Service Provider Survey:
Summary of Survey Questions and Answers

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Washington State Institute for Public Policy

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WASHINGTON STATE INSTITUTE FOR PUBLIC POLICY

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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 services other than chemical dependency 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)

Who Was Surveyed?

The population for this service provider survey was derived from two lists supplied by DSHS's Children's Administration: one was a list of all providers paid for mental health treatment in the past year, the second a list of providers contracted to supply specific family support programs. In addition, the Office of Public Defense created a list through an informal survey of courts. Every effort was made to eliminate any provider who also appeared on the lists of chemical dependency treatment providers and of professionals and agencies paid for psychological evaluations. (See the Appendix for a more complete description of this population.)

Questionnaires were mailed to 563 providers. Of these, 89 were returned as undeliverable. A total of 177 were completed and returned, for an overall response rate of 37 percent.

A preliminary version of the survey was sent to 50 providers on August 12, 2002. A revised version was mailed to the remaining 513 providers on September 5, 2002. This report summarizes the 177 completed surveys returned from both groups by October 14, 2002.

Highlights

- Providers nearly unanimously report receiving case summaries upon referral of new clients. Most (95 percent) report the summaries are fair and accurate.
- Of respondents who have previously served DSHS clients who are parents in child abuse and neglect cases, 14 percent are no longer serving DSHS clients.
- Among providers receiving state or federal payments, about half expect their government funding to remain stable while the other half expect the funding to be reduced in the next year.

A summary of responses to each of the survey questions is provided in Section II. Section III includes responses to open-ended questions and comments.

II. SUMMARY OF SURVEY RESPONSES

Providers were asked questions about ten different services. This section is a summary of those responses.

Q1. Formal Explanation of the Dependency Process (e.g., Dependency 101)

	Percent or Median[3]	Range
Percent of agencies providing this service.	5%	
What is the average duration of this service?	87 days	1 – 545
Percent of agencies with a waiting list, among providers only.	12%	
How many clients are on your waiting list at this time?	0	0 – 18
How long, on average, do clients wait to receive this service?	0 days	0 – 30

Q2. Psychological Evaluation

	Percent or Median	Range
Percent of agencies providing this service.	20%	
What is the average duration of this service?	7 days	0.5 – 120
Percent of agencies with a waiting list, among providers only.	18%	
How many clients are on your waiting list at this time?	0	0 – 40
How long, on average, do clients wait to receive this service?	0 days	0 – 60

Q3. Mental Health Treatment or Counseling

	Percent or Median	Range
Percent of agencies providing this service.	64%	
What is the average duration of this service?	180 days	3 – 730
Percent of agencies with a waiting list, among providers only.	14%	
How many clients are on your waiting list at this time?	0	0 – 15
How long, on average, do clients wait to receive this service?	0	0 – 365

Q4. Parenting Classes

	Percent or Median	Range
Percent of agencies providing this service.	38%	
What is the average duration of this service?	63 days	1 – 1,080
Percent of agencies with a waiting list, among providers only.	13%	
How many clients are on your waiting list at this time?	0	0 – 25
How long, on average, do clients wait to receive this service?	0 days	0 – 90

[3] 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.

Q5. Subsidized Housing or Housing Referral Services

	Percent or Median	Range
Percent of agencies providing this service.	18%	
Percent of agencies with a waiting list, among providers only.	31%	
How many clients are on your waiting list at this time?	0	0 – 2,400
How long, on average, do clients wait to receive this service?	0 days	0 – 611

Q6. Home-Based Support Services

	Percent or Median	Range
Percent of agencies providing this service.	36%	
What is the average duration of this service?	180 days	1 – 1,095
Percent of agencies with a waiting list, among providers only.	8%	
How many clients are on your waiting list at this time?	10	1 – 18
How long, on average, do clients wait to receive this service?	0 days	0 – 365

Q7. Intensive Family Preservation Services

	Percent or Median	Range
Percent of agencies providing this service.	13%	
What is the average duration of this service?	90 days	30 – 365
Percent of agencies with a waiting list, among providers only.	17%	
How many clients are on your waiting list at this time?	4	0 – 18
How long, on average, do clients wait to receive this service?	0 days	0 – 30

