strengths.
- ◆ Structured Decision Making Child Well-being Tool.
- ◆ C.A.G.E. w/adaptations/other AOD screening tools.
- ◆ Structured Decision Making Family Assessment of Needs and Strengths.
- ◆ Adult-Adolescent Parenting Inventory tool (AAPI-2).
- ◆ Specialized foster home education and training for foster parents.
- ◆ Public health nurse visiting programs.
- ◆ *Improving Coordination between Child Welfare and Chemical Health Services*, a summary of preliminary findings, Full Circle Community Institute, August 2000. Contains screening/assessment tools.
- ◆ Workshop handout, *A Case of Collaboration Across Systems: The Single Coordinated Care Plan*, Francine Feinberg, Psy.D., and Patricia Aniakudo, M.S. Prepared by The Management Group, Inc., (TMG).

Most of the resources listed are free. (Ann Miller, Ramsey County Child Protection, (651) 266-3801, fax (651) 266-3709, email: ann.m.miller@co.ramsey.mn.us).

Comprehensive Family Assessment

Model	<p>A meeting very early in the child's placement takes place to develop a concrete plan for necessary assessments and services. The meeting should include a child protection worker, guardian ad litem, chemical health provider, county attorney, public defender, other professionals, and parent mentors or partners to assist in immediate family engagement and case planning. A meeting is recommended as soon as possible, with most models aiming to have the meeting within five to seven days.</p> <p>For the child(ren), the following areas need to be assessed:</p> <ul style="list-style-type: none">◆ Developmental◆ Environment◆ Protective/resiliency factors◆ Strengths◆ Risks◆ Impact of AOD◆ History of involvement with social services and juvenile justice systems◆ Abuse and neglect◆ Mental health◆ Physical health◆ School◆ Relationships (family, peers, others). <p>For the parent(s), the following areas need to be assessed:</p> <ul style="list-style-type: none">◆ Drug and alcohol abuse◆ Parenting skills◆ Mental health◆ Physical health. <p>For the foster parents/extended family, the following areas need to be assessed:</p> <ul style="list-style-type: none">◆ Attitude toward birth parent(s)◆ Caregiving, especially for special needs children in the context of their culture◆ Perceptions/expectations of child(ren)◆ Receptivity to services◆ Family supports. <p>The case manager coordinates the assessment process. It is recommended that a psychiatrist or other mental health professional that specializes in AOD treatment be consulted as needed. Letters of agreement should be developed to expedite the sharing of data on child(ren) or families. The case manager should work toward obtaining informed consent from the family to facilitate</p>
--------------	---

Comprehensive Family Assessment

Other Considerations

sharing of data. This information will better engage families; provide supervisors a way to measure where frontline worker's abilities lie; encourage collaboration with other professionals; and best provide the courts with assessments and reports needed to make decisions and preside over a child/family's safety, permanency and well-being. The DVD and *Facilitator's Guide to Achieving Permanency* are helpful tools in explaining to families, child protection workers, chemical health professionals, and the court system what happens when a family with chemical health issues is in the system.

Counties and tribes could try any of the protocols and practices in an incremental format such as Plan-Do-Study-Act (PDSA) worksheet model, copyright 2004, Institute for Healthcare Improvement, Boston, Mass. PDSA is a tool for documenting a test of change. Ongoing Comprehensive Family Centered Assessment Model is recommended as a practice to best exhibit respect, fairness/equity, mutual accountability, and a strength-based focus for every family. The tools recommended will assist in movement toward cultural competence. National Indian Child Welfare Association (www.nicwa.org) offers numerous resources, including a flowchart walking a parent or family member through a general child welfare case with court involvement. The Annie Casey Foundation has embarked on an Ending Racial Disparities Initiative with Ramsey County as a prototype site based on the county's Anti-Racism Initiative. For more information contact Ramsey County Children and Family Services Director Susan Ault, (651) 266-3882, or: susan.ault@co.ramsey.mn.us.

[\(back to matrix\)](#)

Integrated Case Plan with Extended Case Monitoring

Recommended Resources

The British Columbia Ministry for Children and Families (MCF) was created in 1996 to address the need for a coordinated approach to the wide range of service needs of children, youth, families and adults. This organization brought together professionals, programs and services from five ministries to streamline services to clients within the context of their communities through a regional delivery system. With the formation of the ministry, the provincial government sought to shape the way services were delivered so they were not aligned with professional disciplines or programs, but rather client-centered and integrated to meet the holistic needs of clients. Parents, children, and communities told the government that they wanted greater opportunities to be heard, greater involvement in decision-making, and to have more flexibility in creating solutions to address their issues. It is expected that an inclusive, coordinated approach will result in positive outcomes for children, families and other adults. Integrated case management (ICM) is one practice that the ministry is implementing to promote integration of services that focus on children, recognizes diversity, and maximizes participation of clients.

Integrated case management is used when:

child(ren), family or other adults have complex and often longer-term needs that would require a formal and structured approach among service providers. This necessitates joint decision-making, development, implementation, and monitoring of a single service plan, and clarification of their multiple roles and responsibilities. Each member of the integrated case management team must be clear about their role in the plan (MCF, 1998).

The following resources are available for development of the implementation plan, and overall implementation of ICM:

http://www.mcf.gov.bc.ca/icm/users_guide_1.htm

[http://www.mcf.gov.bc.ca/icm/icm_user_guide/Appendix D.pdf](http://www.mcf.gov.bc.ca/icm/icm_user_guide/Appendix_D.pdf)

http://www.mcf.gov.bc.ca/icm/icm_pamphlet.htm

http://www.mcf.gov.bc.ca/icm/pdfs/ICM_report.pdf

Integrated Case Plan with Extended Case Monitoring

Model

When multiple service providers are involved with the same client and the needs are complex and potentially long-term, the providers, along with the client, should form a team, identify an integrated case manager, and develop a single integrated service plan. Launching the process of integrated case management may occur in a face-to-face meeting or, if this is not possible, by telephone. In deciding whether face-to-face meetings are essential, service providers need to consider the client's vulnerability, and the risk factors in their environment. The more difficult, complex and potentially longstanding the circumstances, the more important it is that services are planned in a face-to-face process. It is important that the integrated case management team include representation from the client's cultural community, and that services are planned and delivered by team members that are culturally competent.

It is important that the service plan incorporate any individual case planning that has already happened between the client and service providers. In the simplest case, team members will already have worked with clients to develop outcomes and services. The integrated case management activities will simply ensure that all members are aware of each other's planning, and provide opportunities to improve the coordination of services. Service plans will be most effective if they are developed following the principles of integrated case management. Outcomes and associated activities must be: concrete and observable; clearly related to the strengths and concerns already identified; and focused on the best interests of the client.

Transition planning and extended case monitoring are key components of integrated case planning designed to prevent relapse and anchor the family in success. Transitions occur when:

- ◆ Parents leave treatment
- ◆ Service providers or social workers change
- ◆ Children are returned home
- ◆ Aftercare ends
- ◆ Court jurisdictions are dismissed.

