Chemical Dependency Treatment Provider Survey: Summary of Survey Questions and Answers

Marna Geyer Miller, Ph.D.

February 2004

Washington State Institute for Public Policy

Chemical Dependency Treatment Provider Survey: Summary of Survey Questions and Answers

Marna Geyer Miller, Ph.D.

February 2004

Washington State Institute for Public Policy
110 Fifth Avenue SE, Suite 214
Post Office Box 40999
Olympia, WA 98504-0999
Telephone: (360) 586-2677
FAX: (360) 586-2793
URL: http://www.wsipp.wa.gov
Document No. 04-02-3901

WASHINGTON STATE INSTITUTE FOR PUBLIC POLICY

Mission

The Washington Legislature created the Washington State Institute for Public Policy in 1983. A Board of Directors—representing the legislature, the governor, and public universities—governs the Institute, hires the director, and guides the development of all activities.

The Institute's mission is to carry out practical research, at legislative direction, on issues of importance to Washington State. The Institute conducts research activities using its own policy analysts, academic specialists from universities, and consultants. New activities grow out of requests from the Washington legislature and executive branch agencies, often directed through legislation. Institute staff work closely with legislators, as well as legislative, executive, and state agency staff to define and conduct research on appropriate state public policy topics.

Current assignments include projects in welfare reform, criminal justice, education, youth violence, and social services.

Board of Directors

Staff

Roxanne Lieb, Director
Steve Aos, Associate Director

CONTENTS

I. INTRODUCTION

In 1997, influenced by statistics showing that many children remain in foster care for prolonged periods of time, Congress passed the Adoption and Safe Families Act (ASFA). ASFA shortened the allowed time to permanent placements for children in out-of-home care. Acceleration of the dependency[1] process has placed greater demands on the courts handling such cases, on the attorneys general prosecuting the cases, on defense attorneys representing parents, and on the Department of Social and Health Services (DSHS), which has responsibility for protecting the children and providing services to the families.

In 2001, the Washington State Legislature directed the Office of Public Defense (OPD) to establish a committee to address the following issues:

- Develop criteria for a statewide program to improve dependency and termination defense;
- Examine caseload impacts to the courts resulting from improved court practices; and
- Identify methods for the efficient use of expert services and means by which parents may effectively access services.[2]

In response, the Dependency and Termination Equal Justice Committee (DTEJC) was created. To inform itself about service providers and practices of the courts and of DSHS, the DTEJC elected to survey five populations:

- The juvenile courts of Washington;
- Social work supervisors in the Division of Children and Family Services at DSHS;
- Chemical dependency treatment providers;
- Other providers of services to families; and
- Evaluators (providers of many sorts of psychological evaluations).

This report focuses a subset of facilities that provide chemical dependency treatment to parents in child abuse and neglect cases. The DTEJC outlined questions of interest, and the OPD and the Washington State Institute for Public Policy (Institute) then designed questionnaires, implemented the surveys, and compiled the data.

[1] "A dependency is a process, involving the Department of Social and Health Services (DSHS), Superior Court, families, and children alleged to be abandoned, abused or neglected, or a without a parent capable of adequately caring for him or her. The process concerns a determination of the child's status as either, abandoned, abused or neglected, or a without a parent capable of adequately caring for him or her (a dependency finding) and then what steps must be taken to protect the child. The court may reunite the family, order services, or require placement of the child out-of-home. The process may also result in the filing of a petition to terminate parental rights." *A Legislator's Guide to the Child Dependency Statutes*, Senate Human Services and Corrections Committee Staff, Washington State Senate, 1999, <http://www.leg.wa.gov/senate/scs/hsc/briefs/dependency.pdf>, Accessed February 26, 2003.

[2] ESSB 6153, Section 114(d)

Survey Methodology

A list of all chemical dependency treatment providers in Washington State was provided by the Division of Alcohol and Substance Abuse (DASA),[3] which certifies these facilities. Facilities are certified to provide specific treatment modalities, such as Intensive Inpatient or Outpatient care. Courts and insurance companies recognize only treatment from certified providers.

One questionnaire was sent to each administrator (some agencies maintain multiple facilities). Facilities which obviously served only youth, and facilities which also provided other types of services (see Appendix A), were eliminated from the mailing list.

A total of 154 agencies, representing 336 facilities, responded, for a response rate of 46 percent. Removing additional youth-only facilities and respondents that no longer provided these services left a total of 162 facilities. Of the facilities serving adults, 88 provided assessment or treatment services to parents in child abuse and neglect cases.

Agencies sometimes differed from the DASA records regarding the types of services provided. For this reason, all modalities for which an agency was certified were determined from DASA records. The only responses used were where facilities indicated they provided a service and where DASA information verified the agency was certified to provide the service.

If clients receive treatment funded by the Alcohol and Drug Addiction Treatment Support Act (ADATSA), two steps necessarily precede treatment:

1. Financial eligibility must be determined by the local Community Service Office (CSO, i.e., the welfare office). By law, the CSO has 45 days to determine eligibility.
2. If the client is financially eligible, he or she must have a chemical dependency assessment at a designated ADATSA Assessment Center. This assessment determines the modality of treatment most appropriate for the client.

At the time of the survey, each county, except Snohomish, had only one ADATSA Assessment Center. Based on the survey of social work supervisors, we estimate roughly 80 percent of parents in child abuse and neglect cases who receive chemical dependency treatment are funded by ADATSA.

Section II provides data from facilities that perform chemical dependency assessments. Section III presents treatment data for facilities serving parents in child abuse and neglect cases. The remaining sections address answers to open-ended questions asked in the surveys.

[3] The author is grateful to personnel at the Division of Alcohol and Substance Abuse for help in understanding how state-funded chemical dependency treatment is accessed and for an exhaustive list of all certified treatment providers. Special thanks to Toni Krupski, Dennis Malmer, Felix Rodriguez, and Ken Stark.

Highlights

According to the Washington Administrative Code (WAC 388-800-0100), ADATSA assessment and treatment programs must give priority to parents in child protection cases. Thus, wait times for parents may be shorter than waits for other ADATSA-funded clients.

- In most (70 percent) facilities, parents wait seven days or less for an assessment.
- Most (88 percent) outpatient treatment programs have no waiting list for parents in child protections cases. Where there is a waiting list, on average, parents wait 14 days.
- Wait lists are more common for parents who require residential treatment.
    - Eight of the ten intensive inpatient facilities report a waiting list, with an average wait of 16 days for parents.
    - Two of the three residential facilities with accommodations for parents' children report a waiting list, with an average wait of 43 days.
    - One of the three other inpatient facilities report a waiting list with a wait of 42 days.
- Forty percent of facilities report that fewer than half of the parents successfully complete treatment.