Q8. Family Preservation

	Percent or Median	Range
Percent of agencies providing this service.	30%	
What is the average duration of this service?	180 days	3 – 365
Percent of agencies with a waiting list, among providers only.	13%	
How many clients are on your waiting list at this time?	0	0 – 18
How long, on average, do clients wait to receive this service?	0 days	0 – 365

Q9. Transporting Parents or Children for Ordered Services

	Percent or Median	Range
Percent of agencies providing this service.	13%	
What is the average duration of this service?	180 days	1 – 730
Percent of agencies with a waiting list, among providers only.	4%	
How many clients are on your waiting list at this time?	0	0 – 10
How long, on average, do clients wait to receive this service?	0 days	0 – 7

Q10. Visitation Services (i.e., facilitating parent-child visits)

	Percent or Median	Range
Percent of agencies providing this service.	22%	
What is the average duration of this service?	180 days	7 – 730
Percent of agencies with a waiting list, among providers only.	13%	
How many clients are on your waiting list at this time?	0	1 – 25
How long, on average, do clients wait to receive this service?	0 days	0 – 90

Q11. Other Services Not Listed in Survey

Percent of agencies providing other services: 58 percent

The most common other services include child care, family reconciliation, anger management/domestic violence treatment, advocacy for victims of sexual assault or domestic violence, and crisis line.

Q12. Where are your agency's services provided?

In client's home	54%
In agency facility	80%
Other	42%

Q13. What are your agency's scheduled hours of operation?

Weekdays, normal business hours	81%
Weekday evening hours	47%
Weekends	22%
Appointments available on flexible basis for working clients	58%
Residential (24 hours a day, 7 days a week)	8%

Q14. Generally, how frequently do clients receive services from your agency?

Appointment almost every day (5 days out of 7)	18%
Appointment 2 to 4 times per week	12%
Appointment once per week	50%
Appointment once every two weeks	14%
Residential (24 hours a day, 7 days a week)	6%

Q15. Are there written rules and policies for participation in services at your agency?

Yes	58%
No	42%

Q16A. In the past 12 months, has your agency provided services or treatment to parents in child abuse and neglect cases (i.e. referred by Child Protective Services)?

Yes	72%
No	28%

Q16B. If not in the past 12 months, have you EVER provided services to parents in child abuse and neglect cases?

Yes	48%
No	52%

Q16C. Why do you no longer serve these clients?

DSHS no longer refers	50%
Compensation in these cases is too low	20%
Agency funding reduced	5%
Dealing with DSHS and the courts is too complicated	10%

(Providers no longer serving parents in child abuse and neglect cases were instructed to skip to the comments section at the end of the survey.)

Q17. Please estimate the percentage of your clients who are referred by DSHS in child abuse and neglect cases.

Median	18%
Average	37%
Range	0.15 – 100%

Q18. In child abuse and neglect cases, who pays your agency for services provided to parents?

DCFS (Children's Administration) of DSHS	72%
Division of Alcohol and Substance Abuse (DASA) of DSHS	6%
Other state funding	27%
County funding	11%
Municipal funding	6%
Parents' own funding	24%
Insurance	16%
Grants	26%

Q19. What transportation to your agency does DSHS provide for clients who have been referred but lack transportation?

Social worker	27%
Contracted transportation service	25%
Bus pass	37%
Other (please specify)	23%
Not applicable/services provided in-home	9%
Foster parents	4%
Volunteer drivers	2%

Q20. How does your agency serve non-English speaking clients in these cases?

Bilingual staff	24%
Agency-supplied interpreters	31%
DSHS-supplied interpreters	20%
Client-supplied interpreters	14%
No bilingual services provided	15%
No non-English speaking clients	32%

Q21. In general, how long after a DSHS referral is made do clients contact your agency?

Don't know	27%
7 days or less	46%
1 week to 1 month	26%
1 to 2 months	1%
2 to 3 months	0%
Over 3 months	0%

Q22. If clients are delayed in starting services/treatment with your agency, what are the reasons for the delay?

Clients' failure to make appointments	76%
Service or treatment is oversubscribed (waiting list)	14%
Difficulty setting appointment due to clients' work schedules	38%
Clients' transportation difficulties	30%

Q23. How are case referrals usually communicated to you by DSHS?

