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Facilitating Cross-System Collaboration: A Primer on Child Welfare, Alcohol and Other Drug Services, and Courts

Substance Abuse and Mental Health Services Administration

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Facilitating Cross-System Collaboration: A Primer on Child Welfare, Alcohol and Other Drug Services, and Courts

Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
and
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau

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I. Introduction

Various studies and anecdotal information indicate that between one third and two thirds of families that come to the attention of the child welfare and family and dependency court systems do so as a result of parental substance use (U.S. Department of Health and Human Services, 1999). The challenges associated with parental substance use disorders among families involved with the child welfare system and the family and dependency courts have been well delineated for more than a decade. Yet, a lack of knowledge remains among professionals from these three primary systems regarding how the systems operate, their principal missions, and the requirements they must meet to receive public funding. The goal of this primer is to provide basic information on the three systems to support cross-system communication and coordination within State, county, and tribal jurisdictions. The primer is intended to identify the operational characteristics of each system, thereby promoting and developing cross-system connections designed to improve outcomes for families and children at the intersection of all three systems.

The *Introduction to Cross-System Data Sources: A Guide for Child Welfare, Alcohol and Other Drug Services, and Courts* is a companion document to this primer. The guide provides information about available child welfare, substance abuse, and court data collection and information management systems. As with the primer, the goal of the guide is to promote collaborative efforts that lead to improved services and monitoring across systems.

The audience for these documents includes those interested in familiarizing themselves with the child welfare, alcohol and other drug services, and court systems. These documents are also intended for jurisdictions interested in or in the process of developing cross-systems relationships. The primer and guide are targeted to management and administrative personnel in State, county, and tribal jurisdictions' alcohol and drug services, child welfare, and court systems.

The primer is not an exhaustive review of each system's mandates, practices, and policies. However, this document does provide an overview of the framework, target population, key legislation and funding sources, and structure and organization of services for each system.

II. Child Welfare System

Framework

The child welfare system consists of services designed to promote children's well-being by ensuring their safety, strengthening families to successfully care for their children, and achieving permanency in a child's living situation. Most families first become involved with the child welfare system due to a report of suspected child abuse or neglect (sometimes called "child maltreatment"). Federal law defines child maltreatment as serious harm (i.e., neglect, physical abuse, sexual abuse, and emotional abuse or neglect) caused to children by parents or primary caregivers, such as extended family members or babysitters. Child maltreatment can also include harm that a caregiver allows to happen (or does not prevent from happening) to a child. In general, child welfare agencies do not intervene in cases of harm to children caused by acquaintances or strangers; law enforcement agencies are responsible for these cases.

The child welfare system is not a single entity. Many organizations in each community work together to strengthen families and keep children safe. Public agencies (e.g., departments of social services, child and family services, human services) often contract and collaborate with private child welfare agencies and community-based organizations to provide families with services, such as in-home ("family preservation") services, foster care, residential care, mental health care, substance abuse treatment, parenting skills classes, employment assistance, and financial or housing assistance.

The Children's Bureau, established in 1912, is the oldest Federal agency with the responsibility of regulating, guiding, overseeing, and monitoring services to children and families. The Children's Bureau works with State and local agencies by providing funding for the full range of services through grant programs and initiatives, as well as training and technical assistance through a network of providers. The Children's Bureau is based in Washington, DC, and has a network of 10 regional offices that work directly with the State child welfare agencies.

State and local agencies establish their own policies and procedures to implement the Federal child welfare programs and regulations. The practices in each child welfare agency vary in many respects. An important variation is whether an agency is administered by the State or administered by the county and supervised by the State. Community-based private nonprofit agencies play a critical role in service delivery under contract to State or local public agencies. Depending on the degree of privatization in a particular State, these community-based organizations may deliver some or all child welfare services.

Child welfare programs do not remove children from the custody of the majority of families that these programs serve. Child welfare programs provide their services along a continuum of increasing family and child oversight, depending on the immediacy of the family's challenges and the extent to which child welfare staff believe that the child is unprotected and unsafe. Child welfare activities include:

- Community-based prevention efforts;
- Creation of statewide processes for receiving and responding to reports of suspected abuse or neglect;
- Triage to determine the immediacy of the response required;
- Investigations to confirm allegations;
- Services while children remain in their home to stabilize families and prevent child removals from parents or caretakers;
- Provision of emergency shelter and longer term protective custody placement for children;
- Services to reunify children with parents, including court oversight for children in protective custody; and
- When the program determines that children cannot return to their parents, adoption services to provide permanent caretaking relationships.

Target Population

Child welfare services include children across the developmental spectrum, from newborns to young adults. The reasons why children receive services vary and can include:

- The children or youth are at risk of child abuse or neglect;
- The child welfare program has confirmed child abuse or neglect allegations and the children remain in their home;
- The child welfare program has confirmed child abuse or neglect allegations and the program has placed the children in out-of-home care; and
- The youth are transitioning from child welfare dependency to independent living.

In some jurisdictions, child welfare agencies may also serve other populations, such as families experiencing parent-child conflict, children and youth with severe behavioral problems, and children and youth reported for truancy.

Key Legislation and Funding Sources

Federal legislation and Children's Bureau policies and guidelines set the minimum standards for State child welfare programs and practices. By implementing their own legislation, States may institute local variation in specific areas, including the definition of child abuse and neglect; the child welfare agency's responsibility for accepting and handling child maltreatment reports; provision of foster care and other services; and relationships to other government entities, such as law enforcement agencies, juvenile courts, and juvenile justice agencies. States also provide different scopes of services.

A combination of Federal and State sources fund child welfare services, and many States require county or local contributions. The Children's Bureau in the Department of Health and Human Services (HHS), Administration for Children and Families (ACF), administers the Federal funds. States must submit Child and Family Services Plans with 5-year projections for the use of the Federal monies in accordance with Federal guidelines.

The Children's Bureau allocates Federal funds across program areas using a formula or through reimbursement. For example, the Bureau uses a formula to fund prevention programs based on the size of the State's population of children under age 18. In contrast, the Bureau reimburses States for their actual foster care program expenditures.

The Children's Bureau monitors child welfare programs in all States and has the authority to enact financial sanctions for noncompliance. The Bureau periodically monitors child welfare services and foster care eligibility through the Child and Family Service Reviews and the Title IV-E Foster Care Eligibility Reviews. More information on these reviews is available at http://www.acf.hhs.gov/programs/cb/cwmonitoring/index.htm. For more information on Federal child welfare laws and policies, see http://www.acf.hhs.gov/programs/cb/laws_policies/index.htm.

In addition, public child welfare agencies are usually subject to oversight from a variety of State and local bodies, including foster care review boards, citizen review panels, legislative committees, county boards, courts, advocacy groups, and ombudsmen. The roles and authority of these bodies vary across jurisdictions. State statutes regarding child welfare are available at http://www.childwelfare.gov/systemwide/laws_policies/state/.

The primary Federal laws concerning child protection and child welfare are briefly described below.

Child Abuse Prevention and Treatment Act (CAPTA)—The Keeping Children and Families Safe Act of 2003 included the reauthorization of CAPTA. CAPTA provides minimum standards for defining child physical abuse, neglect, and sexual abuse that States must incorporate into their statutory definitions to receive Federal funds. CAPTA defines child abuse and neglect as "at a minimum, any recent act or

failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm." For further information on CAPTA, see http://www.acf.hhs.gov/programs/cb/resource/capta2010.

CAPTA includes three formula grant programs to States:

1. The CAPTA State Grants provide funding to all States that operate a statewide system that receives, investigates, and responds to reports of child abuse and neglect. The Children's Bureau distributes CAPTA State grant funds based on the State's population of children up to age 18. The designated State child welfare agency is the only eligible recipient of the CAPTA State Grant. Further information is available at http://www.acf.hhs.gov/programs/cb/programs_fund/state_tribal/capta.htm.