II. CHEMICAL DEPENDENCY ASSESSMENT

Most facilities (91 percent) reported performing assessments. However, only 23 responding agencies were designated ADATSA Assessment Centers. *All responses in this section are from ADATSA Assessment Centers only.*

How Long Has Your Agency Been Performing Chemical Dependency Assessments?

	Percent of Facilities
Less than 1 year	0%
1 to 3 years	0%
3 to 5 years	0%
Over 5 years	100%

What Credentials Are Held By Staff Who Perform Chemical Dependency Assessments?

Credentials of Persons Doing Assessments	Percent of Facilities Reporting Staff With These Credentials	Highest Education Level Among Assessment Staff: Percent of Facilities Reporting
MD/PhD	9%	9%
MS/MA	50%	41%
BA/BS	81%	36%
CD Prof Cert	100%	14%
AA	59%	
Special Training	14%	
Other	18%	

On Average, How Long Have Assessment Staff Been Performing Chemical Dependency Assessments?

Experience	Percent of Facilities
Less Than 1 Year	0%
1 to 5 Years	27%
5 to 10 Years	55%
Over 10 Years	18%

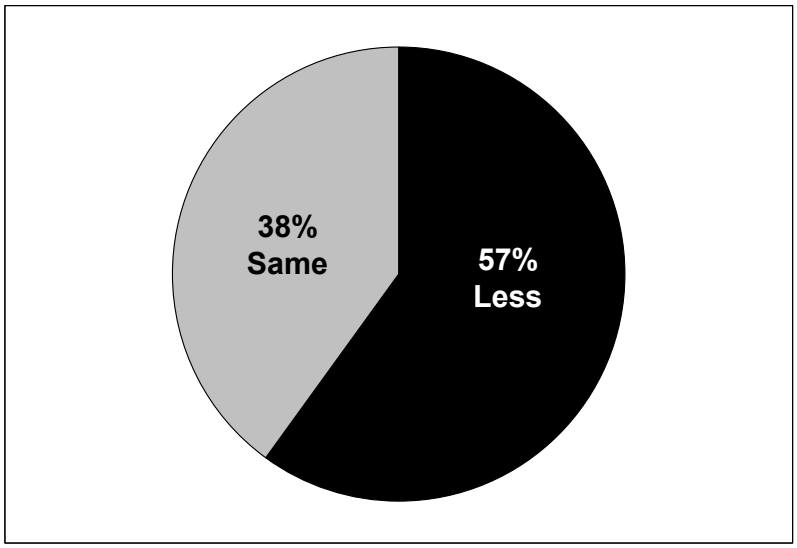
What Percentage of Your Agency's Assessments Consists of DSHS-Funded Clients?

Percent of Assessments Which Are DSHS Clients	73%	(Range 5% to 100%)

How Much Are You Usually Paid for a Typical Chemical Dependency Assessment of DSHS Clients?

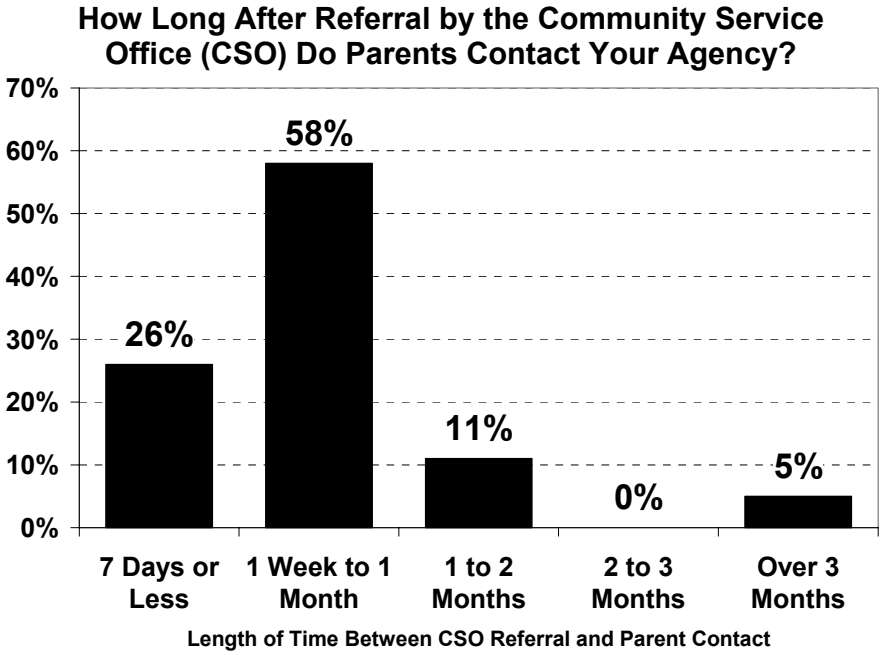
Average DSHS Payment for Assessment	$95

How Does This DSHS Payment Compare With Your Usual and Customary Hourly Rate?



How Are You Advised When DSHS Refers a New Client to You for a Chemical Dependency Assessment?

Referrals for Assessment	Percent
Written Notice From DSHS	77%
Caseworker Calls	68%
Parent Brings Written Referral	27%
Other	27%



Converting the above periods to days, we can derive the median[4] and mean times estimated for parents to contact the assessment center after referral by the CSO:

- Median: 18 days
- Average: 21 days
- Range: 3 to 100 days

Once a Parent in a Child Abuse and Neglect Case Has Contacted Your Office, What Is the Average Waiting Period for an Assessment Appointment?

After parent contact, the average wait for assessment is…	
Less Than 1 Day	5%
2 to 7 Days	65%
Over 7 Days	30%

Converting the above periods to days, we can derive the median and average waiting times for an appointment:

- Median: 4 days
- Average: 6 days
- Range: 1 to 10 days

[4] The median is the mid-point in the range of responses. That is, half the social work units gave a lower value, and half the units gave a higher value.

When Parents in Cases Are Referred to You for Assessment, What Information Do You Generally Receive?

	Percent of Facilities Receiving
Purpose of Assessment	68%
Background Info From Social Worker	62%
Case Documents From DSHS	14%
Facts From Parent Attorney	0%

How Often Is the Following Information Helpful to You in Your Assessment?