Clients bring written referral specifying agency (please attach sample)	6%
Social worker calls to schedule first appointment for clients	42%
Social worker calls to advise agency of referral or mails written referral	60%
Agency not informed by DSHS	16%

Q24. How does a client referred by DSHS begin services with your agency?

Makes appointment by phone, then fills out forms at first appointment	92%
Comes to this agency in person to apply, then later receives first appointment	16%
Goes to another agency to apply for eligibility for services from this agency	8%

Q25. See Section III for responses to this open-ended question.

Q26. Upon initial referral, are you usually provided with a case summary?

	Percent Saying Yes	Oral	Written	Both Oral and Written
By the caseworker	77%	42%	24%	34%
By the parent	68%	80%	6%	15%
By a professional evaluator	29%	5%	80%	15%

Q27. Are initial case summaries useful to you?

Yes	96%
No	4%

Q28. If you receive summaries from DSHS caseworkers, are the summaries generally fair, complete, and accurate?

Yes	92%
No	8%

Q29. Estimating your agency's experience, how many DSHS clients successfully complete services?

More than 75%	36%
Between 50% and 75%	41%
Between 25% and 50%	17%
Less than 25%	6%

Q30. Estimating your agency's experience, of DSHS clients who complete the services, what proportion correct their targeted deficiency/problem?

More than 75%	24%
Between 50% and 75%	49%
Between 25% and 50%	23%
Less than 25%	3%

Q31. How does your agency decide that a client has completed services?

Adequate participation for the scheduled amount of time	58%
Other	63%

Q32. See Section III for responses to this open-ended question.

Q33. When you are serving a parent in a child abuse and neglect case, do you normally file progress reports with DSHS or the court?

Yes	77%
No	23%

Q34. See Section III for responses to this open-ended question.

Q35. 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:			
	N/A	Remain Stable	Be Reduced	Be Increased
Federal	49%	26%	25%	0%
State	17%	39%	42%	1%
County	50%	23%	27%	0%
Municipal	60%	14%	25%	1%

III. RESPONSES TO OPEN-ENDED QUESTIONS

The following are responses to open-ended questions. Identifying information has been omitted.

Q25. How can the referral process be improved?

DSHS social workers are overworked with multiple responsibilities and staff cuts. Referrals not being made also because of call centers.

The cost for a DSHS patient is three times, courts one to one, problems for payment—have changed social worker and we do not get paid.

Give treatment time frame (e.g. within seven days) to make appointment at agency.

We can service more clients at this time. Most social workers are fairly fast in responding, however some don't return phone calls and have trouble following through with billing.

Social worker calls when referring client and verifies payment for services.

Direct contact with case workers.

Case workers realizing availability and helpfulness of neurofeedback treatments. Effects are permanent long term.

Who knows, now that CPS intakes are centralized? Intake persons wouldn't know community, so there might be a lack of trust.

Written information always provided at time of referral, both background and a written letter requesting services and clear information on what will be expected outcomes or evaluations.

Be sure referral includes address, phone number, written synopsis of family deficits and case worker expectations.

Receiving information by mail.

Current process seems to work well.

More subsidy. Board could consider a preference for families in this situation.

Great communication between WSU resources.

I would like to see a paper referral put in place.

Referral process is fine.

It seems to be working well when the social worker calls prior to the client calling.

In Chelan and Douglas County we have excellent communication with DSHS staff.

The client being escorted by social worker to my office for the first visit has worked out the best.

It's OK.

Regular contact between agencies.

I feel it works efficiently as is.

It works very well here in Yakima. Our problem is the severe cut backs on referrals and pressure for clients (court ordered) to see only medical coupon providers—enormous waiting list in Yakima.

If DSHS sees a client with chronic mental illness unable to manage independently they can contact us directly.

Shorten the 10 day period clients have to make contact. Case workers call to set up appointment while client is with them.

Social workers could give agency information to parents and foster parents to speed up coordination period. More information about the case on the referral.

Works great now!

By making referrals earlier in the sequence of deescalating behaviors.

The social workers could complete the referral forms.

If DSHS-DCFS providers would fill out the referral forms completely, otherwise the process works very well in our small rural DCFS office.

It's pretty good, we're very small.