A review of all paperwork and forms is needed so that information can be written in understandable language. A transition plan for the family should be developed that includes a relapse plan, identifiable triggers, and county resources available to prevent relapses. All systems should be educated on relapse and prevention strategies. Components of the transition plan should include education for parents/families on how to access resources without assistance; and for transitions early in the case, a parent handbook that includes a calendar, case plan printed out with dates highlighted for hearings and appointments, and a list of priorities and due dates for all case plans.

Integrated Case Plan with Extended Case Monitoring

Research indicates that aftercare is important. The effects of intervention, in some cases, diminish about four months following intervention. Continuing care and aftercare services (including regular support meetings and alumni contact) should be established prior to case closure. The door should be left open for families to call if they need help following discharge for up to one year following intervention. Many families will require no assistance, while others may just need reassurance. However, if a serious problem with the family is identified and addressed through extended case monitoring, the small amount of funding for aftercare is easily justified and averts more costly and less desirable alternatives.

The integrated case management team should include representation from the client's cultural community (unless this is contrary to that person's wishes), and services planned and delivered by team members should be culturally responsive. Continuing care and aftercare services (including regular support meetings and alumni contact) should be established prior to case closure. Monitoring via monthly telephone contact should be provided for at least one year after discharge to strengthen and reinforce successful relapse prevention strategies and solidify progress in recovery.

If a serious problem with a family is identified and addressed through this "open door," the small amount of funding for continued access to aftercare or other systems for continued support averts more costly and less desirable alternatives. Counties can decide what the "open door" looks like. It might be giving parents formerly involved with child protection for AOD issues access to community-based services on a priority basis; periodic telephone calls at the parents' initiation to supportive persons in the system; it might be periodic telephone check-ins for up to one year to support continued recovery; or it might be "case monitoring" for a time period specified by the court under *Minn. Stat. § 260C.201 subd. 1 (e)*.

[\(back to matrix\)](#)

Incentives and Rewards

Special Considerations

The emphasis on incentives for parents involved with the justice system may be new to many communities. Local officials need to be educated in their use. The key is using sanctions and incentives to promote positive behavioral change (rather than to simply use sanctions as punishment). It is also important to use treatment as a resource, not as a punishment, so that a determination to increase treatment contacts, for example, is based on a determination that this increase is necessary to better serve the participant's needs, rather than to punish the client for past behavior.

Most drug court professionals agree that the hallmarks of any sanctioning and motivational scheme are consistency, predictability and immediacy. When developing incentives, it is important for communities to ask what competencies are being built by parents' response to involvement in the child welfare/court system. Positive rewards and incentives for compliance with program conditions are considered as important as sanctions for noncompliance. Examples of positive incentives that family treatment drug courts frequently use to recognize participant progress are (1) promotion to a subsequent program phase, (2) award of a gift voucher or a ticket to a local sports or other event contributed by local merchants, and/or (3) presentation of a certificate or other token acknowledging the participant's accomplishments. The praise of the judge is of immeasurable motivational value.

The positive incentives that appear most highly valued by both juvenile and adult drug court participants are a judge's handshake and words of encouragement, and the accolades of other drug court participants. Specially designed contracts between the drug court and the participant provide both positive and negative reinforcement, and help to develop the participant's sense of accountability. Some programs require participants to keep a daily journal or maintain a "thinking log." One judge has a drug court library from which all participants must read, and has designated a portion of the courtroom wall for the display of artwork produced by participants.

Recommended Resources Required for Implementation:

- ◆ Certificates
- ◆ Celebrations at reunification
- ◆ Client-centered acknowledgments.

Be sure to meet families where they are. Have reunification hearings be successful by making sure parents and children have the proper resources. Parents do not always realize that they are getting the child(ren) that day. Make sure that they are properly prepared. Ensure effective communication between the court, attorneys, and county workers so that parents are prepared at reunification hearings.

[\(back to matrix\)](#)

Intensive Family Preservation Services

Model and Other Considerations

Intensive Family Preservation Services (IFPS) protocol can be found at: <http://www.nfnp.org/preservation/protocol.php>

Some of the types of services offered with IFPS include:

- ◆ Parent training
- ◆ Family communication building
- ◆ Behavior management
- ◆ Marital counseling
- ◆ Life skills training
- ◆ Self-management of moods/behavior
- ◆ School interventions
- ◆ Safety planning
- ◆ Relapse prevention
- ◆ Concrete advocacy services
- ◆ Referral to ongoing services.

The IFPS worker and the family engage in an ongoing collaborative process of assessing family strengths, values and problems. Specific goals are developed as a result of this process. The IFPS worker is skilled in a wide variety of interventions, and provides families with information and skills so they can learn to more effectively manage their lives. Because of the short, intensive nature of IFPS services, the worker prepares clients from the first meeting for termination of services, and later addresses the attainment of goals, maintenance of progress after termination, and ongoing service needs.

Recommended Resources Required for Implementation:

- ◆ Video – “Pathways to Permanence: Introduction to Mediation, Family Group Conferencing, and Concurrent Permanency Planning,” produced by the Dave Thomas Foundation
- ◆ National Drug Court Institute “Drug Court Practitioner Fact Sheet,” May 1999
- ◆ Monograph: *Family Dependency Treatment Courts: Addressing Child Abuse and Neglect Cases Using the Drug Court Model*. December 2004.

[\(back to matrix\)](#)

Family Dependency Treatment Court

Model and Resources

There is a growing number of Family Dependency Treatment Courts (FDTC) nationwide. A child protection case comes to the juvenile court's attention because of a petition involving child abuse or neglect. In some jurisdictions, FDTC is used. The first and foremost consideration in a FDTC is the best interests of the child(ren). The following questions must be asked:

- ◆ Is the parent with AOD problems able to provide a safe and stable placement for child(ren)?
- ◆ Is the parent with AOD problems able to meet the timelines of the Adoption and Safe Families Act (permanency hearing within 12 months)?
- ◆ How long can child(ren) be expected to wait when parents are making some progress?
- ◆ How long is too long when considering children's developmental needs?

In assessing recovery of the parents and possible return of the child(ren), additional issues that must be addressed include:

- ◆ Parenting skills
- ◆ Vocational training and employment
- ◆ Housing
- ◆ Mental health and medical needs of the child(ren) and family
- ◆ Educational needs of the child(ren) and parents.

Key to the work of a FDTC is a focus on the needs of children. Although working toward the recovery of parents is critical, the safety, permanency and well-being needs of children are paramount. A FDTC combines rapid access to evaluation, treatment, and case management with frequent judicial monitoring and drug testing for parents whose AOD has contributed to the maltreatment of their child(ren). The program coordinates a full array of services to address issues such as mental health, AOD, trauma, domestic violence, child care, housing, transportation and employment. The drug court model provides parents with a unique opportunity to engage in recovery and improve parenting capacity. It also supports appropriate permanency planning for their children. The Family Dependency Treatment Court provides hope and potential for families in crisis, especially when parents' progress toward reunification with their child(ren) would be remote without the services and oversight of the drug court. The drug court provides the court and the participants with options that they simply do not have in the traditional child protection system.