	Find this information helpful?					
	Never	Seldom	Sometimes	Often	Always	N/A
DSHS Case-Specific Information	0%	0%	27%	23%	50%	0%
Social Service Provider Information	0%	5%	14%	38%	43%	0%
Information From Parent Attorney	6%	17%	17%	17%	11%	33%
Information Agency Specifically Requests	0%	0%	15%	25%	50%	10%

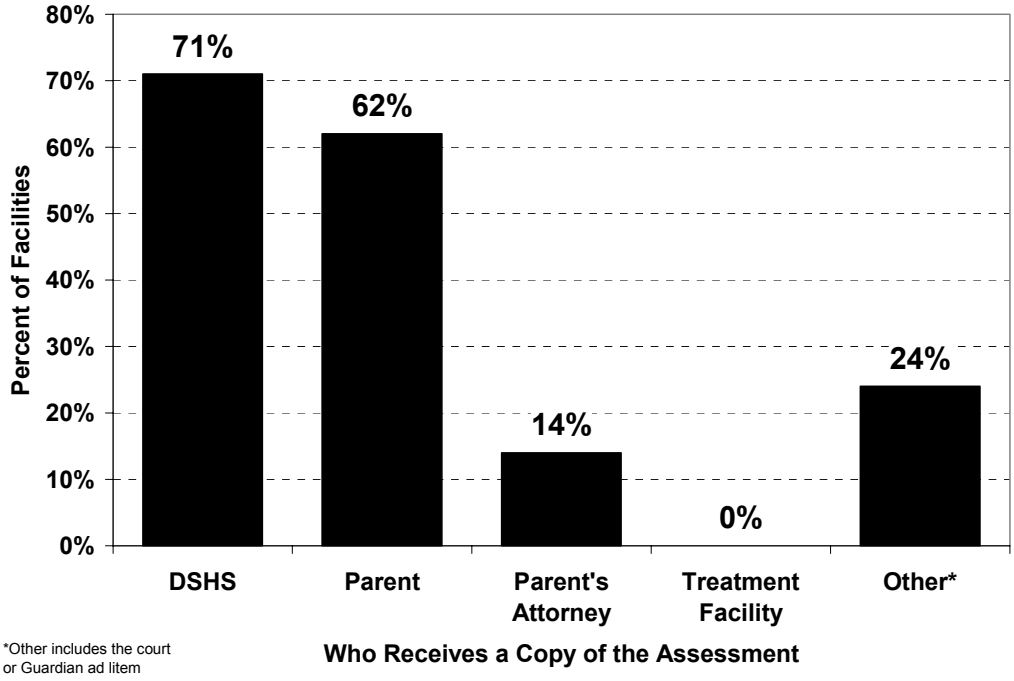
After the Initial Appointment, What Is the Average Amount of Time it Takes to Complete an Assessment?

	Percent of Facilities
Less Than 1 Day	25%
2 to 7 Days	60%
7 to 14 Days	15%
Over 2 Weeks	0%

Converting these periods to days, we can derive the median and average times to complete an assessment:

- Median: 4 days
- Average: 6 days
- Range: 0 to 10 days

In Child Abuse and Neglect Cases, the Completed, Legally Mandated Chemical Dependency Assessment Is Sent to the Following Individuals or Entities

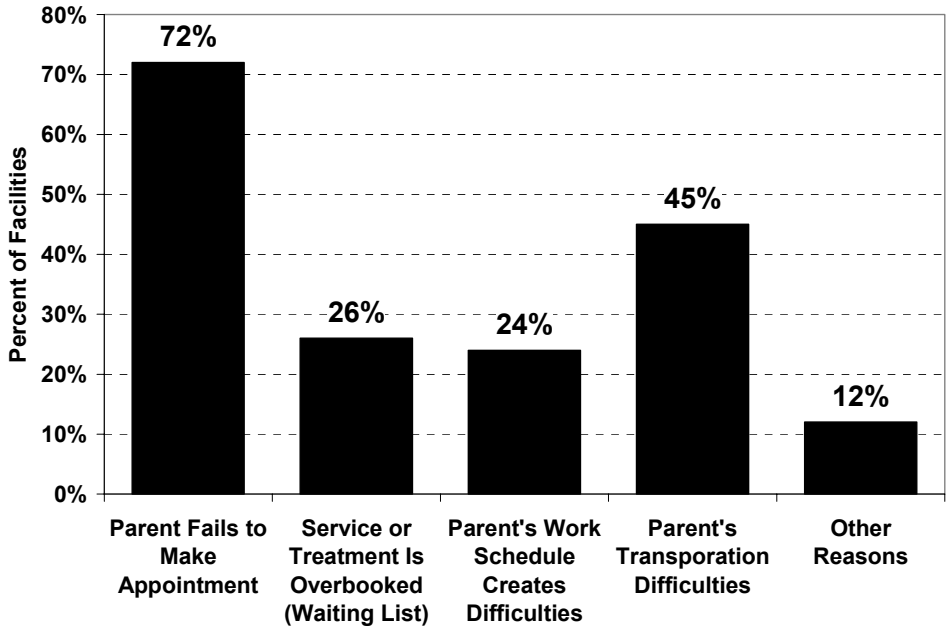


*Other includes the court or Guardian ad litem

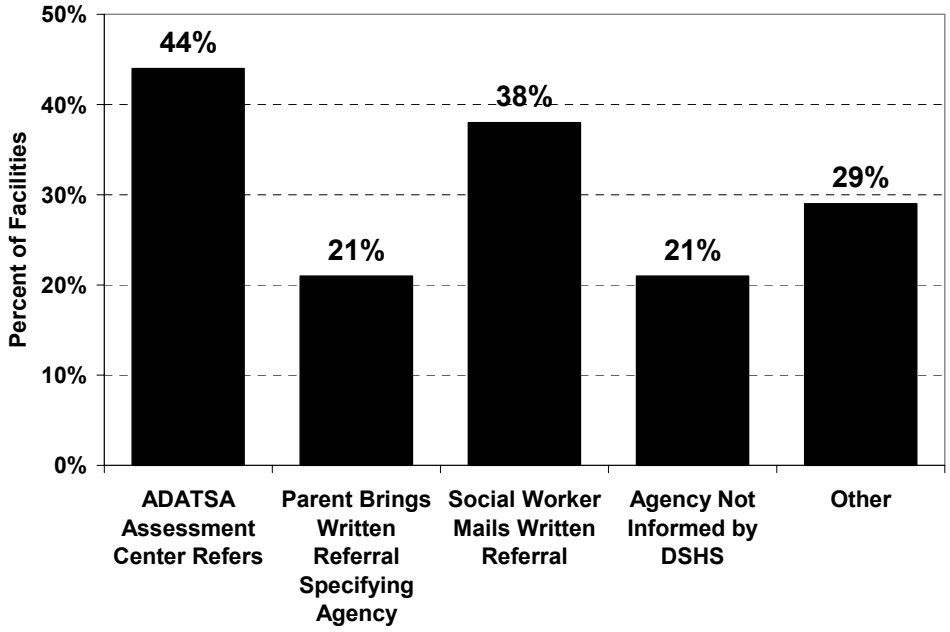
III. CHEMICAL DEPENDENCY TREATMENT

Unless otherwise indicated, the responses in this section refer only to facilities serving parents in child abuse and neglect cases.