DSHS could contract with our agency to handle the client load of parents who abuse/neglect their children.

Sending referrals form to agency which specifies need and or call to find out if we can actually provide the appropriate service.

DSHS worker calling for referral/appointments with client present so that more information can be obtained and a commitment to therapy.

DSHS social worker can sit with client while client makes the necessary call for intake appointment. Social worker cannot do the call for the client.

Clients in our counties could take responsibility for calling PHN.

We haven't had a referral from DSHS in quite some time. Apparently they have no money to pay for the service.

Sustain a live-contact person during first phase of treatment. (Last child, I went through three case workers while we attempted intakes and payment flow.)

Sometimes we have no idea if client has been referred by DSHS even if we ask the client how they heard about our services.

Type referral, complete information, update information (foster home phone numbers), standard referral form.

Explicit written referral letters. Upfront sharing of relevant records example—past mental health treatment evaluations.

Generally, it is not too bad. I would like a written case summary along with goals that DSHS would like.

The DCFS worker should schedule the first appointment with the agency and client present. This insures that all are on board and know what is expected.

Client's attorney (usually public defender) needs to become the coordinator with DCFS in referring the client and arranging transportation.

I've been pleased with the referral process thus far. Communication with DSHS staff has been good to responding to referred clients' needs.

Referring social worker can fax client referral and information immediately after therapist agrees to take case.

Authorization for client to see me be done sooner because I am not to start before written authorization is in my possession.

It works well how it is.

Educate staff on intake requirements as mandated by OCAR, DSHS, i.e. data needed for all referrals.

Seems to be working pretty well with DCFS worker, group home staff or parent/guardian calling to see if I have an opening for SAY referral.

In our community it seems to work well.

DSHS could provide transportation.

DCFS do a better job of educating clients regarding the referral. DCFS making appropriate referrals based on statement of work.

Oral referral to intake, then initial discussion between social worker and therapist prior to client's appointment to discuss goals for referral to counseling with social worker, would help to maintain what social worker expects, what therapist can/will do and client expectations and limitations.

Forms could be forwarded to DSHS case worker prior to first appointment.

It works very well as it is now.

Eliminate need for PCP to seek referral—allow specialty agency to seek directly on their own.

Process works for this agency.

More accurate and front-end identification by DCFS of Native American clients.

I'm not on the referral list.

Increased information from social worker. Clarification of who has custody. Referrals on basis of expertise of counselor, not on basis of who is favored by caseworkers or supervisors.

No improvement necessary at this time.

Obtain release of information from client to our agency before referring.

Greater communication with DCFS case worker!!!

Works well.

By providing transportation or buses—but we are rural and that has not happened.

Difficulties with providing service encountered when clients don't have a phone.

CPS/DCFS workers link clients with our services before closing a case.

More information provided to nurse from DCFS—they need to check out referrals a little more thoroughly.

Just make sure clients are given my cell phone number as well as my name, then have them either call me directly or leave a voice mail message.

Our principal referral route is via foster parents, and they do a pretty good job.

More information about the client provided by DSHS before services begin.

Of our clients with CPS cases usually we receive zero information regarding the case. More info would be helpful.

Transportation problem worked out at time of referral.

DSHS could bring client to office.

It works fine.

Caseworker and social works (through exploring alterative support services) make referrals. They just need to utilize service.

Q32. Other than attendance, how does your agency evaluate a client's success?

Goals are set to be measured by client, client self-report, therapist report.

Written plan for care.

Client satisfaction surveys, knowledge inventories.

Use of the tools of treatment.

Personal evaluation and psych evaluation.

Homework, negative urinalysis, no new charges, violations, etc.

Participation, homework assignments, psych testing, standardized procedures, checking for real change.

Participation.

Outcome reporting, increase in stability of family.

Progress in goals.

We don't.

Evaluation instruments, staff review.

Change in behavior, TOUA test issues check list change, how child feels, school reports, grades, successes, school peer report.

Their subjective response; at times testing.

Clinical judgment.

By keeping appointments, healthy family members, ability to set goals and follow to completion.

Specified outcomes in the DSHS service plan.

Changes in behavior, outcomes, court approval, etc.

Concrete measurable goals that specifically note abuse and neglect in specific domains and demonstrates improved nurturing with specific behavior.