National Council on Juvenile and Family Court Judges Model Court Family Drug Courts:

<http://www.ncjfcj.org/content/blogcategory/168/217/>

National Association of Drug Court Professionals: <http://www.nadcp.org/home.html>

National Drug Court Institute: <http://www.ndci.org/ndcirpub.html>

[\(back to matrix\)](#)

Individualized Services for Children/Early Intervention Programs

Models and Resources

SAMHSA's Children's Program Kit: <http://ncadi.samhsa.gov/promos/coa/>. The kit is designed to provide materials for AOD programs so they can initiate educational support programs for the children of clients in AOD treatment. The program teaches children skills such as solving problems, coping, social competence, autonomy, and a sense of purpose and future. The tool kit has activities for children in elementary, middle and high schools. It contains information for therapists to distribute to their clients to help parents understand the needs of their children, and training materials, including posters and videos, for AOD treatment staff that plan to offer support groups for children. (Would need to be adapted for younger age groups such as preschool and toddlers.)

SAMHSA Model Programs Suitable for Use with Children and Families in Child Welfare, Juvenile Justice and Family Court Systems: <http://womenandchildren.treatment.org/media/misc/CW-JJ.doc>

SAMHSA model programs offer 15 diverse programs suitable for use with children and families involved with the child welfare, juvenile justice and/or family court systems. In communities, the child welfare organization, and/or juvenile justice/family court system may need to partner with other groups or organizations to establish these programs, and make them accessible and relevant to the needs of children and families. Programs focus on troubled behavior of children such as academic problems, aggression, conduct disorders, emotional problems, stress, substance use, trauma and violence. Programs also focus on parental support and development through parenting skills such as communication and setting expectations, discipline, family management, parent-child conflicts, family interaction and problem solving. Programs also provide needed family support services such as case management, counseling, group work, intensive therapy, mentoring and training.

These programs have been delivered at a variety of referral sites used by child welfare and juvenile justice systems such as adolescent residential AOD and/or mental health treatment centers, after school programs, alternative schools, community-based programs, foster care facilities for troubled youth, mental health clinics and treatment centers. Generally, they can be added to existing, ongoing community programs through the training and certification of appropriate staff.

Suggested Models:

- ◆ Irving B. Harris Training Center for Infant and Toddler Development, STEEP facilitator's guide, *Steps Toward Effective, Enjoyable Parenting* and "Seeing IS Believing."
- ◆ Ramsey County ACE program, contact Jack Jones, (651) 266-4500; JSAC program in Ramsey County juvenile court
- ◆ Project STRIVE
- ◆ Early Infant Transition
- ◆ Home-U-Go Safely (HUGS)
- ◆ Best Beginnings Plus.

[\(back to matrix\)](#)

Focus Groups for Fathers

Child Protection and AOD service providers should have a strategy to improve their service delivery to fathers that includes convening focus groups in recovery for those who have experience with the child protection system. This will help to identify barriers in the system and to elicit recommendations for constructively engaging them in the process. The CJI-AOD workgroup used focus groups to gather information from parents. The report of that work can be found at: <http://www.mncourts.gov>

The following questions, used by the state CJI-AOD team, are recommended when forming focus groups:

1. During your involvement with the child protection system, do you agree that your use of alcohol and other drugs affected your family, and impaired your ability to parent your child(ren)? If yes, how so?
2. What services and supports, if any, were provided by the child protection system that worked well for you in dealing with your recovery?
3. What would have been helpful to you in your recovery that was not provided by the child protection system?
4. How can the child protection, court system and alcohol and other drug use areas, improve on engaging families better?
5. What do you feel is an overlooked necessity for services to children?
6. What suggestions do you have to improve recovery when leaving or transitioning to another service?
7. How can the child protection, court system, and alcohol and other drug areas improve on engaging fathers?
8. What would you suggest to improve communication and information-sharing among child protection, court system, and chemical health staff that would make things better for the parent(s) and child(ren)?
9. What could be done to make it easier for parents to participate? This has been identified as key to the Children's Justice Initiative project.
10. Based on your experiences with child protection, courts, alcohol and other drug use systems, what would you like those who work in these three systems to know about the process of recovery?

It would be very useful to have a parent actually facilitate the groups. Some stakeholders might find that they can leave out certain questions, or they might also want to add questions more focused on father's issues. It is not essential that the men participating in these groups be successes; it is valuable to have a breadth of experience in the group. The primary intention of these groups is to allow professionals to hear the voices of the fathers and their experiences in the system. In reviewing the data from the CJI-AOD focus groups, the workgroup found that fathers and mothers were very aware of biases against fathers, as well as the lack of services directed toward fathers.

Special Considerations

Focus Groups for Fathers

Special Considerations Related to Cultural Competency

People of color often have a different experience with the system than white people. This disparity is even more pronounced when socioeconomic factors are taken into consideration. What was found is that mothers and fathers are very interested in providing feedback on their experiences with the system, as long as they are listened to and respected. These groups represent a great opportunity for people of color to feel that they have been heard, and could even help them to reframe their perceptions about the child protection system.

[\(back to matrix\)](#)

Father-specific Case Planning and Agency Cross-training

Recommended Resources

Best practice dictates that work with families should be based on a holistic approach, which requires engagement of all family members and individuals that play a role in the family. Engaging fathers in child welfare cases is a complex issue. Cross-system training is critical. To successfully engage fathers, workers need training to dispel many of the myths related to “absent fathers,” believed by not only case managers, but society as a whole. Case managers need adequate training that will give them the skills to build respect and trust between the child welfare system and fathers. Agency staff, from directors to line staff, need to increase the focus on the importance of improving the father-child relationship and the benefits to child(ren). Fathers and paternal family members need support and encouragement in case planning and implementation; and they need to be provided services that address their individual needs.

Resources for Implementation:

- ◆ National Practitioners Network for Fathers and Families, Inc.: <http://www.npnff.org/>
- ◆ *Engaging Fathers in Child Welfare Cases: A Case Manager’s Perspective*
- ◆ *Expanding the Goals of ‘Responsible Fatherhood’ Policy* (2002, SPAN/NPNFF), includes tips for engaging low-income fathers in social services. Copies are available from the National Practitioners Network for Fathers and Families: www.npnff.org.

Father-specific Case Planning and Agency Cross-training

Model and Other Considerations

Father-specific case planning must ensure that mental health needs are addressed. Men need more resources for, and opportunities to learn about, grief and loss. Men need to be able to talk about their fears of being fathers, of not knowing how to do it, and in understanding their relationship with their fathers, as well. Caseworkers and clinicians need to be trained to do this in effective ways. Fathers who have children in the child protection system pose unique challenges when they are also incarcerated. The key to engaging these men, when appropriate, is to support them in receiving treatment services and incorporate issues unique to fatherhood into their treatment plans. One particular strategy is partnering with libraries, and using literacy as a tool to encourage men to learn how to read and write by establishing and maintaining correspondence with their child(ren).

Unmarried parents of abused and neglected children who have alcohol and other drug addiction problems are at greater risk of failure to achieve family recovery. AOD addiction hampers the unmarried father's ability to take affirmative steps to establish paternity. Without clear paternity established the rights of unmarried fathers to notices, to participate in decisions about their children, and even their ability to participate in court proceedings, may be hampered or extremely truncated.