If Parents in Child Abuse and Neglect Cases Are Delayed in Starting Services/Treatment With Your Agency, What Are the Reasons for the Delay?



How Are Child Abuse and Neglect Case Referrals Communicated to You by DSHS?



How Does a Parent Referred by DSHS Begin Services With Your Agency?

	Percent of Facilities
Applies for Financial Eligibility at Another Agency	26%
Goes to ADATSA Assessment Center	47%
Makes Appointment by Phone, Fills Out Forms at First Appointment	54%
Applies at the Agency in Person, Later Has First Appointment	32%
Other	11%

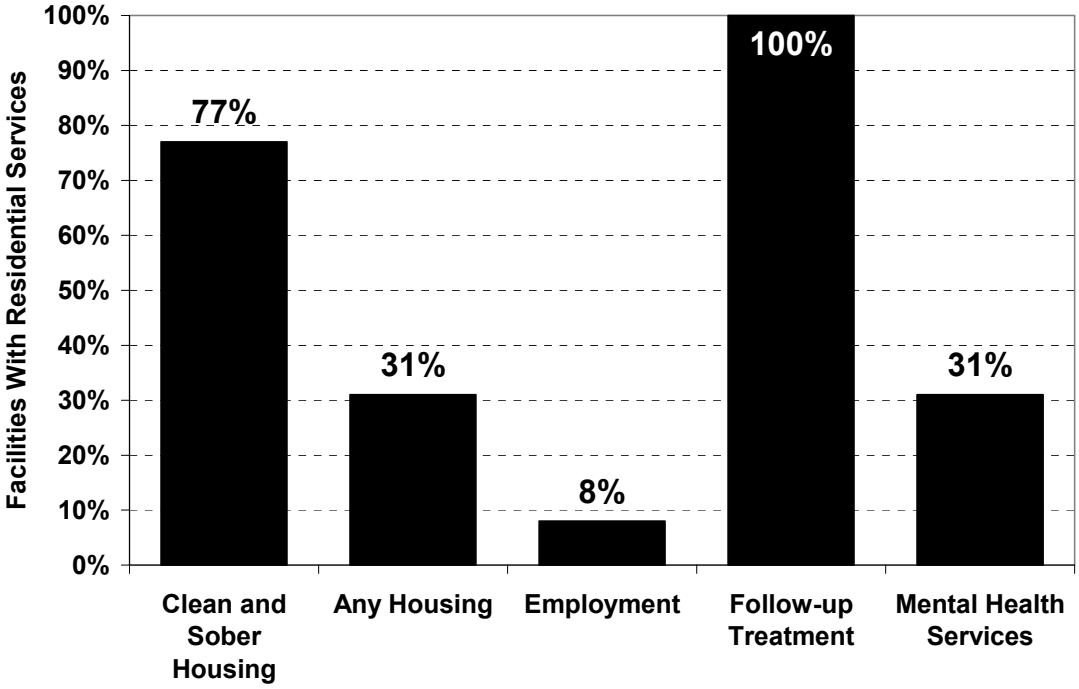
The following table summarizes responses from several questions on chemical dependency treatment modalities. Responses are from among the 85 facilities that are licensed to serve adults and report serving parents in child abuse and neglect cases. Data on wait lists and wait times refer specifically to parents in child abuse and neglect cases. Because parents in child protection cases receive priority for treatment, the wait times reported here may be shorter than waits for other ADATSA-funded clients.

Services	Urinalysis	Intensive Inpatient	Other Inpatient	Residential With Children	Outpatient
Percent Facilities Offering	86%	12% (N=10)	4%	4%	84%
Have a Waiting List	Data not collected	80%	33%	67%	12%
Average Wait Time in Days (Where Wait List)	Data not collected	16	42	43	14
Average Duration of Services in Days	Data not collected	27	63	180	104*

Note: As validated using DASA data.

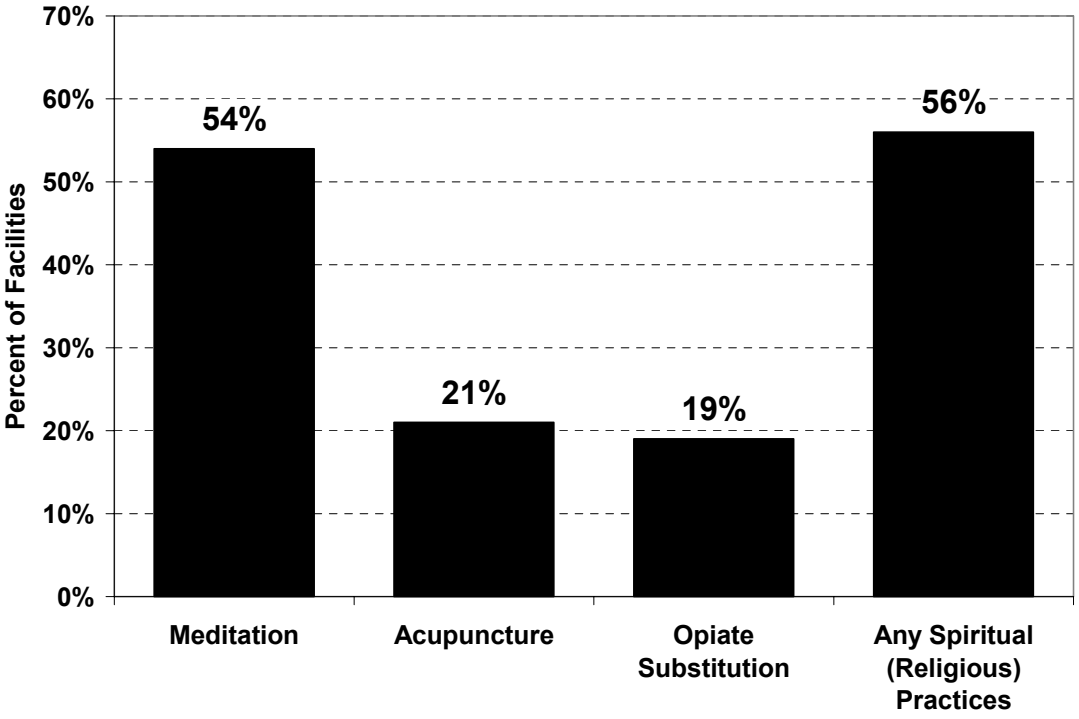
*The duration of outpatient services is ambiguous as the survey question made no distinction between regular outpatient and intensive outpatient services. According to the Division of Alcohol and Substance Abuse, outpatient treatment ranges from 90 to 180 days.

When Clients Are Discharged From Inpatient or Residential Treatment, Which of the Following Services Are *Secured* for Them (Not Just A Referral)?