2. States and localities use Community-Based Child Abuse Prevention (CBCAP) program funds to develop prevention programs. To apply for funds through this program, States must be eligible for and receive a CAPTA State Grant. The State's governor is responsible for selecting the State agency that is eligible to receive the CBCAP funds. Although eligible agencies must apply for CBCAP funds each year, the awards are not competitive. CAPTA sets aside 1 percent of CBCAP funds for tribal and migrant populations, and the Children's Bureau awards these funds competitively. More information on CBCAP is available at http://www.acf.hhs.gov/programs/cb/resource/cbcap-state-grants.

3. The purpose of the Children's Justice Act (CJA) is to improve the investigation and prosecution of child abuse and neglect, especially child sexual abuse. Funds for CJA grants to States come from the Office of Victims for Crime (OVC) in the Department of Justice. The Children's Bureau manages and distributes these funds based on the size of the State's population of children aged 18 or younger, with a minimum allocation. Only States that receive a CAPTA State Grant are eligible to apply for the CJA funds. For further information, see http://www.acf.hhs.gov/programs/cb/resource/childrens-justice-act.

   OVC also provides funds for CJA grants to Indian tribes to address unnecessary trauma to child victims of sexual abuse during investigation and prosecution. OVC awards and manages these grants, known as the CJA Partnerships for Indian Communities Program.

In CAPTA's reauthorization, Congress responded to concerns about prenatal drug exposure by making three important changes in the CAPTA State Grant program. To maintain their CAPTA grant, States must have:

- Policies and procedures to address the needs of infants born and identified as affected by illegal substance abuse or withdrawal symptoms, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such conditions in such infants;
- A safe care plan for the infant born and identified as being affected by illegal substance abuse or withdrawal symptoms; and
- Procedures for the immediate screening, risk and safety assessment, and prompt investigation of such reports.

CAPTA also requires States to establish procedures to refer children under the age of 3 years who have substantiated cases of child abuse or neglect to early intervention services. Although the CAPTA amendments regarding substance-exposed infants state that the identification of a substance-exposed infant should not be construed as establishing child abuse or neglect, these infants can be referred for developmental assessments.

The *Adoption Assistance and Child Welfare Act* of 1980 (Public Law [PL] 96-272), a Federal program, requires States to establish family reunification programs and show reasonable efforts to prevent a child's removal from the home. This act strengthens the foster care program by providing financial assistance to parents who adopt children in foster care.

The *Adoption and Safe Families Act (ASFA)* (PL 105-89) continues to address the goals of the Adoption Assistance and Child Welfare Act. ASFA, enacted in 1997, promotes more timely permanent placements for children in the child welfare system by qualifying when States need to make "reasonable efforts" to find permanent placements for children in foster care. ASFA also requires States to make reasonable efforts to prevent a child's removal from the home (unless the circumstances require immediate removal to protect the child), try to return the child to his or her home, and, if the child is not returning home, make reasonable efforts to find the child another home. ASFA specifies that the key factor in child welfare decisions is safety and that safety, along with permanency and well-being, are the expected outcomes for each child.

ASFA provides for quick review when aggravated circumstances (as determined by the State) exist with respect to whether it is reasonable to try to return the child to his or her home. Examples of aggravated circumstances include when a parent has murdered or tortured a sibling of the child.

Among other changes, ASFA created adoption incentive bonuses for States and reauthorized the Family Preservation and Family Support program (renaming it the Promoting Safe and Stable Families program). ASFA also continued the child welfare demonstration waivers (42 United States Code [USC] § 1305).

In the Social Security Act, *Title IV-B, Subpart 1: Child Welfare Services*—The Child Welfare Services program helps States establish, extend, and strengthen child welfare services provided by public child welfare agencies, with the goal of keeping families together when possible. States achieve this goal through interventions to prevent removal of children from their homes, services to develop alternative placements when children are removed, and reunification services so that children can return home. States may use Child Welfare Services funds for a wide range of activities, including prevention, case management, placement of children in out-of-home care, reunification of families, and substance abuse treatment for a parent when needed to resolve child welfare problems. Related supportive services include case management, child care, transportation, housing assistance, mental health services, screening and assessment, aftercare or recovery community supports, trauma and violence services, parenting and child development education, income support, job training, and education.

In the Social Security Act, *Title IV-B, Subpart 2: Promoting Safe and Stable Families (PSSF)*—The PSSF program provides funds to States to help stabilize families, strengthen family functioning, prevent out-of-home placements, enhance child development, increase parenting competence, facilitate timely reunifications, and promote and support appropriate adoptions. PSSF is one of the few Federal funding sources for prevention and intervention services that addresses the problems that cause family involvement with the child welfare system, and it is critical for meeting ASFA's goals. The Child and Family Services Improvement Act of 2006 reauthorized the PSSF program until 2011 and included $40 million for a competitive grant program (with declining amounts over 5 years) to increase the well-being of and improve permanency outcomes for children affected by parental or caregiver abuse of methamphetamine or other substances.

In the Social Security Act, *Title IV-E, Federal Payments for Foster Care*—Title IV-E is the largest Federal funding source for child welfare services. This program reimburses States for services to children in foster care and for training and administrative costs. In addition, Title IV-E provides subsidies for adoption of children with special needs. This program is intended to prevent the unnecessary separation of children from their families, promote family reunification when feasible, improve the quality of care and services to children and families, and encourage the movement of children in foster care to permanency. Title IV-E also provides for court oversight of foster care placements and for regular, periodic reviews of children's cases by the court or agency.

Indian Child Welfare Act (ICWA)—Congress passed ICWA in 1978 to promote the stability and security of Indian families (see description of tribal child welfare system below for details on ICWA).

Foster Care Independence Act (FCIA)—Congress passed the FCIA in 1999. This act expands funding to States to develop and promote programs for youth transitioning out of foster care to adulthood. This law includes the John Chafee Independent Living Program, which provides Federal dollars to States to assist youth with educational, vocational, practical, and social services.

FCIA provides funding for programs to extend services to foster youth up to age 21, expand their access to medical care, and teach them the skills they need for successful independence. The FCIA also gives States the option of extending Medicaid coverage to youth who were in foster care on their 18th birthday until they reach age 21 years.

Fostering Connections to Success and Increasing Adoptions Act of 2008—The many provisions of this law, enacted on October 7, 2008, include an amendment to the Social Security Act to extend and expand adoption incentives through fiscal year (FY) 2013; creation of an option to provide kinship guardianship assistance payments; creation of an option to extend eligibility for Title IV-E foster care, adoption assistance, and kinship guardianship payments to age 21; and provision of the option to operate a Title IV-E program to federally recognized Indian tribes or consortia.

Structure and Organization of Services

Child welfare agencies are either administered by the State or administered by the county and supervised by the State. The government (State or county) agency that administers the child welfare agency makes decisions about policy implementation and operating procedures.

Key staff members in child welfare agencies include the following:

- Child welfare managers and administrators oversee all aspects of their systems and have a principal role in creating policies and protocols and providing adequately trained staff to meet the system's demands and responsibilities.
- Casework supervisors oversee case practice and provide support to caseworkers to ensure that they are meeting child and family needs and using all resources and services appropriately.
- Caseworkers assess risk, manage cases to ensure safety, identify the needs of the child and caregiver, and provide or refer children and families to needed services and supports.
- A contracted network of service providers delivers community-based services to meet the needs of children and their families. The continuum of services they provide ranges from prevention to intervention and treatment. These agencies may provide these services to families while children remain in the home or are placed in out-of-home care. Child welfare agencies are becoming more "privatized" as they have increased the use of more contracted community-based organizations to provide child welfare services.

Child welfare agencies have instituted many changes in service delivery in recent years, including the addition of substance abuse specialists in child welfare agencies and in the courts. The goal of this approach is to promote cross-system collaboration. Each specialist operates differently, depending on the roles and responsibilities that his or her agency assigns.