Information is gathered from school, parent, foster parent, case worker, doctor, etc. as to the changes in the child's behavior.

Behavioral goals met, treatment goals met.

Verbal from family and client.

Progress made on action plan.

Pay rent in a timely manner, no lease violations, report changes promptly, able to eventually pay their own rent.

Evaluation Treatment plan completion.

Completion of hands-on activities.

By monitoring service plan with goals and objectives set by social worker and client.

Reduction in behavioral, emotional, and academic difficulties.

Treatment goals reached by client.

Demonstration of change in behavior in a consistent manner.

Compliance with treatment.

By achieving treatment goals.

Sufficient behavioral changes to have the child live with them again.

Review specified goals and revise goals as needed.

Abstinence, response to program objectives.

Documented observed parenting improvement. Collateral reports.

Identified goals met.

Self report.

Compliance with DCFS/court mandates. Client demonstrates willingness to participate and demonstrates change.

Client reports, reports from other agencies.

Behavior change.

Success in addressing concerns and progress toward provision of/for child's physical and emotional needs, processed trauma events toward positive resolution.

Ability and progress in changing behaviors that caused them to abuse or neglect their children.

Ongoing evaluations of independent living skills.

Performance skills standards.

Attainment of goal, or progress towards goal attainment.

The social worker initialized our reports to evaluate client processes in parent-child relationship. Contract does not allow agency to evaluate.

Behavior and ability shown to apply skills learned.

No evaluation process, we make recommendation.

Lack of referrals to other agencies.

Evidence of improved skills.

If they meet the outlined goals and objectives with the children remaining safely and happily in their homes.

Monthly review.

The level of participation needs to meet therapists perceptions that client is benefiting from information provided. Homework/participation in groups. Verbal quizzing by therapist as to the level of understanding of materials presented, self reports from life skills homework, feed back from the group to the client.

Through the actual work client does to improve cognition and behavior. Goals are set and client takes the steps to complete.

Client makes goal plan, then progress is followed and completion tracked.

Treatment goals completed, family, DSHS and other supports providing feedback and agency outcome measure.

Completion of treatment goals.

Completion of goals, social work, parenting plan completed.

Collaborating party reports, affect, written work, etc.

Case worker feedback.

Evaluation of treatment goals, team discussion with other involved agencies.

Outcome evaluation—a pre and post test, client's individual goals evaluation, and a set evaluation.

We do not make that decision.

Completion of goals, participation in program goals.

Have they met their goals, period of time without re-offending, one year sobriety.

Active participation in treatment and candid disclosure in evaluation.

Client's functioning in the world.

Behavioral changes, positive actions.

Compare behavior to treatment goals and lifestyle changes occur.

Completion of effort in providing all history data and access to current sources of information.

Treatment goals achieved.

Progress measured through goal setting and assessment.

Measurable progress regarding treatment goals established at beginning of service.

Change in behavior, goals achieved.

Client reaches goals mutually agreed upon by therapist and client.

Observation of client and completion of tests set by DSHS and courts.

Goals accomplished.

Evaluation by therapist. Not using further services within next twelve months.

Their interactions with their children, their ability to be a safe, mature and loving parent.

Youth has demonstrated the specific skills or behavior we have focused on in treatment. The SAY youth is demonstrating in key areas of his life (family, school, peers) that they are not engaging in specifically, sexually inappropriate behavior or generally antisocial behavior.

By meeting treatment goals.

Completion of treatment plan goals, reunification or adoption placement finalized, client report and parent report.

Improved parent child interaction as evidenced by test scales and observation.

Initial and secondary treatment goals met by client. Subjective experience of the client, objective information, observation, use of testing materials, etc.

Concrete goals.

Psychometrics, which measures particular symptoms, i.e. mood, anxiety, behavior, AND client meets goals developed by themselves and DSHS.

Clinical ways are change in caliper reading, number of times purging, and change in food pattern.

Increased reflective surroundings, integration of teaching into relationship with child.

Decrease in presenting symptom and increased functioning in community.

Based on court compliance.

Completed family goals. We do what we can within the basic health 12 sessions a year benefit.

Treatment plan, client reports, stability—lack of need for renewed services after termination of therapy.