Only responses from the 13 facilities providing any residential care and serving parents in child abuse and neglect cases

Does Your Agency Incorporate Any of the Following in Its Treatment Program?



Who Pays Your Agency for Services Provided to Parents in Child Abuse and Neglect Case?

	Percent of Facilities
DSHS/DCFS	47%
DSHS/DASA	60%
TASC	6%
Other State Funding	25%
County Funding	54%
Municipal Funding	1%
Parent's Own Funding	64%
Parent's Health Insurance	72%
Grants	18%
SSI	31%
TANF	55%
Other	7%

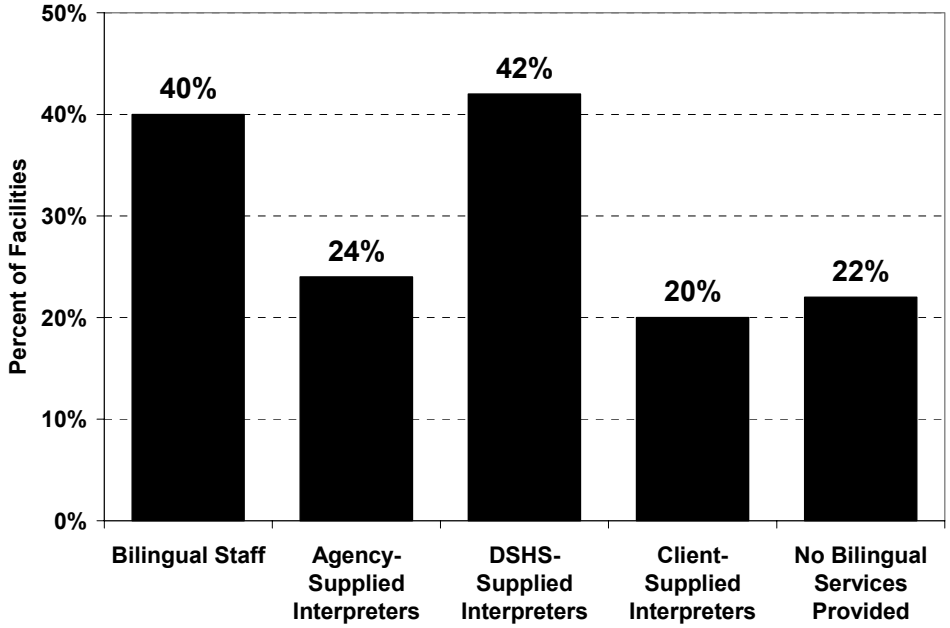
Estimate the Percentage of Your Clients Who Are Referred by DSHS or the Court in Child Abuse and Neglect Cases

	State or County Contract?		
	Yes	No	All Facilities
Median	10%	2%	5%
Average	17%	4%	14%
Range	1% to 100%	1% to 15%	1% to 100%

What Transportation to Your Agency Does DSHS Provide for Clients Who Have Been Referred But Lack Transportation?

	Percent of Facilities
Social Worker	13%
Contracted Transportation Service	40%
Bus Pass	52%
Other	27%

How Does Your Agency Serve Non-English Speaking Clients?



What Are Your Agency's Scheduled Hours of Operation for Outpatient Services and Urinalysis?

	Percent of Facilities
Weekdays, Normal Business Hours	66%
Weekday Evening Hours	59%
Weekends	8%
Appointments Available on Flexible Basis	39%
N/A, No Outpatient Services	0%

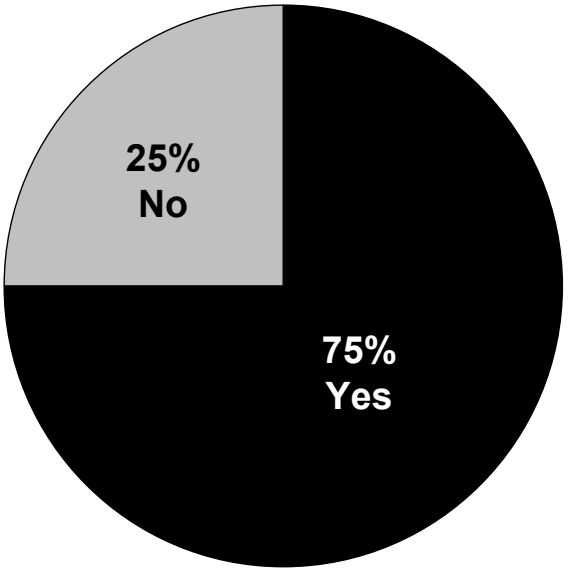
Generally, How Frequently Does an Outpatient Client Receive Services From Your Agency?

	Percent of Facilities
Appointment Every Day (5 Days Out of 7)	11%
Appointment 2 to 4 Times Per Week	68%
Appointment Once Per Week	22%
Appointment 2 or 3 Times Per Month	8%
Other	5%
N/A, No Outpatient Services	8%

Upon Initial Referral, Are You Generally Provided With a Case Summary?

Case Summaries From	Percent of Facilities	Summaries		
		Written	Oral	Written and Oral
Caseworker	45%	53%	27%	20%
Parent	46%	15%	77%	8%
Professional Evaluator	31%	93%	0%	7%
ADATSA Assessment Center	75%	98%	0%	2%

If You Receive Summaries From DSHS Caseworkers,
Are the Summaries Generally Fair, Complete, and Accurate?



How Many Parents in Child Abuse and Neglect Cases Successfully Complete Treatment?

	Percent Successfully Completing Treatment
Less Than 25 Percent	14%
Between 25 and 50 Percent	26%
Between 50 and 75 Percent	34%
More Than 75 Percent	26%

How Does Your Agency Decide a Client Has Completed Services?

Adequate participation for the scheduled amount of time?

- Yes: 98%
- No: 2%

Other?

- 94% of respondents use other criteria.
- 27% of respondents report using the criteria of the American Society of Addiction Medicine (ASAM).

To the Best of Your Knowledge, Will Your Federal, State, County, or Municipal Funding for Services to Clients in These Cases Continue at the Present Level in the Next Year?

		Expect Funding to:		
Funding Source	N/A	Remain Stable	Be Reduced	Be Increased
Federal	31%	43%	23%	3%
State	21%	34%	45%	0%
County	26%	32%	42%	0%
Municipal	70%	4%	26%	0%

IV. OPEN-ENDED QUESTIONS: IMPROVE REFERRAL PROCESS

Agencies providing chemical dependency treatment were asked the following question: ***How can the referral process be improved?*** The answers they provided follow.

Allow individual agencies in Whatcom County to do assessments, thereby ensuring party of referrals. Increased communication between DSHS & DASA licensed treatment facilities via release of information.