III. Tribal Child Welfare System

Framework

More than 560 federally recognized Indian tribes exist. Although some tribes operate their own child welfare programs, most work with their State child welfare agencies to provide services to Indian families and children. Tribes operating their own child welfare systems must have a cooperative agreement with the State to receive the pass-through grants of Title IV-E funds, which are Federal monies distributed by the State for eligible children. The Federal Foster Care Program allows tribes to apply directly for Title IV-E funding. However, tribes may not receive Social Services Block Grant funds directly from the Federal Government; they can obtain these funds only by submitting a competitive application to the State.

On September 30, 2006, 2 percent of the 510,000 children who were in foster care were Indian (U.S. Department of Health and Human Services, 2006). In contrast, Indian children comprised only 1.2 percent of the total U.S. population under age 19. Tribes face a number of challenges in front-line child welfare practices and agency-level child welfare policies. These challenges include dependence on external child welfare services, cultural differences between tribes and external entities, complicated jurisdictional issues, historical disenfranchisement of tribes, inadequate staff to perform basic child welfare functions, inconsistent funding, lack of youth services, the need to deliver services to families in isolated and autonomous villages, and limited infrastructure for monitoring and evaluating programs.

In 1978, Congress enacted ICWA to protect Indian families from unwarranted removal of their children and to give tribes a role in making child welfare decisions for their children. When serving an Indian child, regardless of whether the child resides on tribal land, the child welfare agency must comply with ICWA, send a notice to the child's tribe and the parents' tribe, and make "active efforts" to reunify the family. ICWA also requires that child welfare agencies try to place Indian children with relatives or tribal families unless a good reason exists not to do so. Agencies' placement decisions may be influenced by how long it takes to determine that ICWA requirements apply, the availability of Indian foster and adoptive homes, and the level of cooperation between States and tribes. These factors play an important role in determining the characteristics of the foster home in which the child will be placed, the number of placements a child will have, and the duration of the child's stay.

States are required to provide active efforts to reunify families and courts must determine whether States have made active efforts. ICWA does not define active efforts to accommodate individual case decisions. To alleviate the need to remove an Indian child from his or her parents, Federal guidelines stipulate that active efforts involve consideration of the social and cultural context of the Indian child and the use of available resources.

In addition to being over-represented in the child welfare system, Indians reportedly suffer disproportionately from substance use disorders compared to other racial and ethnic groups (Substance Abuse and Mental Health Services Administration [SAMHSA], 2006). In 2005, Indians had the highest rates of current and past-year illicit drug use compared to other racial and ethnic groups in the general population. In particular, Indians aged 12 and older had significantly higher rates of stimulant (i.e., methamphetamine), marijuana, cocaine, hallucinogen, and inhalant use than other racial and ethnic groups (SAMHSA, 2007). Rates of having a current or past-year substance use disorder (i.e., meeting criteria for substance abuse or dependence) were highest for Indians. Although Indians reported the lowest rates of current and past alcohol use, they reported the highest rates of binge drinking and having a past-year alcohol use disorder (SAMHSA, 2007). In spite of their high rates of illicit drug use and substance use disorders, Indians only represented 2.1 percent of treatment admissions in 2006 (SAMHSA, 2008). In addition, only 2.1 percent of the treatment facilities in the United States had served Indian clients in 2002 (SAMHSA, 2005b).

Target Population

All children and families who identify themselves as Indian and meet standard eligibility criteria are eligible for child welfare services from State child welfare agencies (as previously mentioned). For a child to be covered by the ICWA requirements, the child must be a member of or eligible for membership in a federally recognized tribe. In addition, the child must be an Indian child as defined by Federal law. Tribes have a right to determine tribal eligibility, membership, or both.

Tribal sovereignty requires referral of children reported to the child welfare agency who might be Indian to the appropriate tribe for determination of tribal membership and jurisdiction.

Tribal child welfare agencies provide services to Indian children involved in State child custody proceedings. However, ICWA does not apply to divorce proceedings, intrafamily disputes, juvenile delinquency proceedings, or cases under tribal court jurisdiction.

Key Legislation and Funding Sources

Congress designed ICWA (PL 95-608) in 1978 to establish standards for the placement of Indian children in foster and adoptive homes and to prevent the breakup of Indian families. Congress's intent was to "protect the best interests of Indian children and to promote the stability and security of Indian Tribes and families" (25 USC § 1902). ICWA sets Federal requirements that apply to State child custody proceedings involving an Indian child who is a member of or eligible for membership in a federally recognized tribe. The Act's major provisions include:

- Minimum Federal standards for the removal of Indian children from their families;
- Requirement to place Indian children in foster or adoptive homes that reflect Indian culture;
- Assistance to tribes in the operation of child and family service programs;
- Exclusive tribal jurisdiction over all Indian child custody proceedings when requested by the tribe, parent, or Indian "custodian";
- Preference to Indian family environments in adoptive or foster care placement;
- Funds to tribes or nonprofit off-reservation Indian organizations or multiservice centers to improve child welfare services to Indian children and families;
- Requirement for State and Federal courts to give full faith and credit to tribal court decrees; and
- Standard of proof for terminating Indian parents' parental rights requiring the proof to be beyond a reasonable doubt.

States and tribes must determine whether a child is Native American from the start of each child welfare case. ICWA sets Federal requirements on the removal and placement of Indian children in foster or adoptive homes and allows the child's tribe to intervene in the case. The act also establishes minimum standards for removing Indian children from their homes when necessary for their safety and for their placement in homes that reflect Indian cultural values. ICWA strengthens the role of tribes in determining the custody of Indian children, regulates State handling of child abuse and neglect cases, and requires that courts give placement priority to extended families.

Both ASFA and ICWA apply to Indian children receiving services from the child welfare system. ICWA's requirement for active efforts is a higher standard than ASFA's requirement for reasonable efforts to reunify the child with his or her family. When ICWA applies to a child's case, the child's tribe and family have an opportunity to participate in decisions affecting services for the child. A tribe or a parent can also petition to transfer jurisdiction of the case from the State to the tribal court. ICWA specifies that preferred placements are with extended family, members of a child's tribe, or an Indian family.

Fostering Connections to Success and Increasing Adoptions Act of 2008 (PL 110-351) provides federally recognized Indian tribes, tribal organizations, or consortia of Indian tribes with the option of applying to operate a Title IV-E program and seeking Federal reimbursement of a share of allowable tribal expenditures made pursuant to an approved Title IV-E plan. This option is available beginning October 1, 2009 (Federal fiscal year (FY) 2010).

Any Indian tribe, band, nation, or other organized group or community that the Federal Government recognizes as eligible for special programs and services provided by the United States to Indians because of their status as Indians may submit a Title IV-E plan or apply for the Title IV-E plan development grant. The law also gives the option of operating a Title IV-E program or receiving a development grant available to tribal organizations (recognized bodies of Indian tribes) or consortia of Indian tribes or tribal organizations [Sections 479B(a) and(c)(3) of the act and 25 USC § 450b]. Hereafter, we refer to such Indian tribes, tribal organizations, or consortia collectively as "Indian tribes."

PL 110-351 explicitly permits Indian tribes to continue existing agreements or enter into new agreements with States to share in the administration of a State Title IV-E plan. The law does not modify the terms of such agreements [Section 479B(e)]. To support such State–tribal agreements, the law permits Federal reimbursement of certain Title IV-E payments under such agreements at the tribal Federal Medical Assistance Package (FMAP) rate, if that rate is higher than the State FMAP rate [Section 303(c)(2)]. Finally, the law adds a State plan provision for States to negotiate in good faith with Indian tribes seeking Title IV-E agreements [Section 471(a)(32)].

Structure and Organization of Services

The State or local child welfare agency usually delivers services to Indian families and ensures that ICWA's requirements are met. In some cases, the tribe delivers the child welfare services and tribal courts have jurisdiction over those cases. Tribally licensed foster homes have similar requirements and provide the same services as State-licensed homes. Adoption proceedings occur in tribal court in the absence of good cause or parental objection.