Information about what fathers need to do to establish their rights and obligations as parents may include registering with the Father's Adoption Registry operated by the Minnesota Department of Health, or taking affirmative steps with or without the child's mother to establish paternity upon the child's birth, or within a short time after birth.

More information about being a father and the Father's Adoption Registry is available at:

http://www.courts.state.mn.us/districts/fifth/Paternity_Child_Support.htm

http://www.mnfathers.org/documents/Unmarried_Fathers_Guide.pdf

http://www.dhs.state.mn.us/main/groups/children/documents/pub/DHS_id_000753.hcsp

<http://www.health.state.mn.us/divs/chs/registry/top.htm>.

[\(back to matrix\)](#)

Brochures for Fathers

Model and Other Considerations

Most posters, brochures, flyers, and public service announcements regarding parenting focus on the needs of mothers and their children. The limited print media that is geared toward fathers is usually punitive and frequently related to child support enforcement. There are few resources specifically for fathers. While the workgroup was able to find several brochures that spoke about father's rights, or even the rights of people with alcohol and other drug problems, there was not a brochure that spoke to issues of fathers with alcohol and other drug problems. It is necessary to augment existing resources, or develop a completely new resource, that addresses both fathers' rights issues and the rights of people with alcohol and other drug problems. A local brochure with local references would be most helpful.

Recommended Resources for Implementation:

- ◆ Resource Center for Fathers and Families, (763) 783-4938 (Twin Cities metro area, Anoka and Hennepin Counties)
- ◆ African American Men Project, (612) 302-4690 (Minneapolis)
- ◆ Fathers First, (651) 291-6771, (Twin Cities metro area, Ramsey County)
- ◆ FATHER Project, Goodwill/Easter Seals, (612) 724-3539, (Minneapolis)
- ◆ Fathers' Resource Program, Otter Tail, Wadena Counties, (218) 385-2907 x144, (New York Mills, Fergus Falls, west central Minnesota)
- ◆ 10 Ways to be a Better Dad: <http://www.fatherhood.org/10ways>.

Special considerations related to cultural competency:

- ◆ ICWA, the Indian Child Welfare Act: <http://www.abanet.org/genpractice/compleat/f95child.html>
- ◆ Minnesota's "Recognition of Parentage" forms and videos are available in English, Spanish, Hmong and Somali from the Department of Human Services:
http://www.dhs.state.mn.us/main/groups/children/documents/pub/dhs_id_008808.hcsp.

[\(back to matrix\)](#)

Support Groups

Models and Resources

Men: Support groups for fathers involved with child protection and AOD must include a recovery component and awareness of recovery. The focus does not have to be on the father's recovery, but his resolution of AOD problems must be seen as essential to his progress in the group. They should also be encouraged to find additional supports for their recovery issues, if appropriate. Research indicates that two things are most important when convening these groups: the skill of the facilitator, and their ability to establish connections with the fathers. Domestic violence is often an issue that needs to be addressed without shame. Information about the challenges parents/fathers in recovery can face trying to find time for their recovery, and their child(ren) can be found at: <http://www.nacoa.net/families.htm>

Children: An important service component ensures that children are given age appropriate information about living with a loved one's AOD problem. This is commonly overlooked, yet critical to children in understanding what is happening in their family.

Domestic violence and AOD problems often go hand-in-hand. Different cultures have different interpretations of discipline, and what is appropriate, and not considered abuse. This can be a difficult subject to approach persons of color with – but is absolutely essential. Abuse should not be minimized. Each man needs to understand his own history of abuse as a perpetrator and as a victim. Only then can he make informed decisions about what is appropriate discipline. If the domestic violence issue is primary, these groups may not be appropriate. Contact Dr. Oliver Williams, director, Institute on Domestic Violence, African American Community Office 290A, Peters Hall, (612) 624-9217, e-mail: owilliam@tc.umn.edu.

Resources

- ◆ Circle of Parents (Parents Anonymous): <http://www.circleofparents.org/>
- ◆ The Nurturing Father: <http://www.nurturingfathers.com/journal.htm>
- ◆ MELD: www.meld.org
- ◆ The Minnesota Children Safety Centers offer supervised visitation and safe exchanges of children: <http://www.childrensafetycenters.org/>
- ◆ The Twin Cities Men's Center offers support groups for men dealing with chemical or behavior addictions, anger management classes, and other services for men in the Twin Cities: <http://www.tcmc.org/>
- ◆ Fathers Direct, England's national information center on fatherhood: <http://www.fathersdirect.com/index.php> (click on "Child Protection" and open "Involving fathers in decisions about the care of their children"), April 2005.

[\(back to matrix\)](#)

Interagency Communication Protocols

Model and Resources

Agencies must overcome the issue of confidentiality so they can share relevant client information on a consistent basis. Federal confidentiality guidelines incorporate mechanisms for information sharing to take place. AOD and child welfare agencies may establish Memoranda of Understanding (MOUs) to facilitate information sharing. Qualified Service Organization Agreements (QSOAs) may be established between an AOD agency and other organizations that provide services to the program and its clients. The regulations specifically mention agencies that provide “services to prevent or treat child abuse and neglect” as being among those with whom QSOAs may be established to facilitate services. Under a QSOA, information may be disclosed between two agencies without the individual consent of clients (although both agencies remain bound by rules about re-disclosing information outside the agreement). The University of North Carolina at Chapel Hill developed a CD and online training on the federal confidentiality regulations dealing with AOD patient records (42CFR, Part 2). This electronic course offers interactive video, audio, text and testing technologies. Information can be accessed through Chapel Hill Training Outreach, (800) 888-7979.

Agencies that want to cooperate have been able to establish working relationships within the rules to provide CPS with updates regarding clients’ progress in treatment, and to ensure that treatment agencies are partners in efforts to achieve child safety. Excellent working relationships between treatment and child welfare agencies facilitate use of their mutual expertise to work on behalf of the family: <http://www.ncsacw.samhsa.gov/files/BlendingPerspectives.pdf>. Treatment providers’ clinical files should clearly describe the demonstrable signs of treatment progress that child welfare agencies and courts can use to inform child welfare decisions. In addition, treatment providers should share notes that correspond with key case junctures, such as the court review timelines established by Adoption Safe Families Act. Both agencies should agree ahead of time on the format and content of updates to ensure its usefulness. Interagency agreements also outline the monthly reporting format for AOD treatment providers to submit information on mutual clients

Agencies and providers can establish policies and protocols to improve working relationships. Confidentiality policies might establish the process to obtain consent from the client at the time of referral to share treatment information between the agencies. They also might address the circumstances under which the treatment agency will notify CPS of a relapse. Other policies might state that each system will receive a record of the family’s history and current situation before making permanent decisions; how each system will be involved in parent/child visitation; and who has responsibility for providing post-treatment supports.