Outcome surveys, treatment plan review.

Various measurement tools required by funders, as appropriate for service delivery needs.

Better behavior—self report.

Outcomes related to treatment plan goals.

Client met goals set by him/herself.

Many ways—client is involved in treatment plan process—provides feedback on work areas—assessments are offered, etc.

Progress towards goals regarding getting custody of child.

Set goals, completed counseling, changing patterns.

Does behavior match verbal comments?

Observation—parent's behaviors with children, children's functioning in school and with peers.

Use of polygraphs, plethismographs, also completes assigned work, stays within structure of the outlined program.

Progress compared to service plan.

Follow up into other services or agencies.

Evidence of improved functioning, such evidence can be gleaned in a variety of ways.

Obtaining objectives set during treatment planning.

Progress in mastery of initial goals for treatment.

Self reports, family reports, testing assessments.

Written surveys.

Meeting goals established in their treatment plan.

We use an outcome evaluation for support groups and those receiving legal advocacy.

Goal achievement and symptom reduction.

Performance at school.

Goal attainment. Adequate reduction of risk factors.

When they meet the family goals they set for themselves.

Measurable changes in behavior accessing additional supports and participating in work programs.

Q34. Please describe your agency's most challenging issue in providing services(s) to DSHS-referred clients in these cases.

Conflict within agency and past providers, cases are transferred so often that providing continuity can be very difficult.

Clients are referred to our service by DCFS, DSHS & court systems, but they are not the primary funders. We have to find funding elsewhere to keep services going.

Walk the talk.

The initial connection—bonding with the client. Helping the client understand how services will benefit them and family. Helping them want to return.

Initially getting them started and termination of jurisdiction before client has completed treatment.

Client does not show up for service or drops before completing.

Follow through by clients.

Lack of communication and follow through by DSHS.

Sometimes the client does not follow through.

DSHS child adoptive services awareness of our service.

Unplanned, abrupt changes in funding or placement disrupt services.

Mental health issues.

Getting stakeholders invested and bought into plan.

Providing mental health counseling for children. Very difficult with Family Preservation Clients—long waiting lists—bad or ineffective services—no consistency with providers.

Denial on part of clients, case workers who are cynical, lack of professional qualifications and training for case workers.

No return phone calls, long delays in payments for services, difficulty getting necessary information.

Payment is sometimes months behind.

Finding safe housing.

Follow through by the family and communication between agencies serving the clients.

Clients unhealthy, refuse to engage in services.

Money to conduct classes/programs, distance in rural-isolated areas, communication.

Cut back of services for long-term referral after our six month termination.

Cooperation of client to meet timelines and treatment goals.

Scheduling appointments to meet the working parents' schedule.

Social workers who DO NOT do their job.

Transportation; no shows.

DCFS attempted to micro-manage my practice. While I love working with foster kids, foster parents, DCFS workers, DCFS management was unacceptable.

Lack of funding for transportation, psych evaluations, no interactive parenting classes in King County, poor documentation cooperation from drug and alcohol treatment programs, no case aides—programs available for visitation on weekends on a regular basis.

Families reluctant to engage.

Coordination of services, willingness of social worker and other service providers to work cooperatively.

Parental drug use, residual effects on parenting and parent child relationships, relapses.

No information regarding background.

They don't show up. Lately they aren't referred as often, but get on big long waiting list at non-profit agencies.

Haven't had DSHS-referred clients. Our residential clients have, coincidently, been involved with these issues.

Lack of motivation by client.

Because we are not a designated mental health provider, we cannot accept medical coupons, which would allow us to serve more people.

Lack of timely payment. Insurance requirements are large part of budget. Transportation liability when transporting children. Lack of foster parent involvement.

The clients' denial that they did/are doing anything wrong.

Sometimes it is timely payment. Some workers take over 90 days for payment.

The grave seriousness of many issues, especially if several children are involved, not enough resources of any kind.

Getting paid for all the work involved with providing the service.

When clients live either very far away or in hard to reach mountain areas with no phone, or when clients really do not want services because they are angry at CPS.

Initial engagement and compliance by client.

Co-morbidity of mental health/substance abuse which we address through coordinated efforts with other programs in our agency or with outside agencies. With DSHS it is getting paid for services provided to clients.