ASFA does not modify or supersede ICWA and does not necessarily affect ICWA's application to cases of children involved in custody proceedings.

IV. Alcohol and Drug Services System

Framework

The amount of service structure and intensity that parents, their children, and families need at different time points varies. Services in the substance abuse continuum of care include outreach, engagement or pretreatment, treatment, aftercare, and ongoing recovery support. Throughout the continuum of care, parents, their children, and families may receive a broad array of comprehensive services (e.g., substance abuse treatment, medical care, mental health services, parenting education, child care, life skills training, job training, developmental services, and housing) that are provided by the primary treatment provider or through a coordinated network of agencies.

Substance abuse treatment is a set of activities or services ranging from screening and assessment to intensive counseling, pharmacotherapy, and behavioral interventions, as well as less intensive followup services. Treatment can include therapy (e.g., counseling, cognitive behavioral approaches, psychotherapy), medications, or a combination of services.

Therapies teach coping and avoidance strategies and ways to deal with relapse if it occurs. Substance abuse providers deliver treatment in outpatient, inpatient, and residential settings. Studies on drug addiction treatment have classified treatment programs into several general types or modalities, including pharmacotherapy such as agonist maintenance treatment (e.g., methadone and LAAM) and narcotic antagonist treatment (e.g., naltrexone) for opiate addiction, outpatient drug-free treatment (which includes different types and intensities of services), short- and long-term residential treatment, medical detoxification, prison-based treatment programs, and community-based treatment for criminal justice populations (National Institute on Drug Abuse (NIDA), 1999).

Treatment duration can range from weeks or months to years. NIDA has established a 90-day threshold to improve longer term outcomes (NIDA, 1999). The severity, types of drugs used, support systems available, and other individual factors determine the type, length, and intensity of treatment. Prior to beginning treatment, some individuals require detoxification and stabilization. After treatment, most individuals require some type of continuing support, including sober living houses, and often participate in 12-step fellowship programs such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA).

Substance abuse treatment includes varying approaches such as brief interventions, motivational enhancement therapy, social skills training, contingency management, community reinforcement, behavioral contracting, cognitive behavioral interventions, 12-step facilitation, pharmacotherapy therapies, and collaborative systems treatment (NIDA, 1999). Each approach is designed to address certain aspects of substance use disorders and their consequences for the individual, family, and society.

Although specific treatment approaches are often associated with particular treatment settings, providers can offer a variety of interventions and services in any given setting. Case management and referral to other medical, psychological, and social services are crucial components of treatment for many clients. The best programs provide a combination of therapies and other services to meet the needs of the individual, and are shaped by such issues as gender, age, race, culture, sexual orientation, pregnancy, parenting experience, housing, employment, and physical and sexual abuse (NIDA, 1999).

As with the child welfare system, the State or locality can administer public funds, such as Medicaid, to assist substance abuse treatment agencies. An alternative to public funds for treatment is private insurance. Individuals might pay for treatment services entirely out of pocket or be charged a copayment, depending on their individual or group insurance benefit under their plan for treatment services. Insurance benefits may include treatment services similar to publically funded (e.g., Medicare and Medicaid) individuals. However, individuals rarely receive both public and private substance abuse treatment services.

Nongovernmental organizations or local government agencies directly provide most substance abuse treatment in the United States, except for treatment administered directly by State institutional providers, such as correctional facilities. Some providers are "quasi-public" and operate with some autonomy outside the typical city, county, or State organizing structure (Re-Entry Policy Council, 2005). Some States employ clinicians to provide substance abuse treatment, while others contract out some or all treatment provision to private organizations.

In all States and major territories, a Single State Authority (SSA) coordinates substance abuse prevention and treatment. The SSA is often part of the State's department of health and human services. In a few States, the SSA directorship is a cabinet-level position, which allows the SSA director to work directly with the State's Governor. The SSA implements federally funded programs, determines the array of services available in the State, and develops and enforces treatment standards. To leverage all available funding and effectively serve their clients, SSAs must work closely with other State agencies—particularly child welfare, mental health, welfare, criminal justice, and courts—that also serve these individuals and their families.

Target Population

Substance abuse agencies provide alcohol and drug services to individuals and families needing high-quality community-based substance abuse treatment services.

Key Legislation and Funding Sources

Public financing for substance abuse treatment includes support from Federal, State, and local governments. In 2003, public sector expenditures for substance abuse treatment accounted for 77 percent of all substance abuse treatment spending, up from 50 percent in 1986 (Mark et al., 2007). By 2014, public sector expenditures will account for an estimated 83 percent of substance abuse treatment spending.

In the past, public substance abuse treatment programs usually relied on three primary funding sources: the Federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG), Medicaid reimbursement, and State general funds. More recently, other funding sources (e.g., Temporary Assistance for Needy Families, child welfare services, Social Security Block Grants, and discretionary grants) supplement these. At least 30 major Federal formula and block grant programs can help fund substance abuse treatment and related support services for individuals with substance use disorders and their children and families. The two largest Federal funding sources, SAPTBG and Medicaid, are described in more detail below.

The local agencies that deliver substance abuse services receive support from government funds, private insurance or self-payment, and, less frequently, voluntary or charitable organizations. In some locales substance abuse treatment funding comes from State and county earmarked taxes, fines, fees, and other sources. Despite this array of public financing, access to effective community-based services remains a major challenge for individuals and families affected by substance use disorders. Community-based providers must juggle competing priorities related to clients' access to services and the priorities of various funders.

Substance Abuse Prevention and Treatment Block Grant (SAPTBG)—The major Federal funding source for substance abuse treatment is the SAPTBG. SAMHSA provides SAPTBGs to States, U.S. territories, and the District of Columbia. In FY 2009, the SAPTBG funding totaled $1.7 billion.

SAPTBG's overall goal is to support a national system of substance abuse treatment and prevention programs and services. To fund services, States may work closely with their county structures and networks or with managed care organizations. Substance abuse administrative agencies in each State administer the SAPTBG program. The State alcohol and other drug directors manage the block grants and make awards primarily to networks of community-based treatment provider organizations. More than 10,500 community-based organizations receive SAPTBG funding from the States (SAMHSA, 2005). Providers must use 20 percent of their block grants for primary prevention, 5 percent for early HIV intervention services, and at least 5 percent (based on a formula related to FY 1994 expenditures) for pregnant and parenting women who receive priority admission preference (SAMHSA, 2005). SAPTBG facilitates increased and faster access to services for pregnant women, a priority population for the program. Programs for pregnant women and women with dependent children must include:

- Delivery of or referral to primary medical care;
- Delivery of or referral to primary pediatric care for children;
- Provision of gender-specific treatment;
- Therapeutic interventions for children;
- Child care;
- Case management; and
- Transportation.

Since FY 2008, the SAPTBG application has collected data, including National Outcome Measures, that reflect how States are managing and improving their substance abuse systems.

Medicaid—The Federal Medicaid program provides health care coverage based on income guidelines for qualifying beneficiaries—including children and their parents, the elderly, and individuals with permanent disabilities. Because every State administers its own Medicaid program, guidelines on Medicaid eligibility and services, including the substance abuse treatment services covered, vary considerably from State to State.

In 2003, Medicaid funded approximately 23 percent of substance abuse treatment costs in the United States (Dennis, Young, & Gardner, 2008). Medicaid can fund child welfare case management and substance abuse treatment as optional services at the State's discretion. As of January 2007, the Federal Medicaid program pays for screening and brief intervention services for alcohol or other drug addiction. Medicaid-eligible providers may deliver mental health or substance abuse treatment as inpatient medical hospital services, outpatient medical hospital services, rural health clinic services, federally qualified health center services, and physician services (including psychiatrist services). Optional services can include clinic services, rehabilitation services, other licensed practitioner services (e.g., from psychologists and psychiatric social workers), targeted case management, inpatient hospital services for children under age 22, and home- and community-based services (Dennis et al., 2008). The Deficit Reduction Act of 2005 resulted in State-specific changes, such as expanding Medicaid eligibility and providing alternative benefit packages.