The Illinois Department of Children and Family Services and the Office of Alcoholism and AOD have an interagency agreement that allows them to use a jointly developed standard release of information for sharing information on mutual clients throughout the life of a case. The document is Appendix 8 (pp. 59-63) in the APhSA publication titled *Connecting Child Protection Services and Substance Abuse Treatment in Communities*. This document can be found at: <http://www.aphsa.org/Policy/Doc/cpssubabuse.pdf>

[\(back to matrix\)](#)

“Father Friendly” Agency Checklist

http://www.headstartinfo.org/pdf/father_involvement.pdf (pp. 21-22)

http://www.mnfathers.org/documents/top_5_legal_issues.pdf

Recommended Resources for Implementation:

- ◆ *Assessment Guide on Father Inclusive Practices* – National Practitioners Network for Fathers and Families – a comprehensive assessment tool for organizations when looking at how father friendly they are.
- ◆ Fatherhood Programs Self-Assessment Tool: http://www.friendsnrc.org/download/fatherhood_assessment.pdf
This self-assessment tool has been developed, pilot-tested, and used by several states as a way to focus on and improve a program’s ability to engage fathers. Community-based child abuse prevention lead agencies and their networks have a strong interest in building capacity to include fathers in productive and useful ways. This tool can help create dialogue among staff, identify areas of focus, and help evaluate current activities. How do program’s consider and reinforce involving fathers in programs, services and community activities? This self-assessment tool organizes a set of basic considerations needed to develop or improve a program that serves the needs of both fathers and mothers. The assessment tool addresses the dimensions of engagement and outreach, working with individual fathers, parenting, child development, supports for fathers, program operations and evaluation.
- ◆ Friends National Center for Community-based Child Abuse Prevention:
<http://www.friendsnrc.org/CBCAP/priority/fatherhood.htm>
- ◆ Seven Core Learning’s on Fatherhood: http://www.friendsnrc.org/download/seven_core_learnings.pdf
- ◆ Promoting Father Involvement in Early Childhood: http://www.friendsnrc.org/download/male_part.pdf.

[\(back to matrix\)](#)

References

Appendix A: Workgroup Participants

Engagement in Care

Carole Johnson – Chair
Child Welfare Reform Consultant
Minnesota Department of Human Services
Child Safety and Permanency Division
444 Lafayette Road N.
St. Paul, MN 55155-3832
Email: carole.johnson@state.mn.us

Jackie Crow Shoe – Co chair
Social Service Program Consultant
Minnesota Department of Human Services
Child Safety and Permanency Division
444 Lafayette Road N.
St. Paul, MN 55155-3832
Email: jackie.crowshoe@state.mn.us

Kim Landrigan
Social Service Program Consultant
Minnesota Child Welfare Training System
Minnesota Department of Human Services
Child Safety and Permanency Division
444 Lafayette Road N.
St. Paul, MN 55155-3830
Email: Kimberly.landrigan@state.mn.us

Transition/Exit Strategies

Ann Miller
Ramsey County Human Services
Child Protection Unit Supervisor
160 E. Kellogg Blvd., Room 6200
St. Paul, MN 55101
Email: Ann.m.miller@co.ramsey.mn.us

John Hudson
Social Service Program Consultant
Minnesota Department of Human Services
444 Lafayette Road N.
St. Paul, MN 55155-3830
Email: john.hudson@state.mn.us

Carol Ackley
River Ridge Treatment Centers
1510 East 122nd St
Burnsville, MN 55337
Email: ackley@riverridgetreatmentcenter.com

Denise Lindquist, American Indian Programs Manager
Minnesota Department of Human Services
444 Lafayette Road N.
St. Paul, MN 55155-0977
Email: denise.c.estey@state.mn.us

Appendix A: Workgroup Participants

Brigid Murphy

Stearns County Drug Court Coordinator
(320) 656-6364, (320) 656-3626 (fax)
Email: brigid.murphy@courts.state.mn.us

Suzanne Koeplinger,

Executive Director
Minnesota Indian Women's Resource Center
2300 15th Ave. South
Minneapolis, MN 55404
(612) 728-2008
Email: skoeplinger@miwrc.org

Janet Dinsmore, BCC, LADC

Senior Counselor, Director of Relapse Prevention - Recovery Plus
713 Anderson Avenue
St. Cloud, MN 56303
(320) 229-3760 ext. 23803
Email: DinsmoreJ@centracare.com

Joan Truhler

Department of Human Services
444 Lafayette Road North
St. Paul, MN 55155-0951
(651) 297-5385(w), (651) 215-1818 (fax)
Email: joan.truhler@state.mn.us

Deonne Shotley Menzel,

Minnesota Indian Women's Resource Center
2300 15th Ave. South
Minneapolis, MN 55404
(612) 728-2008
Email: dshotley@miwrc.org

Carey Schnabel

ICWA Coordinator
Minnesota Indian Women's Resource Center
2300 15th Ave. South
Minneapolis, MN 55404
(612) 728-2008 (w)
(Carey has left the MIWRC to pursue further education)

Services for Children

Ruthie M. Dallas – Chair

Women's Services Consultant
Minnesota Department of Human Services
Chemical Health Division
444 Lafayette Road North
St. Paul, MN 55155-3823
(651) 582-1834 (v), (651) 582-1865 (fax)
Email: ruthie.dallas@state.mn.us

Sue Stoterau – Co-chair

Program Consultant
Minnesota Department of Human Services
Child Safety and Permanency Division
444 Lafayette Road North
St. Paul, MN 55155-3832
(651) 296-1496 (v), (651) 297-1949 (fax)
Email: sue.stoterau@state.mn.us

Debra Davis-Moody

Minnesota Department of Human Services
Chemical Health Division
444 Lafayette Road North
St. Paul, MN 55155-3823
(651) 582-1784 (v), (651) 582-1865 (fax)
Email: debra.davis-moody@state.mn.us

Danielle Davis, Alateen Intergroup Chair

3185 Karth Road, #316
White Bear Lake, MN 55110
(651) 271-3156
Email: danaanna024@hotmail.com

Joanne Mooney

Minnesota Department of Human Services
Children's Trust Fund
444 Lafayette Road N
St. Paul, MN 55155-0962
(651) 284-4235 (v), (651) 297-1949 (fax)
Email: joanne.mooney@state.mn.us

Melanie Williams, Guardian ad Litem Coordinator

Ramsey County District Court-Special Courts Division
25 West 7th Street
St. Paul, MN 55102
(651) 266-5365 (w)
Email: Melanie.Williams@courts.state.mn.us

Valerie Larsen

Office of Minority and Multicultural Health
Minnesota Department of Health
P.O. Box 64975
St. Paul, MN 55164-0975
(651) 215-0701 (w)
Email: Valerie.Larsen@state.mn.us

Trisha Beuhring, Ph.D.

Minnesota, Institute on Community Integration
College of Education and Human Development
105 Patee Hall
150 Pillsbury Drive S.E.
Minneapolis, MN 55455
(612) 624-4847 (v), (612) 624-6300 (w), (612) 624-9344 (fax)
Email: beuhr001@umn.edu

Carol Belling

Journey Home/Passage Home
210 5th Avenue NE
St. Cloud, MN 56304
(320) 259-9149 (w), (320) 259-4565 (fax)
Email: bellingc@centracare.com

Jeff Martinka

Vice-President of Community Affairs
Perspectives, Inc.
3381 Gorham Avenue
St. Louis Park, MN 55426
(952) 926-2600, ext. 29 (w), (952) 926-9395 (fax)
Email: jmartinka@perspectives-family.org

Valerie Harris, M.A.