One stop shop, fast track.

Improve lines of communication, provide patient checklist of specific steps to achieve, to be initialed/dated by appropriate department or provider, so that there is updated feedback to the caseworker.

A referral form sent to us by DSHS with contact number for patient, we then can follow up.

More treatment providers made eligible by DSHS especially in rural areas, like island communities such as ours.

Send referral and make sure the client contacts in person the service provider.

N/A—DCFS underutilizes our chemical dependency program—"Native American Pregnant and Parenting Women."

Fax referrals and case specific information prior to assessment appointment.

Fax authorization and information.

We already go to CPS or anywhere to do assessment but treatment has waiting list.

Having a DSHS CSO office in Columbia County would be beneficial.

As long as state government dictates CD policy the process will not change.

Develop a standard procedure "statewide" that all DSHS workers "must" follow—have a CDP be on the committee that develops the reporting/referral form.

Do away with ADATSA Assessment Center.

Would be helpful to receive background information. Referral process is working.

A standardized referral state form of four parts sent from CSO. 1. Referral, 2. Assessment 3. Place out 4. Closure.

Direct Referrals.

Make referral by phone from CPS.

We could use more information from the referring agency, to us.

In this small county, coordination goes well because everyone knows each other.

Spokane County has an excellent system already in place.

Works good as is.

A simple initial screening for people who start at CSO so that people who clearly are not appropriate for ADATSA can get into services faster with other forms of funding.

Our agency could actually do more outreach and this is in process now.

Contact collaterals has been slow at times, thus slows down the assessment completion.

DSHS should send referral letter with client's name and telephone number and specify the purpose of the referral.

Referral should contain as much pertinent information regarding client as possible. In particular, known AOD issues.

We need information directly from DSHS caseworker explaining reason for referral and treatment expectations for patient.

Better communications.

It is effective—good communication with DSHS.

Use TANF or other forms to give reasons/signs for referral.

Referral process seems okay, but limited slots for TANF available in Washington.

More phone contact with DSHS case managers would be helpful, especially with new referrals.

Better information about client referred.

Have parents or child call immediately upon referral. Or have caseworkers at DSHS provide intake packet paperwork directly to parent to fill out and submit.

Direct contract with DCFS—fee for service.

Let state certified agencies receiving funds make both the financial and clinical screenings for ADATSA funds.

Continued contact with case workers.

It appears to be working. There is just not enough money for the need.

Faxing information would be good, need to develop secure fax system.

Put CD assessment staff in each CPS unit to assist caseworkers who generally have little training/experience working in CD treatment field (but they think they know how to work with addicts).

Allow Tribal CD providers to do ADATSA assessments.

Sometimes when they don't have proof of medical coverage, takes more time to clear if services are covered by medical coupons.

V. OPEN-ENDED QUESTIONS: OUTCOMES TO EVALUATE SUCCESS

Agencies providing chemical dependency treatment were asked the following question: ***Other than attendance, what outcomes does your agency use to evaluate a client's success?*** The answers provided follow.

ASAM[5]-Step Work-Sponsorship-Support, Living Situation-abstinence.

Urinalysis, attitude towards treatment.

Application of skills to support recovery and prevent relapse, establishment of clean and sober environment that supports recovery, review outcomes for trends and meaningful data that assists in recovery process. Questionnaire discharge surveys.

Outcome studies.

Growth in recovery.

Demonstrated and documented behavior.

Progress in meeting treatment plan goals.

Changes made maintaining abstinence.

Change, collateral reports, ASAM PPC2R[6] criteria.

Compliance, completion, adherence to treatment plan.

Demonstrated integration of learned skills into patient's life.

Changes in off duty activities, change in the patient's readiness for change, or lack of change.

Treatment plan—goals and objectives relating to recovery activity, relationships, job, behavior changed.

Relapse reports, client satisfaction evaluations, depression and anxiety tracking, family evaluations, monthly reports after completion of Phase I weekly reports during Phase I pre and post treatment skill ratings.

Survey in Spanish after completion of treatment, three to six months later.

Sobriety investment in recovery, attitude and honesty.

[5] American Society of Addiction Medicine (ASAM).
[6] Patient Placement Criteria, 2nd Edition, Revised (PPC-2R).

Behavioral changes.

Pre and post test.

Medical testing such as liver function tests, UA's and observation. Talk to significant others.

Behavioral changes, active change and ongoing resource development, self actualization change.

Completion service hours, new legal involvement, employment.

Returned to work/school/community activities. Natural support systems developed.

Attitude/behavior change in family management, school, career, employment, no reoffense, clean UAs, financial stability, social activities or/and hobbies.

Positive attitude, willingness to do whatever it takes for recovery.

Verification of abstinence, employment or school, development of sober social support and reports from other professionals involved with client, i.e. CPS.

Life and social assessment, employment.

Urinalysis, AA support documentation monthly self-evaluation.

Treatment outcomes package psychological assessment.

ASAM PPC criteria.

Compliance with treatment plan.

1) Well established relapse prevention plan, 2) physical, psychological, and behavioral stabilization, 3) increased responsibility taken.

1) Attitude. 2) Psychological profile.

Use ASAM PPC criteria.

No withdrawal symptoms, vital signs within normal limits.

Urine testing, employment or school participation, completion of parenting class.

Growth in relationships, employment, family spiritual, some degree of happiness.

Motivation, work completed.

Outcome management being worked on at this time.

Attitude, behavior, treatment plan completion, follow-through on discharge plans.

Random UA testing, employment, living/support environment, pre-post testing.

Patient feedback.

UA's, group participation, behavior change.

Connection to outside support groups, no longer associating with using friends, completion of treatment goals, attitude.

ASAM placement criteria.

Task completion, willingness to continue in after care or recovery house, sober housing.

12 step involvement, sobriety, abstinence, positive attitude.

Sobriety, compliance with courts, DCFS, decrease in family conflict, decrease in hospitalization.

Homework, participation AA/NA attendance, sponsor.

UA's, outside support network, clean and sober lifestyle changes to include housing, social activities.

Recidivism rates—does patient re-offend?

Clean UA's, 12 step attendance, stability in major life areas.

12 Step Program participation, improvement in life.

Completing goals set on treatment plan such as expanding sober supports.

Treatment plan goals and objectives agreed upon by client and counselor.

Improvement in life domains commitment to ongoing sober support.

Abstinence, external support groups, client report.

Observe behavior and attitude changes.

Active use of multi-faceted community support systems based on individual need.

Lifestyle changes, resolution of chaotic decision making ability, goal setting, involvement in community support services.

Criteria per ASAM PPC-2.

Completion of treatment plan objectives, patients attitude and engagement, patient satisfaction, quarterly chart audit, patients needs get addressed, weekly multiple disciplinary treatment staffing.