The Medicaid Institutions for Mental Disease (IMD) exclusion prohibits Federal financial participation in mental health and substance abuse treatment services to individuals between the ages of 22 and 64 years who receive care at an "institution for mental diseases" (SAMHSA, 2005a). These institutions include hospitals, nursing facilities, and other institutions with more than 16 beds that provide diagnosis, treatment, or care.

Federal discretionary grants are also available to support substance abuse treatment programs and related services. For additional information about current discretionary grants from SAMHSA visit http://www.samhsa.gov/grants.

Confidentiality of Alcohol and Drug Abuse Patient Records (42 Code of Federal Regulation [CFR] Part 2) covers individuals receiving addiction treatment in a federally supported program and has a strict set of guidelines. This law also imposes restrictions on the disclosure and use of alcohol and drug abuse patient records that are maintained in connection with the performance of any federally assisted alcohol and drug abuse program. This regulation is intended to ensure that patient record availability does not make patients in federally assisted alcohol or drug abuse programs more vulnerable than people with an alcohol or drug problem who do not seek treatment. This law applies whether the person seeking the patient's records already has the information or is seeking the information for a judicial or administrative proceeding; is a law enforcement or other government official; has a subpoena or a search warrant; or is the patient's spouse, parent, relative, employer, or friend.

State confidentiality laws may be more restrictive but may not override Federal regulations. When State law is not stricter than and conflicts with the Federal regulations, State law must yield. State confidentiality laws also prohibit the disclosure and use of patient records unless certain circumstances exist that override State laws, but this circumstance does not compel disclosure. Exchange and disclosure of the patient's confidential information is permitted only if patients sign a consent form to release their confidential medical information.

Health Insurance Portability and Accountability Act (HIPAA)—In 1996, Congress passed HIPAA's administrative simplification provisions to improve the efficiency and effectiveness of the Nation's health care system. HIPAA's Standards for Privacy of Individually Identifiable Health Information cover the use and disclosure of protected health information. These standards also establish some patient rights, including the right of access to records. HIPAA's standards, disclosures, and rights pertain to substance abuse treatment providers and clients, although the more stringent rules in 42 CFR Part 2 take precedence over HIPAA.

Structure and Organization of Services

SAMHSA's Center for Substance Abuse Treatment and Center for Substance Abuse Prevention administer and manage the SAPTBG. These funds are provided to every State and the territories based on a formula.

Every State has an SSA that serves as the substance abuse agency operating division. The organizational structure for SSAs varies by State. In 2007, 3 of 50 SSAs were independent cabinet-level agencies, 27 were based in State mental health departments, 18 were based in State public health or health departments, and 3 were based in State children and family agencies.

State substance abuse agencies have coordinators who focus on specific areas or special populations. SSA staff members include women's services coordinators, national treatment network representatives, National Prevention Network representatives, HIV coordinators, State methadone authorities, data coordinators, and block grant coordinators. Networks of prevention and treatment providers deliver services in the States, funded by the various sources discussed.

V. Family, Juvenile, or Dependency Courts

Framework

Across States and local areas, courts that oversee child abuse and neglect cases are variously referred to as "family courts," "juvenile courts," or "dependency courts." In this paper, we use "dependency courts" to refer to all courts that have jurisdiction in child abuse and neglect cases.

Courts oversee the cases through a series of court reports and hearings. The court cases begin with the filing of an abuse petition, neglect petition, or both.[1] States vary in who has responsibility for filing the petition, but generally the petition is written by the child welfare agency and an attorney representing the agency files the petition with the court. This petition describes the allegations of abuse or neglect incidents that necessitate removing the child(ren) from the home or court oversight in cases in which the child remains at home. States vary in their approach to court oversight of cases in which the child is not placed in protective custody. In many locales, however, the court may find that the level of risk to the child does not necessitate placement in protective custody but that there is justification for the court to retain oversight of the child's custody while the family receives supportive services. In many locales this is referred to as court-supervised "in-home" services. In both circumstances of in-home or out-of-home services, after the petition is filed,the court case proceeds through a series of hearings and formal court processes. Again, the nomenclature for these hearings varies by jurisdiction; the most common sequence of events in different States is described below.

Preliminary Protective Hearing: This is the first court hearing and it must take place within a short time after the child's removal from the home. State law establishes the time period within which the hearing must take place. In most States, the preliminary protective hearing must occur within 1–3 judicial working days after removal. Some jurisdictions refer to the preliminary protective hearing as a "shelter care hearing," "detention hearing," "emergency removal hearing," or "temporary custody hearing."

Adjudication Hearing: This stage of the proceedings determines whether the evidence of abuse or neglect is legally sufficient to support State intervention on the child's behalf. The timing of this hearing varies in each State. According to the Juvenile Court Act of 1996, the adjudication hearing must take place within 10–20 days of filing a petition.

Disposition Hearing: The court disposition hearing determines who will have custody and control of the child. At this hearing, the court decides whether to continue out-of-home placement. The court must examine and approve the child welfare agency's case plan and determine whether the agency has made reasonable efforts to prevent out-of-home placement. Depending on State law, the court may set conditions for the child's placement and may issue specific directions to the parties

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[1] An exception is an emergency removal hearing that may take place prior to the petition's filing, when the children's protection agency removes the child after hours or on weekends, when court is typically not in session.

concerned. In many States the timing of the dispositional hearing is set in State statute to occur 30 days after the preliminary protective hearing.

Review Hearing: After the disposition hearing, the court comprehensively reviews the status of the case. Review hearings examine progress made by the involved parties and provide an opportunity to correct and revise the case plan. Review hearings are typically conducted at least every 6 months (Title IV-E requires review hearings every 6 months), or sooner on an-as needed basis. Some States hold hearings more frequently than every 6 months, and some base their hearing schedules on the characteristics of their cases.

Permanency Planning Hearing: Federal law requires that a court or administrative body appointed by the court conduct permanency planning hearings within 12 months of the date when the child entered placement. These postdispositional proceedings are designed to reach a decision concerning a child's permanent placement.

Termination of Parental Rights Hearing: Termination eliminates parental rights to visit, communicate with, and obtain information about the child. Termination proceedings must allow for full procedural protections for parents and children. Under ASFA, the court must show findings to support "reasonable efforts toward adoption." These efforts must start at the beginning of the permanency hearing and continue until permanency is achieved. As a result, the termination of parental rights trial is a two-part process. First, the trial addresses termination issues and, second, if the court grants termination of parental rights, it typically requires the child welfare agency to make reasonable efforts toward adoption. Termination of parental rights petitions, according to ASFA, must be filed for children who have been in foster care for 15 of the most recent 22 months (42 USC § 1305).

Parents may agree to voluntarily relinquish their parental rights, or the child welfare agency may bring the case to trial. During the court process for a child abuse and neglect case, courts must decide whether the statutory grounds for termination of parental rights have been satisfied and whether termination is in the child's best interest.

Many States use other terms to define these termination hearings, including "severance," "guardianship with the power to consent to adoption," and "permanent commitment" of the child.

The dependency court judge relies on reports from the child welfare caseworker that describe the child's and family's current situation, their progress with their case plan, and any problems that need to be addressed, including parental substance use. The judge may consider a parent's substance use in the hearing and determine whether the substance use interferes with the parent's ability to care for and keep the child safe; assess whether the parent is receiving the services outlined in his or her case plan in a timely manner; note whether the parent is participating and progressing in treatment; assess the child's needs and developmental progress; and determine whether the parent is likely to recover, demonstrate appropriate parenting skills, and be able to provide a safe and acceptable home for the child.