Washburn Child Guidance Center
2430 Nicollet Avenue South
Minneapolis, MN 55404
(612) 871-1454 (w), (612) 871-1505 (fax)
Email: vharris@washburn.org

Layla Asamaria

African American Family Services (AAFS)
100 W. Franklin Avenue
Minneapolis, MN 55404
(612) 238-2340 (w), (612) 871-2811 (fax)
Email: layla@aafs.net

Rashida Fisher

African American Family Services (AAFS)
2616 Nicollet Avenue So.
Minneapolis, MN 55404
(612) 238-2361
Email: rashida@aafs.net

Pat Nygaard

Minnesota Department of Human Services
Children's Mental Health Division
444 Lafayette Road North
St. Paul, MN 55155-0985
(651) 431-2332 (w), (651) 215-5714 (fax)
Email: patnygaard@state.mn.us

Services for Fathers

Dan Griffin - Chair

Court Operations Analyst - Chemical Health
Minnesota Supreme Court
State Court Administrator's Office, Court Services Division
25 Rev. Dr. Martin Luther King Blvd., Suite 105
St. Paul, MN 55155
Email: Dan.Griffin@courts.state.mn.us

Neil Tift

Director of Training
National Practitioners Network for Fathers and Families
304 Darrel Court
Stillwater, MN 55082
Email: ntift@npnff.net

Helen Basset

Program Administrator
Minnesota Department of Health
Father's Adoption Registry
85 E. 7th Place
P.O. Box 64882
St. Paul, MN 55164-0882
Email: Helen.Basset@state.mn.us

Paul Masiarchin

State Coordinator
Minnesota Fathers and Families Network
1700 Second Street Northeast
Minneapolis, MN 55413
Email: PMasiarchin@mnfathers.org

Tom Anderson

Community Coordinator
Resource Center for Fathers and Families
Human Services Building, Suite 305
1201 89th Avenue NE
Blaine, MN 55434
Email: tdaddy@myexcel.com

Hank Hickman

Treatment Provider
African American Family Services
2616 Nicollet Avenue South
Minneapolis, MN 55408
Email: hank@aafs.net

Mark Toogood

Guardian Ad Litem Program Manager
Minnesota Supreme Court
State Court Administrator's Office, Court Services Division
25 Rev. Dr. Martin Luther King Blvd., Suite 105
St. Paul, MN 55155
Email: Mark.Toogood@courts.state.mn.us

Appendix B: Data Sources and Citations

1. *Strategies for Integrated Substance Treatment in the Juvenile Justice System*: A practical guide through the US Department of Health and Human Services, Denver Juvenile Justice Integrated Treatment Network, June 1999.
2. The Center for Community Partnerships and Child Welfare: www.ccpcw.org.
3. *Service and Practice Perspectives*. Residential treatment for parents and their children. The Village Experience. Report to Virginia's FFRP advisory community, compendium of evidence based on promising practices.
4. Santa Clara, Calif. Family Drug Court. Sacramento County Child Protective Services.
5. Minnesota Department of Human Services 2005, *Bulletin 5-68-01*, "Revision of Out-of-Home Placement for Children."
6. A Newsletter for Colorado's child welfare professionals, www.perspectivesonpractice.org.
7. Mentors for Mothers Program, Santa Clara Juvenile Defenders Law Firm, (408) 995-0442
8. Kern County Child Protective Services, 100 E. California Ave., Bakersfield, Calif. 93307, (661) 631-6613, <http://www.co.kern.ca.us/dhs/>. Contact Charlotte Daniel, parent leader.
9. Brochure: *Parent and Staff Shared Leadership Task Force*, Sacramento County Department of Health and Human Services, Parent Leaders (916) 875-0729, email: cpsparentleaders@saccounty.net, CPS Staff Liaison, Martha Haas, (916) 875-0143, email: haasma@saccounty.net.
10. *A Comparative Look at Seven Family Care Programs* (n.d.). Retrieved Sept. 8, 2005, from University of California, Berkeley, National Abandoned Infants Assistance Resource Center, School of Social Welfare, http://aia.berkeley.edu/information_resources/shared_family_care/comparative_chart.html.
11. Allen, M., Larson, J. (1998). *Healing the Whole Family: A Look at Family Care Programs*. Retrieved Sept. 6, 2005, from Children's Defense Fund Web site: <http://www.childrensdefense.org/childwelfare/abuse/healing.pdf>.
12. Clovis, C., Price, A., & Wichterman, L. (2002). Annual Report on Shared Family Care: *Progress & Lessons Learned* (June 2001 - May 2002). Retrieved Sept. 9, 2005, from University of California, Berkeley, National Abandoned Infants Assistance Resource Center, School of Social Welfare Web site: <http://aia.berkeley.edu/media/pdf/sfc2002annual.pdf>.
13. Family Partnerships, Inc (n.d.). *Shared Family Care Handbook*, Innovative Family Partnerships, Inc. Milwaukee Shared Family Care Program. Retrieved Sept. 6, 2005, from: http://aia.berkeley.edu/media/pdf/sfc_handbook.pdf.
14. Johnson, K., Wilson, J. (2004). *Assessing Shared Family Care Programs and their Effectiveness*. Unpublished manuscript, Minnesota Department of Human Services, Child Safety and Permanency, St. Paul, Minn.
15. Wisconsin Department of Health and Family Services, Madison, Wis. (2001). SFC Program IV-E Waiver Request, Retrieved Sept. 6, 2005. University of California, Berkeley, National Abandoned Infants Assistance Resource Center, School of Social Welfare Web site: http://aia.berkeley.edu/media/pdf/sfc_waiver.pdf.
16. *Changing the Landscape, Study of the Impact of AOD*, Sacramento County.
17. National Certified Recovery Specialist (NCRS): www.ahhap.org/media/ncrs_app.pdf.
18. Specialized Treatment and Recovery Services (STARS), Sacramento County, <http://demo.danva.com/ncsacw>.
19. Michigan's Substance Abuse/Child Welfare Protocol for Screening, Assessment, Engagement and Recovery.
20. Protecting Children: Substance Abuse and Child Welfare Working Together.