Goal and Objective.

Drug Screens, completion of treatment objectives.

Family reports.

Client satisfaction questionnaires, SASSI [Substance Abuse Subtle Screening Inventory], developing others.

Stabilization within dimensions of ASAM PPC-2R, acknowledge understanding and demonstrate need for change.

Social and emotional stability.

Abstinence, application of life skills, improvement of quality of life.

Treatment reviews filled out by patient and counselor.

Personal progress abstinence and A.A.

Participation in sober/recovering community support network programs.

Attainment of objectives.

Treatment plan completion, phase in treatment upon completion.

ASAM criteria.

Employment, clean UA's, improved family relationship.

Attitude.

Social, emotional, behavioral, self reporting.

Abstinence, children reunited, employment or school.

Reunification of families, no use (clean UA's), overall growth, civility and self sufficiency.

Participation, content of group work and self reporting.

Achieving treatment plan goals and objectives.

Outcome Management Systems.

Clean UA's, GED completion, completed levels of program.

Feedback forms from clients and families.

Outcome survey.

Progress towards treatment plan goals.

Improvement in housing, personal relationships, physical health, mental health and overall problems.

Replace support groups, abstinence.

ASAM criteria, negative UA's, withdrawal from medication (methadone), improved lifestyle.

Sobriety, employment, evidence of a program of recovery.

Participation, internalizing, following rules, working towards treatment goals. Interaction with other patients and staff.

Changes in attitude, behavior, thought process, sufficient support system.

Satisfaction survey, therapist opinion of sobriety/stability, community feel both sobriety/stability.

ASAM cross walk—enter and chart changes during treatment. Compare data at entry and discharge. Are they healthier? Happier? Disease in remission? Etc.

Tracking will be implemented.

Self-help group attendance and involvement in group tasks and completed assignments on time.

VI. COMMENTS

This section contains selected comments by chemical dependency treatment providers made throughout the survey.

DSHS pays 52% less than our usual and customary charges.

They [parents in child abuse and neglect cases] are priority population.

Regarding opiate substitution: Client takes dose at Spokane Regional Health District.

We are available to provide services to parents in child abuse and neglect cases but to our collective memory we have never done so.

We have no wait list for inpatient services if they have insurance or private pay.

Successful completion of treatment by parents has been improving with Dependency Drug Court.

Section I, question 13: reviewed with parent, copy provided upon request. Section I, question 13: when requested by parent. Forms enclosed: Priority client rapid response referral for assessment and treatment services and authorization to release confidential information to the Division of Children and Family Services.

Our agency is a for profit treatment center. We do treat some cases of child abuse and neglect, but not through DSHS. Usually these cases come to us by way of Department of Corrections.

Section I, question 6: Do not do DSHS. Section I, question 10: The county program gets the referrals. I have done two assessments in maybe four years and that is because the person refused to go to other program. In both cases the guardian ad litem called to tell me what they wanted me to find instead of doing usual evaluation of patient, because of this I do not deal with those patients. Guardian ad litem thinks they know best!

Section II, question 19: We are ADATSA.

Section II, question 6: Depends on client progress. Section II, question 6: Not a list, but appointments are 4-6 weeks out. Section II, question 9: No list. Section II, question 25: Even if funding is stable, our costs to provide services continue to increase.

Section I, question 13: If they request a copy, most our clients do not have an attorney!! Section II, question 18B: Decreases over time. Section II, question 19A: Brief.

Section I, question 9: emergencies. Section I, question 10: DCFS. Section I, question 13A: DCFS case worker, 13C: when requested, 13D: when requested. Section II, question 1D: if they do not meet criteria for medical transportation. Section II, question

3A: may start at CSO but can apply on-line at our agency. Section II, question 3B: we are ADATSA. Section II, question 10: Family services immediately are implemented!!! Section II, question 11A: if needed. 11C: during IOP [Intensive Outpatient] & OP [Outpatient] com trades and careers. 11E: only by referral. 11F: But we do these referrals if it is an ADATSA we sent to inpatient and or upon intake into our services. Section II, question 12: Our outpatient covers stress reduction practices and support patients in regards to referrals, outside self help. Section II, question 16B: Contract with county. Section II, question 18B: in IOP. Section II, question 18C: in OP. Section II, question 19A: most of the time, yes, sometimes sporadic, written. Section II, question 19B: during assessment. Section II, question 20: No, mostly not complete.

Spokane County is our facility, but there are 14 counties total where the DOC conducts CD treatment. Section I & Section II: None referred by DSHS, not directly anyhow. D.N.A. Section II, question 14: None directly as all of our CD cases come via corrections staff referrals. Section II, question 18: IOP=2-4 x per week. Section II, question 21: No reason to believe any different than overall clientele—A: in prison, B: in community settings.

Section I, question 5: We assess DSHS clients and are paid by the client, not DSHS. Clients pay because they want our services. Section II, question 12D: Christian counseling available to clients who request it.

Section I, question 1: one employee is for one contract.

Section II, question 17B: group only.

Section II, question 9C, D: Intake CLOSED for CNP coupons.

Section I, question 11: We get no additional information.

Section II: DSHS No.

Section I: We are not an approved agency by the state to conduct assessments. Section I, question 6: VA funding is such there is no way to make an intelligent response. Section II: We do not contract with DSHS or the county.

Section I, question 6: We did contract with DSHS/CPS, but they would not pay for services after they were rendered! Section II, question 16: Spanish- and Russian-speaking staff.

Section II, Question 10 E and F: No waitlist, walk-in basis.

Section II, question 19C: OR. Evaluator.

Section II, Question 7E: Usually lose custody.

Section II, question 6B: ASAM Level II.I.

Section II, prior to question 5: The number of months the service of treatment lasts is 6 months. Whether there is a waiting list for service: not if direct referral is made. The

number of people on the waiting list: approximately 150+. The average number of days a client must wait for service: 2 to 10 days.

Section II, question 10C: ADIS is one day and RPG is generally six months.

Section II, question 12D: optional.

Section II, question 17: Outpatient services, weekday normal business hours. Urinalysis, weekdays and weekends.

Section II, question 12D: cultural sweat houses.

Section II: Duration of services: depends on the patient, up to one year of treatment is usual. Average wait is two weeks or less. There is no "waiting list." Section II, question 6C, 7C: sometimes, booked a bed. Section II, question 9B: One week after assessment. Section II, question 11A: When available. Section II, question 17: Outpatient: weekdays, normal and evening hours. UA's 24-7 thru our detox unit. Section II, question 18B: IOP or ADATSA. Section II, question 18C: OP.

We only do adult non-DSHS clients.