Target Population

Family, juvenile, and dependency courts participate in the cases of children who come to the attention of the child welfare system through allegations of child abuse, neglect, or both and for whom the child welfare agency is seeking court oversight.

In some locations, the dependency court is involved with child welfare cases that are served in the home (i.e., the child has not been placed in out-of-home care). Dependency courts are involved in *all* cases in which children are removed from the home and are placed in protective custody.

Key Legislation and Funding Sources

Federal legislation influences policymakers to adopt certain laws in their State and drives the policies and regulations set forth by dependency courts. One example is the Program Instructions regarding the Court Improvement Program that the Children's Bureau has issued to States. States use the Program Instructions to "clarify and explain procedures and methods for operationalizing program policies, add details to program regulations or policy guide requirements, and convey to grantees program guidance information on actions they are expected or required to take." For a list of Court Improvement Program Instructions, see http://www.acf.hhs.gov/programs/cb/resource/pi1202.

In general, juvenile and family court funding comes from counties, States, or both. Eligible courts can try to obtain one of the limited numbers of Federal grants for projects to improve outcomes for children and families involved in the dependency system. Grants for courts are available from both the U.S. Department of Justice and the U.S. Department of Health and Human Services' Administration on Children, Youth and Families, Children's Bureau.

The Children's Bureau authorizes and manages the State Court Improvement Program (CIP) grants. CIP grants are awarded to the highest court in each State to improve the handling of dependency court proceedings. There are three components to the CIP. The basic CIP grant requires States to assess, make recommendations, and implement improvements in the proceedings or handling of dependency cases. Currently, all States plus the District of Columbia and Puerto Rico receive the basic CIP grant. States may also apply for a CIP grant to support data collection and analysis. A third type of CIP grant supports training, including cross-training of child welfare agency staff members, judges, and attorneys to improve court processes and collaboration between courts and child welfare agencies. States must apply for CIP grants each year. CIP grants are funded from appropriations to the Promoting Safe and Stable Families Program. Funds have been appropriated through 2011.

Structure and Organization of Services

State law and the State's constitution determine jurisdictional responsibility for child abuse, neglect, or dependency cases, and counties provide court-related services to children and families. Dependency proceedings can take place under any of these court jurisdictions:

- Juvenile and domestic relations district court;
- General court of justice;
- Circuit court, child protection division;
- Juvenile court;
- Judicial district;
- Family court;
- Superior court, juvenile division; and
- Family drug treatment court.

Not only judges but also judge-appointed and -supervised judicial officers can hear dependency cases. These judicial officers preside over hearings and make decisions concerning cases. The judicial officers typically serve at the pleasure of the judge who appointed them, and their decisions are subject to review by a judge. Such judicial officers are often referred to as "associate judges," "magistrates," "referees," "special masters," "hearing officers," or "commissioners."

In some States, judicial officers may only hear noncontested cases; in other States, they preside over all types of hearings, including termination of parental rights hearings. A few States and courts allow judicial officers to hear the same cases as judges, including termination of parental rights hearings. In addition, some States permit parties to request that a judge rather than a judicial officer adjudicate their dependency matter.

In some jurisdictions the same judicial officer oversees the dependency petition and child welfare components of the case as well the substance abuse services. In other family drug courts, those components are assigned to two different judicial officers. The family drug treatment court model focuses on the parent's engagement in treatment and other services and offers family reunification as the parent's primary motivation. Family drug treatment courts address similar issues to dependency courts and adult drug courts and also schedule regular hearings, offer judicial monitoring, and provide treatment services and drug testing.

VI. Tribal Dependency Courts

Framework

Tribal courts are formal systems that Indian communities establish for resolving criminal and other legal matters. The types of tribal courts and how they apply tribal laws vary greatly. The Bureau of Indian Affairs manages a small number of courts under the CFR.

Tribal councils establish tribal dependency courts, usually under the authority of the tribe's constitution. These courts are subject to the authority of Tribal councils or law and order committees. Tribal constitutions may require Bureau of Indian Affairs' approval of council ordinances or resolutions affecting the tribal court. Tribal councils define procedures through codes or ordinances. Tribal judges may develop rules of procedure for hearings and trials. The tribal membership may elect judges, or tribal councils may appoint them if they are paid by the tribe.

The National Council on Juvenile and Family Court Judges has actively collaborated with the National Indian Child Welfare Association (NICWA) to assess and improve the resources and knowledge available to State, Federal, and tribal court personnel. Collaborative initiatives between State and Federal agencies and tribal courts are assessing crime, delinquency, and abuse in Indian Country to develop judicial procedures and interventions to address criminal activity that merge the Indian and criminal justice approaches in dispute resolution and sentencing. An integral part of these programs is investigating the cultural and economic conditions that give rise to higher than average levels of alcoholism and other substance abuse, child abuse, and other violent crimes in Indian Country.

The investigation and prosecution of child sexual abuse in Indian Country are complicated by multijurisdictional issues. The U.S. Supreme Court has ruled that charging a defendant in both Federal court and tribal court does not amount to double jeopardy, providing flexibility to tribal and Federal courts in handling child sexual abuse cases (*United States v. Wheeler*, 435 U.S. 313 [1978]). Because tribal courts are usually in a better position than Federal courts to proceed quickly with child abuse investigations and interventions, they frequently make the first move to punish the offender. Nevertheless, Federal, tribal, and even State agents may eventually carry out investigations, leading to multiple interviews and a long, frustrating process for the victim. Written protocols clarifying agency roles for the coordinated investigation of child abuse cases in Indian Country, agreed upon by the participating agencies, are essential to minimize further trauma to the child victim and the victim's nonoffending family members.

The Tribal Drug Court Initiative: Healing To Wellness Courts

A high rate of violent crime and victimization committed by Indians under the influence of alcohol prompted the U.S. Department of Justice's Drug Courts Program Office (DCPO) to launch the Tribal Drug Court Initiative in 1997. Research has shown that in tribal communities, alcohol is the most abused substance by both adults and juveniles (the term "drug" in the initiative includes alcohol). DCPO initially awarded planning and implementation grants and, later, continuation and enhancement grants to tribal governments. The Tribal Drug Court Initiative's specialized training and technical assistance programs help tribal communities develop drug court programs that work effectively within tribal justice systems and tribal culture (Tribal Law & Policy Institute, 1999).

The number of Indian tribal drug courts is growing. Each tribal court has a different name for its program, but these programs are referred to throughout Indian Country as the "Healing to Wellness Courts." Their challenge has been to merge the traditional, sociocultural, and restorative aspects of the Indian justice system with the criminal justice model for drug courts that help offenders achieve abstinence and alter criminal behavior through a combination of judicial supervision, treatment and drug testing, incentives, sanctions, and case management.

Each tribe describes its drug court program differently. For example, one Indian community leader described the drug court as a Council.[2]

Target Population

Tribal courts have jurisdiction over Indian children and families who meet the ICWA definition of "Indian." Tribal courts have only civil jurisdiction over non-Indian alleged offenders who commit child sexual abuse in Indian Country.

Key Legislation and Funding Sources

It was not until 1934, with the passage of the Indian Reorganization Act, that the Federal Government encouraged tribes to enact their own laws and establish their own justice systems. Because they had limited financial resources, many smaller tribes could not afford to operate their own tribal courts and retained the CFR courts operated by the Bureau of Indian Affairs. Approximately 23 CFR courts still exist.

Tribal courts operate under Program Instructions for Tribal Courts, which are similar to the Program Instructions for Court Improvement Programs (see https://www.acf.hhs.gov/programs/cb/resource/tribal-consultation-response for these instructions).

[2] "[C]ouncil of responsible professional elders and their warriors of both genders coming together in harmony to do battle against both a visible and an invisible enemy—the disease of alcohol and drug abuse. The tactic that the team/council/war party takes is to act as a legal and culturally sanctioned authority that meets the patient/client/tribal member where he or she is at in relation to his or her abusive relationship with the mood and behavior altering chemical" (Tribal Law & Policy Institute, 1999).