21. McComish J.F., Greenberg R., Ager J., Essenmacher L., Orgain, L. S., Bacik W. J., Jr. (July-Sept., 2003). *Family-Focused Substance Abuse Treatment: A Program Evaluation*.
22. Journal of Psychoactive Drugs, Vol. 35(3), pp. 321-31.
23. Journey Home, http://www.centracare.com/sch/centers/behavioral/extended_care.html#journey.
24. Wayside House Inc. (Incarnation House), <http://www.waysidehouse.org>
25. http://www.dhs.state.mn.us/main/groups/publications/documents/pub/DHS_id_038815.pdf
26. Rule 31, (9530.6490), Additional requirements for license holders serving clients with children.
27. <http://www.revisor.leg.state.mn.us/arule/9530/6490.html>
28. Annie E. Casey Foundation, <http://www.aecf.org/initiatives/familytofamly>
29. “Family Group Decision Making in Minnesota: An Evaluation Study of the First Two Years,” January 2003. Measures of reunification, safety, permanence and satisfaction were positive in the evaluation findings. Contact Gerald Lindskog, Minnesota Department of Human Services, 444 Lafayette Road, St. Paul, MN 55155-3839, (651)-296-3910, email: gerald.a.lindskog@state.mn.us
30. Wattenberg, Esther, Forum Wrap-up, “Providing Safety and Well-being for Children in Substance-abusing Families: A Model of Risk Reduction.”
31. SCODA handout - Parent/caregiver drug issues check list.
32. Hazelden video – The Clinical Innovators Series, Carlo DiClemente on Stages of Change and Addiction.
33. Comprehensive Family Assessment Guidelines for Child Welfare. June 2005, http://www.acf.hhs.gov/programs/cb/publications/family_assessment/index.htm.
34. *Family Centered Assessment Guidebook: “The Art of Assessment.”* July 2002, National Resource Center for Family-Centered Practice and Permanency Planning (NRCFCPP).
35. <http://www.hunter.cuny.edu/socwork/crcfcpp/>.
36. Abbreviated version of *Family Centered Assessment Guidebook* adapted by Ramsey County Child Protection Worker Vicky Erickson.
37. State of Mississippi, Division of Family and Children Services. Supervisor’s Guide to Implementing Family Centered Practice. 2005, NRCFCPP, <http://www.hunter.cuny.edu/socwork/nrcfcpp/>, and http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/MS_SUPERVISORS.
38. *Partnership in Permanency: Achieving Permanency for Children*, (2003). Developed by city of Philadelphia Department of Human Services in consultation with Cornerstone Consulting Group and Temple University’s Center for Social Policy and Community Development. A DVD/video and facilitator handbook in English and Spanish. Copies available through the Philadelphia Department of Human Services, (215) 683-4DHS, www.phila.gov/DHS.
39. Seven (7) Day Meeting Format. Adopted from a series of Family Meeting Models by Ramsey County. See attachment.
40. *Improving the Quality of Care for the Most Vulnerable Children, Youth and Their Families: Finding Consensus*. (2005), Steve Hornsberger with Sid L. Gardner, Nancy K. Young, Nancy P. Gannon, and Trina Osher. Child Welfare League of America Press. Email books@cwla.org
41. Bower, Amanda (2003). “Sharing Family Values – Troubled parents are getting a second chance: foster care for them, along with their kids.” [electronic version] *TIME* Magazine, Feb. 17, 2003. www.tgorske.com/news/family_foster_care_030217.htm
42. Kendall, Mike (Lake County), email: mike.kendall@co.lake.mn.us. Phone: (218) 834-8400.

43. Price, A., (2003). "Shared Family Care: An Innovative Model for Supporting & Restoring Families through Community Partnerships." Retrieved Sept. 9, 2005, University of California, Berkeley, National Abandoned Infants Assistance Resource Center, School of Social Welfare.
44. http://aia.berkeley.edu/information_resources/shared_family_care.html
45. Shared Family Care Evaluation Plan (n.d.) Retrieved Sept. 9, 2005, University of California, Berkeley, National Abandoned Infants Assistance Resource Center, School of Social Welfare, http://aia.berkeley.edu/media/pdf/sfc_evaluation_plan.pdf
46. Community Reinforcement and Family Training (CRAFT), <http://casaa.unm.edu>.
47. ARISE Method, article "ARISE NETWORK for engaging Substance Abusers in treatment."
48. Jackson, V. (2004, August). "Residential Treatment for Parents and Their Children: The Village Experience." *Science & Practice Perspectives*, pp. 44-55, <http://www.drugabuse.gov/PDF/Perspectives/vol2no2/05Perspectives-Residential.pdf>
49. Rule 25: "Chemical Dependency Care," view at:
www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs_id_029436.hcsp
50. Mallon, Gerald P., McCartt Hess, Pat (2004). *Child Welfare for the Twenty-First Century: A Handbook of Practices, Policies and Programs*, <http://columbia.edu>
51. Washington's Endangered Children's Assessment and Response. *We Care. Recommended Best Practices Addressing the Needs of Drug Endangered Children*, August 2004, <http://www.doh.wa.gov/ehp/ts/cdl.htm>
52. Paper by Esther Wattenberg, Ph.D. "The Co-occurring Conditions of Mental Illness and Substance Abuse: The Search for an Integrated Treatment Plan." Forum Presenter: Dee Wilson, MSW, under the auspices of the Center for Advanced Studies in Child Welfare, School of Social Work and Center for Urban and Regional Affairs, University of Minnesota. July 1, 2005.
53. IV-E lecture series, "Harm Reduction Models for Alcohol and Drug Use." Forum Presenter: Gayle T. Thomas, MSW. Sponsored by the Center for Advanced Studies in Child Welfare and the School of Social Work, University of Minnesota.
54. See integrated services plan 05-06 at <http://www.dpw.state.pa.us>
55. Wattenberg, Esther and Zeise, Christina. *Interim Report: An Exploratory Study of Protective Supervision*. University of Minnesota, Aug. 1, 2005.
56. Kropenske, Vickie and Howard, Judy. *Protecting Children in Substance Abusing Families*. Virginia: Circle Solutions, Inc. 1994.
57. Center for Substance Abuse Treatment. *Center for Substance Abuse Treatment Model for Women and Children (draft document)*. CSAT Women, Youth and Families Task Force, June 2004.
58. Wattenberg, Esther. *The Co-occurring Conditions of Mental Illness and Substance Abuse: The Search for an Integrated Treatment Plan*, University of Minnesota, July 2005.
59. Atwood, Thomas C. and Ravenel, Virginia C. *Performance Measures for Courts: The Next Step in Foster Care Reform*. (Adoption Advocate, No. 001, June 2, 2005).
60. Conger, Betty. *Young Children of Substance Users: The Case for Alcohol and Other Drug Education*. National Abandoned Infants Assistance Resource Center: The Source, Vol. 14, No. 1, Spring, 2005, pp. 1-5.
61. Tisch, Rosemary, Deborah Dohse, and Linda Sibley. *Celebrating Families: "An Innovative Approach for Working with Substance Abusing Families."* National Abandoned Infants Assistance Resource Center: *The Source*, Vol. 14, No. 1, Spring 2005, pp. 6-10.