Section II, question 17C: Saturday. Section II, question 18A: receive methadone six days a week. 18B: Acupuncture. 18C: Counseling groups. Section II, question 20: do not usually receive.

If the patient is on ADATSA there is a waiting list for intensive inpatient chemical dependency treatment. If private pay for outpatient chemical dependency treatment no waiting list.

We rarely get involved with DSHS-funded cases. Further, we tend to avoid CPS-involved clients due to liability factor and lack of trained staff in such cases.

Section I, question 9: pregnant and or parenting women with a child under five get assessment within 72 hours by law.

APPENDIX A: TARGET POPULATIONS

Target Populations for Surveys of Evaluators and Service Providers

Three different surveys were prepared for providers:

- Service Provider Survey
- Evaluator Survey
- Chemical Dependency Treatment Provider Survey

The Institute was supplied several lists of providers by the Department of Social and Health Services (DSHS) and the Office of Public Defense (OPD). The lists are described below.

The Division of Children and Family Services (DCFS) at DSHS supplied three lists:

1. ***CAMIS*** (Case Management and Information System). This list consisted of individuals and agencies contracted in fiscal year 2002 (July 2001 through May 2002) to provide the following services:

   - Family Reconciliation
   - Early Intervention
   - Alternate Response
   - Home-Based Support
   - Intensive Family Preservation
   - Family Preservation
   - Parent/Child Visit

   Providers of the first three services were eliminated, as they were unlikely to be serving families in dependency cases.

2. ***Mental Health Treatment Providers.*** This list consisted of providers paid by Children's Administration in fiscal year 2002 to provide mental health treatment.

3. ***Evaluators.*** This list consisted of providers paid by Children's Administration in fiscal year 2002 to provide psychological evaluations.

The Division of Alcohol and Substance Abuse (DASA) provided two lists:

1. ***Certified Chemical Dependency Treatment Providers.*** DASA certification indicates to clients, insurers, and the state that the facility meets certain criteria for various treatment modalities. While uncertified providers may offer such treatment, the state and insurance companies are unlikely to pay for such treatment. Because many agencies operate multiple facilities with a single administrator, this list was unduplicated so that each administrator appeared only one time.

2. ***ADATSA Assessment Centers.*** Each county has a single ADATSA assessment center which provides assessment of ADATSA-funded clients and determines the appropriate level of treatment for each client. An exception to the one-per-county rule is Snohomish County, where several treatment facilities are authorized to conduct ADATSA assessments. All but two ADATSA assessment centers also appeared on the DASA list of chemical dependency treatment facilities.

The OPD conducted an informal survey of courts, gathering a list of providers of services to families in dependency cases.

Assignment of Providers to the Three Surveys

In an effort to minimize the effort on the part of providers and maximize survey response, an effort was made to send only a single survey to any given provider. However, there was considerable overlap among the lists. The following rules were used in determining which of the three surveys a provider would receive.

The priority was as follows:

- All providers on the CAMIS list received the Service Provider Survey.

- All providers on either DASA list, but not on the CAMIS list, received the survey for Chemical Dependency Treatment Providers.

- All evaluators not on the CAMIS list nor on either DASA list received the Evaluator Survey.

- All remaining providers from the DSHS list of mental health providers and the OPD list received the Service Provider Survey.

APPENDIX B: SURVEY QUESTIONS

This appendix lists the questions asked of chemical dependency treatment providers.

Section I

Does your agency conduct chemical dependency assessments?

Q1. Is your agency certificated by DSHS to conduct ADATSA assessments?

Q2. How long has your agency been performing chemical dependency assessments?

Q3. What credentials are held by staff who perform chemical dependency assessments?

Q4. On average, how long have assessment staff been performing chemical dependency assessments?

Q5. What percentage of your agency's assessments consist of DSHS-funded clients?

Q6. How much are you usually paid for a typical chemical dependency assessment of DSHS clients?

Q7. How are you advised when DSHS refers a new client to you for a chemical dependency assessment?

Q8. In general, how long after parents are referred by the Community Service Office (CSO) do parents contact your agency?

Q9. Once a parent in a child abuse and neglect case has contacted your office, what is the average waiting period for an assessment appointment?

Q10. When parents in child abuse and neglect cases are referred to you for assessment, what information do you generally receive?

Q11. In general, how often is the following information helpful to you in your assessment?

Q12. After the initial appointment, what is the average amount of time it takes to complete an assessment?

Q13. In child abuse and neglect cases, the completed, legally mandated chemical dependency assessment is sent to the following individuals or entities.

Section II: Complete this section only if you contract with DSHS or your county as a chemical dependency treatment facility.

Q1. If parents in child abuse and neglect cases are delayed in starting services/treatment with your agency, what are the reasons for the delay?

Q2. How are child abuse and neglect case referrals communicated to you by DSHS?

Q3. How does a parent referred by DSHS begin services with your agency?

Q4. How can the referral process be improved?

Q5. Urinalysis

For Q6 through Q10, if you provide the service, please indicate:
The number of days, weeks, or months the service or course of treatment lasts;
Whether there is a waiting list for the service;
The number of people on the waiting list; and
The average number of days, weeks, or months clients must wait for the service.

Q6. Intensive Inpatient Chemical Dependency Treatment

Q7. Other Residential Chemical Dependency Treatment With No Accommodations for Children

Q8. Other Residential Chemical Dependency Treatment With Accommodations for Children to Stay With Their Parents

Q9. Outpatient Chemical Dependency Treatment

Q10. Other Services

Q11. When clients are discharged from inpatient or residential treatment, which of the following services are *secured* for them (not just a referral)?

Q12. Does your agency incorporate any of the following in its treatment program?

Q13. Who pays your agency for services provided to parents in child abuse and neglect cases?

Q14. Please estimate the percentage of your clients who are referred by DSHS or the court in child abuse and neglect cases

Q15. What transportation to your agency does DSHS provide for clients who have been referred but lack transportation?

Q16. How does your agency serve non-English speaking clients?

Q17. What are your agency's scheduled hours of operation for outpatient services and urinalysis?

Q18. Generally, how frequently does an outpatient client receive services from your agency?

Q19. Upon initial referral, are you generally provided with a case summary?

Q20. If you receive summaries from DSHS caseworkers, are the summaries generally fair, complete, and accurate?

Q21. Estimating your agency's experience, how many parents in child abuse and neglect cases successfully complete treatment?

Q22. How does your agency decide that a client has completed services

Q23. Other than attendance, what outcomes does your agency use to evaluate a client's success?

Q24. Please briefly describe your agency's most challenging issue in providing service(s) to parents in child abuse and neglect cases.

Q25. To the best of your knowledge, will your federal, state, county, or municipal funding for services to clients in these cases continue at the present level in the next year?

Q26. May we contact you again about this survey?