The U.S. Department of Justice has implemented several programs to improve coordination between Federal and tribal courts and offers training and technical assistance to implement these programs. The programs:

- Created the Tribal Courts Project to strengthen tribal courts' ability to respond to family violence and juvenile issues;
- Added criminal lawyers with expertise in child sexual abuse in Indian Country;
- Created and awards grants under the Violence Against Women Act for improved domestic violence programs;
- Support a demonstration project for tribal children's advocacy centers that will become a model; and
- As part of the Department's Indian Country Law Enforcement Initiative, administers grants to support the development, implementation, enhancement, and continuing operation of tribal judicial systems.

Structure and Organization of Services

Approximately 275 Indian communities have established formal tribal court systems. The types of forums and laws applied are unique to each tribe. Like other U.S. courts, some tribal courts apply written laws and court procedure rules. However, an increasing number of tribes are returning to traditional approaches to resolve disputes using peacemaking, elders' councils, and sentencing circles.

VII. Summary

This primer described the framework, target population, key legislation and funding sources, and structure and organization of services for the child welfare, alcohol and other drug services, and court systems with the intention of promoting and developing cross-system collaborations. The purpose of these collaborations is to improve outcomes for families and children at the intersection of all three systems by improving communication and coordination within State, county, and tribal jurisdictions.

VIII. Key Definitions and Terms

Terminology used and their definitions vary among agencies. The following partial list includes terminology commonly associated with the child welfare, alcohol and other drug abuse, and court systems. Child welfare terms are obtained from the Child Welfare Information Gateway, a service of Children's Bureau. There are multiple sources for the alcohol and other drug abuse terms, and they are noted with each term. The terms used for the court system are obtained from Child Welfare Information Gateway and the National Council of Juvenile and Family Court Judges. The tribal terms are obtained from NICWA.

Child Welfare

Adoption: a legal transfer of parental rights and responsibilities from one parent to another, usually from a birth parent to an adoptive parent.

Case Plan: the casework document that outlines the outcomes, goals, and tasks necessary to reduce maltreatment risk.

Child Abuse: any action (or lack thereof) that endangers or impairs a child's physical, psychological, or emotional health and development. Child abuse may be physical, emotional, or sexual.

Child Maltreatment: serious harm (i.e., neglect, physical abuse, sexual abuse, or emotional abuse or neglect) caused to children by parents or primary caregivers, such as extended family members or babysitters. Child maltreatment can also include harm that a caregiver allows to happen (or does not prevent from happening) to a child.

Child Protective Services: the social services agency designated by most States to receive and investigate reports and provide intervention and treatment services to children and families with which child maltreatment has occurred. Frequently, this agency is located in a larger public social service agency, such as a department of social services.

Court-Appointed Special Advocate: person (often a volunteer) who ensures that the needs and interests of a child in child protection judicial proceedings are fully protected.

Cultural Competence: a set of attitudes, behaviors, and policies that integrates knowledge about groups of people into practices and standards to enhance the quality of services to all cultural groups served.

Dependent Child: a term used in statutes that provide for the care of dependent, neglected, and delinquent children, referring to children who depend on public support. Children who depend on public support are all children under age 18 who are destitute or whose home is unfit due to neglect by their parents, or whose father, mother, guardian, or custodian does not properly provide for them.

Differential (or Alternative) Response: an area of child protective service reform that offers flexibility in responding to allegations of abuse and neglect. Also referred to as "dual track" or "multitrack" response, differential response permits child protective service agencies to respond differentially to children's needs for safety, the degree of risk present, and the family's needs for services and support. See "dual track."

Dual Track: reflects new child protective service response systems that typically combine a nonadversarial service-based assessment track for cases where children are not at immediate risk with a traditional child protective service investigative track for cases where children are unsafe or at greater risk for maltreatment.

Emotional Abuse: caregiver behaviors or incidents that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another person's needs. Spurning; terrorizing; isolating; exploiting; denying emotional responsiveness; and neglecting mental health, medical, and educational needs are types of emotional abuse.

Family (or In-Home) Services: services that strengthen and support families so that they can safely care for their children.

Foster Care: the 24-hour substitute care for children when the State has placement and care responsibilities. This term can refer to nonrelative family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and preadoptive homes.

Foster Care (or Placement) Episode: the period of time from a child's entry into protective custody until the transfer of custody back to his family or to an alternative caregiver. Some children experience more than one foster care episode.

Guardian Ad Litem: a lawyer or layperson who represents a child in juvenile or family court. Usually, this person considers the child's "best interest" and may perform a variety of roles, including those of independent investigator, advocate, advisor, and guardian. A layperson who serves in this role is sometimes known as a "court-appointed special advocate" or "CASA."

Guardianship: an out-of-home placement designated by a court that, in most cases, is intended to be permanent (the child is no longer a ward of the court).

Independent Living or Transitional Services: support to help youth in foster care acquire the skills and connections they will need to live on their own successfully.

Kinship Care: placement of children in protective custody with a relative or person with whom they have a family-like relationship.

Mandatory Reporters: individuals required by State statutes to report suspected child abuse and neglect to the proper authorities (usually child protective service or law enforcement agency staff members). Mandated reporters typically include professionals, such as educators and other school personnel, health care and mental health professionals, social workers, childcare providers, and law enforcement officers. In some States, all citizens are mandated reporters.

Neglect: the failure to provide for the child's basic needs. Neglect can be physical, educational, or emotional.

Physical neglect can include not providing adequate food or clothing, appropriate medical care, supervision, or proper weather protection (heat or coats).

Educational neglect includes failure to provide appropriate schooling or special educational services, or allowing excessive truancies.

Psychological neglect includes the lack of emotional support and love, chronic inattention to the child, or exposure to spouse abuse or drug and alcohol abuse.

Out-of-Home Care: child care, foster care, or residential care provided by persons, organizations, and institutions to children who are placed outside their family home, usually under the juvenile or family court's jurisdiction.

Permanency: placement in which the child can remain and grow to adulthood. Federal law requires public child welfare agencies to facilitate the permanent placement of children in homes outside of the foster care system, if at all possible.

Physical Abuse: the inflicting of a nonaccidental physical injury upon a child. This may include burning, hitting, punching, shaking, kicking, beating, or otherwise harming a child. Physical abuse can also result from overdiscipline or physical punishment that is inappropriate to the child's age.

Placement: the setting in which a child lives while in foster care or the home in which he or she goes to live permanently. Children in foster care can experience multiple placements, although agencies strive to prevent this.

Prevention: activities that build protective factors and reduce risk factors in communities, families, and children. Protective factors can exist in family functioning and resiliency, social support, concrete support, nurturing and attachment, and knowledge of parenting or child development. Risk factors for maltreatment include child (such as illness or disability), parental or family (such as substance abuse), or social or environmental factors (such as community violence). The presence of sufficient protective factors can reduce or eliminate risk factors.

Risk: the likelihood of maltreatment with an open-ended timeframe and consequences that may be mild or serious.

Safety: absence of an imminent or immediate threat of moderate-to-serious harm to the child.

Sexual Abuse: inappropriate adolescent or adult sexual behavior involving a child. Sexual abuse includes fondling of a child's genitals, forcing of the child to fondle the adult's genitals, intercourse, incest, rape, sodomy, exhibitionism, sexual exploitation, or exposure to pornography. To be child abuse, a person responsible for the child's care (e.g., a babysitter, parent, or daycare provider) or someone related to the child must commit one of these acts. If a stranger commits these acts, the act is a sexual assault and the police and criminal courts have jurisdiction.

Substantiated, Founded, and Indicated: an investigation disposition concluding that the allegation of maltreatment or risk of maltreatment was supported or founded by State law or State policy. A child protective service determination means that credible evidence exists and that child abuse or neglect has occurred.

Substance Abuse

Addiction: characterized by the repeated, compulsive seeking or use of a substance despite adverse social, psychological, and/or physical consequences. For more information, see http://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction.