62. Stauffer, Laura Marie. *Best Beginnings Plus: Reducing Risk Factors Among Families Affected by Substance Abuse*. National Abandoned Infants Assistance Resource Center: The Source, Vol. 14, No. 1, Spring, 2005, pp. 13-15.
63. Young, Henry Jr. *Preschool Drug Prevention Program* National Abandoned Infants Assistance Resource Center: The Source, Vol. 14, No. 1, Spring, 2005, pp. 17-19.
64. National Abandoned Infants Assistance Resource Center *Good Bets* (list of resources), The Source, Vol. 14, No. 1, Spring 2005, pp. 21-23.
65. Substance Abuse and Mental Health Services Administration (SAMHSA), *Children's Program Kit*, www.samhsa.org
66. Belcher, Harolyn, et. al. *Spectrum of Early Intervention Services for Children with Intrauterine Drug Exposure*. Infants and Young Children, Vol. 18, No. 1, January-March 2005, pp. 2-15.
67. U.S. Department of Health and Human Services. *Blending Perspectives and Building Common Ground*. Washington, D.C., U. S. Government Printing Office, April 1999.
68. Center for the Improvement of Child Caring. *Parenting Skill Building Programs*, <http://www.ciccparenting.org/ParSkillBuildingPrograms.aspx>
69. Washington State Institute for Public Policy. *Benefits and Costs of Prevention and Early Intervention Programs for Youth*. Olympia, July 6, 2004, www.wsipp.wa.gov.
70. Washington State Institute for Public Policy. *Outcome Evaluation of Washington State's Research-based Programs for Juvenile Offenders*. Olympia, Jan. 2004, www.wsipp.wa.gov.
71. Rolnick, Art, and Grunewald, Rob. *Early Childhood Development: Economic Development with a High Public Return*. Federal Reserve Bank of Minneapolis: *fedgazette*, Mar. 3, 2003, <http://minneapolisfed.org/pubs/fedgaz/03-03/index.cfm>
72. SAMSHA/CSAT Treatment Improvement Protocol (TIP) Series 2: Pregnant Substance-using Women, U.S. HHS, Rockville, Md., www.samhsa.org
73. Handout: "The Four Clocks" – CJI Chemical Health Issues pilot county workshop, Humanities Center, St. Paul, Minn. 2004.
74. Abstract: "Parenting in Dependency Drug Court," Jaime L. Dice, M.Sc., Angelita H. Claussen, Ph.D., Lynne F. Katz, Ed.D, Judge Jeri B. Cohen, *Juvenile and Family Court Journal*, Summer, 2004.
75. SAMSHA/CSAT Treatment Improvement Protocol (TIP) Series 36: Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues, U.S. HHS, Rockville, Md., www.samhsa.org
76. Steps Toward Effective, Enjoyable Parenting (STEEP)/Seeing is Believing Programs, Irving B. Harris Training Center for Infant and Toddler Development, Institute of Child Development, Minneapolis, Minn., IBHarris@umn.edu
<http://education.umn.edu/icd/HarrisCenter/STEEPinfo.htm>
77. National Association for Children of Alcoholics. *Children of Addicted Parents & Core Competencies for Involvement of Health Care Providers in the Care of Children and Adolescents in Families Affected by Substance Abuse*. Rockville, Md., Contact: (888) 554-2627. Nacoa@nacoa.org , or <http://www.nacoa.org>
78. U. S. Department of Health and Human Services. *The Child Welfare-Substance Abuse Connection: A Compendium of Training Curricula and Resources*. Caliber Associates, www.samhsa.gov.
79. Connect for Kids. *A Toolkit for Funding*, www.connectforkids.org.
80. *Lost Childhood: Growing Up in an Alcoholic Family* (video), www.lostchildhood.org/program.htm.

81. *Recovering Hope* (video), <http://store.health.org/catalog/ProductDetails.aspx?ProductID=16955>
82. *Helping Hands* (video), University of Washington, Pediatric Therapeutic Care Unit.
83. Hennepin County Community Services. *200 Families Phase 2: A Foundation for Reform Process*. Minneapolis, Aug. 25, 1999.
84. Washington State Institute for Public Policy (WSIPP). *Proposed Research Approach for the WSIPP Study of Juvenile Crime Prevention and Intervention Programs*. Olympia, Aug. 17, 2001.
85. Washington State Institute for Public Policy. *The Comparative Costs and Benefits of Programs to Reduce Crime*. Olympia, May 2001.
86. The Center for Substance Abuse Prevention (CSAP). Office of National Drug Control Policy, *Evidence-based Principles for Substance Abuse Prevention*, http://about.preventiondss.org/html/documents/AnnualUpdate99/ondcp_principles.htm. 10/22/2001
87. Factsheet: "Cultural Competence in Serving children and Adolescents With Mental Health Problems," Mar. 4, 98, <http://www.mentalhealth.org/child>
88. TRIAD Women's Project. Handbook for Addressing Parenting Needs/Workbook for Successful Parenting. Contact Louis de la Parte, Florida Mental Health Institute, University of Southern Florida, Tampa, Fla. (813) 974-7188
89. Parent-Child Interaction (PCI) Program, Nursing Child Assessment Satellite Training (NCAST), Parent-Child Interaction Feeding and Teaching Scales.
90. Parenting with Love and Limits: A Class for Parents and Their Teens, Connie Blackburn, coordinator, (507) 453-0301, cblackburn@hbc.com.
91. Parenting Wisely, Family Works, Inc., Athens, Ohio. Contact: (866) 234-9473, familyworks@familyworksinc.com, or www.familyworksinc.com.
92. *Heritage & Helping: A Model Curriculum for Indian Child Welfare Practice*. Module IV: "Family-Centered Services for Indian Children," addresses the provision of at-home services, assisting the alcoholic family, and parent education, <http://www.nicwa.org/resources/catalog/curriculum/index.asp>.
93. Materials from Minnesota Indian Women's Resource Center (MIWRC), including: "Our Sacred Gifts: Trainers Manual," Franzen, Lenore, Minnesota Indian Women's Resource Center. Illustrated by Robert Desjarlait, 1993. *Our Sacred Gifts* draws on the values and traditions of native culture. Includes pre-natal and first-year developmental flipcharts. (Unit 1, "Preparing for Parenthood," Unit 2, "Pregnancy and Fetal Developmental," Unit 3, "The First Year of Life," Unit 4, "The Second Year of Life.") *Cherish the Children: Parenting Skills Training for Indian Families*, Buffalohead, Priscilla, Minnesota Indian Women's Resource Center. Illustrated by Robert Desjarlait, 1988. *Cherish the Children* is comprised of a trainer and participant manual. The trainer's manual offers a complete parenting program. Each of the 14 lessons include learning objectives, materials needed, procedures, lectures and worksheets, parent-child activities, evaluation suggestions, and supplementary readings. The participant's manual contains culturally-specific information and resource materials parents can use during the class and at home with their children.
94. Father engagement in early childhood development: a list of resource documents is available online at: www.mnfathers.org/resources.html.
95. "Fathers and Early Childhood Programs," Fagan, Jay, and Palm, Glen, (2004). Copies of the 300-page book are available via the Minn. Fathers & Families Network, info@mnfathers.org or (612) 787-4091.
96. <http://www.npnff.org/>
97. http://www.cffpp.org/legal/minnesota_en.html

98. http://www.mnfathers.org/documents/Unmarried_Fathers_Guide.pdf
99. http://www.mnfathers.org/documents/top_5_legal_issues.pdf
100. http://www.samhsa.gov/news/newsreleases/050408ma_rights.htm
101. <http://lac.org/lac/main.php?view=profile&subaction1=MN>