Continuum of Care: a range of intervention activities that substance abuse agencies can implement progressively to support individual goals and avoid the use of illicit drugs and alcohol and the misuse of prescription drugs, and to assist individuals who abuse substances and have become dependent on substances to abstain from use. The interventions along the continuum are prevention, early intervention, treatment, recovery, and recovery support. Find out more at http://www.samhsa.gov/about/.

Co-Occurring Disorders: co-occurring substance-related and mental disorders. Individuals with co-occurring disorders have one or more substance-related disorders and one or more mental health disorders. Additional information is available at http://www.samhsa.gov/co-occurring/.

Detoxification: the process by which an individual who is physically dependent on a substance withdraws from it, often by gradual administration of decreasing doses of the drug of dependence or of a cross-tolerant drug. The primary objective of detoxification is to relieve withdrawal symptoms while the patient adjusts to a drug-free state. Detoxification is not, in itself, a treatment for addiction because it does not affect the long-term course of addiction. To find out more, visit http://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction.

Recovery: an ongoing process of abstaining from alcohol, illicit drugs, and/or the misuse of prescription drugs that begins in treatment and continues for the rest of one's life. Recovery requires behavioral, social, psychological, physiological, and lifestyle changes. More information can be found at http://www.samhsa.gov/recovery/.

Relapse: the return to drug use after a significant period of abstinence. Relapse is a common characteristic of addiction. For additional information, see http://www.drugabuse.gov/publications/addiction-science/relapse.

Substance Abuse: a pattern of substance use that results in at least one of the following consequences: (1) failure to fulfill role obligations, (2) use that places the user in danger (e.g., driving under the influence of a substance), (3) legal consequences, or (4) interpersonal or social problems. Find out more at http://www.ncsacw.samhsa.gov/files/Understanding-Substance-Abuse.pdf.

Substance Abuse Prevention: Primary prevention involves helping at-risk individuals avoid the development of addictive behaviors. Secondary prevention consists of uncovering potentially harmful substance use prior to the onset of overt symptoms or problems. Tertiary prevention involves treating the medical consequences of drug abuse and facilitating entry into treatment to minimize further disability. For more information, see http://www.samhsa.gov/prevention/spf.aspx.

Substance Abuse Treatment: involves the screening and assessment of an individual to determine alcohol abuse or dependence. If the individual meets alcohol abuse and dependence criteria, a qualified clinician develops a treatment plan and delivers an intervention. A treatment approach often includes counseling and behavioral therapies in a setting that matches the client's needs. Additional information is available at http://www.drugabuse.gov/publications/principles-drug-addiction-treatment.

Substance Dependence: a pattern of use that results in at least three of seven dependence criteria: (1) tolerance, (2) withdrawal, (3) unplanned use, (4) persistent desire or failure to reduce use, (5) spending a great deal of time using, (6) sacrificing activities to use, or, (7) physical or psychological problems related to use. Additional information is available at http://www.ncsacw.samhsa.gov/files/Understanding-Substance-Abuse.pdf.

Substance Use: the use of selected substances, including alcohol, tobacco products, drugs, inhalants, and other substances that can be consumed, inhaled, injected, or otherwise absorbed into the body with possible detrimental effects. More information is available at http://www.cdc.gov/nchs/fastats/druguse.htm.

Juvenile or Dependency Courts

Adoption Hearing: heard in the juvenile, family, or probate court depending on the jurisdiction. The court has the authority to proceed with adoption when parental rights have been terminated.

Appeals Process: process for appealing cases involving termination of parental rights petitions that go to trial. The appellate court hears the appeal. The appellate process is often slow, resulting in additional months or years for the child in foster care, without permanency. Many States, through legislation or court rule, have created mechanisms for expediting cases involving adoption and termination of parental rights issues, giving these cases preference over other cases on the appellate docket.

Notice of Summons: Locating and notifying both parents of the termination of parental rights hearing. It is a legal requirement that every possible effort is made to provide this notice to both parents. Unlike notice prior to adjudication, when a second parent can enter the litigation once that parent is located, the finality of termination proceedings makes subsequent notice and involvement of additional parties impossible.

Petition: must cite the statutory grounds relied upon and provide a summary of facts in support of each statutory ground. When the petition concerns an Indian child, the petition must rely on 25 USC § 1912, which outlines specific procedures involving parents of an Indian child. A termination petition typically addresses such issues as agency efforts to work with parents; parents' cooperation with the agency; parents' condition, behavior, progress, and improvements after adjudication; and the effects of foster placement on the child. The petition may allege facts in summary form because of the breadth of the issue, but the document must have sufficient detail to clarify the facts of the case. Allegations must be sufficiently precise to give the parties notice of the issues at stake.

Post-Termination Placement Plan: the case plan prepared by the child welfare agency and approved by the court outlining the strategy and timetable for the child's permanent placement.

Pretrial Conferences and Meetings: might be convened on an ad hoc basis or be required for every case, depending on the court's needs.

Review Hearings After the Permanency Hearing: take place because permanency has not been fully achieved. The court is therefore still responsible for reviewing progress and evaluating whether the child welfare agency is making reasonable efforts to achieve permanence.

Tribal

Customary Adoption: a practice, ceremony, or process conducted in a long-established, continued, reasonable, and certain manner, considered by a tribe's people to be binding or by the tribal court to be authentic. This practice, ceremony, or process gives a child a legally recognized permanent parent-child relationship with a person other than the child's biological parent without a requirement for termination of parental rights.

Enrollment in a Tribe: registration with a tribe that verifies membership in that tribe.

Expert Witness: according to ICWA, someone who can provide the court with knowledge of the social and cultural aspects of Indian life to diminish the risk of any cultural bias. The testimony of a qualified expert witness is required to make foster care placements or termination of parental rights for Indian children. The child's tribe, the Bureau of Indian Affairs, or Indian organizations can help identify qualified expert witnesses, who should have more knowledge about Indian culture than the average social worker or anthropologist.

Indian: used in U.S. Federal language, including ICWA, to refer to any person who is a member of a federally recognized American Indian tribe or Alaska Native village or who is an Alaska Native and a member of a regional corporation. See http://www.indians.org for a list of federally recognized tribes.

Indian Child: any unmarried person under age 18 who is either (a) a member of an Indian tribe or (b) eligible for membership in an Indian tribe and the biological child of a member of an Indian tribe.

Indian Custodian: any Indian person who has legal custody of an Indian child under tribal law or custom or under State law or to whom the child's parent has transferred temporary physical care, custody, and control.

Involuntary: in Indian child welfare, the process by which a parent loses custody of a child to a State agency and the child is placed in foster care due to child abuse, neglect, or both. To regain custody, the parent and social worker develop a service plan outlining remedial or rehabilitative services.

Notice to Tribe: ICWA requirement that once the State receives custody of an Indian child, that child's tribe(s) be notified by registered mail with return receipt requested that the child is in its custody so that the tribe may decide if it wishes to intervene.

Remedial and Rehabilitative Services: support services required by ICWA and provided by the State to help families offer safe placements for a child. These services are designed to prevent a child's removal by "rehabilitating" or strengthening the family in its parenting and other related skills, help "remediate" or correct the situation in a home that led to a child's removal, or both. These services can include family group conferencing, parent counseling, substance abuse counseling, and job-skill training.

Tribal Intervention: occurs when a tribe acts on its right to participate in child custody proceedings at any point. ICWA states that "in any State court proceeding for the foster care placement of, or termination of parental rights to, an Indian child, the Indian custodian of the child and the Indian child's Tribe shall have a right to intervene at any point in the proceeding" (25 USC § 1911.C.). Tribes may interpret this requirement broadly. For example, tribes may ask to transfer the case to tribal court (a "transfer of jurisdiction") or choose to only monitor the case through court records. Parents and tribes can request transfer of jurisdiction.

IX. Acknowledgments

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