In domestic violence cases one must keep all our clients' records confidential to protect the victim, however if any information comes up regarding additional child abuse "imminent risk of danger," we honor our mandated duty and report.

Parent active involvement.

Client willingness to continue services long enough to complete treatment goals.

Lowest paying work we do with highest amount of collateral (unpaid) work necessary. Don't know how long we will keep the contract at this rate.

Communication with the right people—finding someone who cares.

Providing mental health services to kids and families who are not able to meet their own basic and safety needs.

Often clients are resistant to begin with and often they don't follow through and complete services.

No call backs from parents, update information, not enough information on case.

Transportation of children in foster care, parents' participation.

Communication. Even with releases, they refuse to share information.

Misunderstanding of clinical role by DSHS/DCFS including attribution to therapist of case worker or case management duties.

Sometimes what a parent, court or DSHS plan wants is incompatible. Some case workers expect perfection, rather than adequate or appropriate.

The worker's lack of knowledge and training as to all facets of child abuse (i.e. sexual, physical, neglect).

The continued adversarial problems and manipulation by attorneys, caseworkers, supervisors, clients, and other treatment providers and professionals in the case—everyone has their version of what they demand to be the truth—if you do not give it they retaliate.

1. Long standing problems, limited ability, nothing for clients. 2. Fluctuation in funding, referrals impacting program stability.

None have been referred.

As a private practitioner providing services to DSHS referred clients, I don't have any particular issues unique to these clients.

Client's behavior and compliance.

Paperwork.

Excess paperwork, getting written authorizations, too much for clients to successfully complete in time given.

Making initial contact and gathering information.

Getting paid for services in a timely manner.

Trying to teach them good parenting skills when they have no history of receiving good parenting and or have a mental illness.

With my SAY youth, it is very difficult getting early accurate histories of what child has experienced by way of SA/PA/EA or also periods of healthy parenting.

Working with poorly trained or new case worker. There are several workers in the local office who are doing well, but some that should not be case workers. Also, there are times when individuals in the local office do not work well with the community and seem to take an "us" against the rest of the community.

Court appearances and getting appropriate authorizations.

Repeat offenders and appropriateness of referrals.

Clients lack of follow through, limited progress, relapse, client unprepared to attend treatment by referral.

Parents are going thru the hoops and don't want to participate.

Foster parents "forgetting" appointments, decisions being made by DSHS without input from therapist.

Client lack of motivation initially. I'm seen as part of CPS.

When the client turned eight, no services for disordered eating are available.

The system is not focused on the needs of the children.

Authorization, lack of DSHS employees being clear about who serves mental health patients through which agency, i.e., community MHC or all ADATSA, GAX coverage.

Not required to participate with tribe.

No direct referral.

No accountability or reimbursement for no shows, court reports, low reimbursement rate, lack of adequate authorized visits.

Confidentiality issues—our agency's policies and DSHS policies.

Communication, specific documents required, engagement of client, chronic problems have too short of time frame.

Lack of funding to assist in doing all that would be helpful or beneficial. We are, however, pleased with our success rate due to phenomenal cooperation among agencies and organizations.

Not getting adequate information from worker—everyone is too busy.

Not enough communication from DSHS to AYR (Community Service Provider) around any issue.

Lack of understanding of relevant confidentiality laws; lack of understanding of our client empowerment philosophy.

LACK OF COMMUNICATION!!!

Getting clients to keep appointments.

Clients not following through.

Dealing with parents who are unable or unwilling to cease alcohol or drug use.

Referral lacks linkage effort, clear expectations and consequences of lack of follow through.

Level of service required is unclear. Need more specifics.

Can't think of any at present time. DCFS referrals have "dried up." I do some occasional work for DV.

Massive turnover in caseworkers. Lack of responsiveness by case workers.

I have provided very few services—recent case went well.

Getting paid promptly. Social workers slow to file payment papers.

Lack of communication between our agency, the client, and DSHS.

No consequences if they fail to comply with treatment recommendations.

Issue of client trust.

Making sure I make a difference in a child's life. I am hopeful my tutoring services are helping these children gain self confidence and self esteem.

Getting DSHS to make referrals.

Provision of mental health services for the family—parent participation.

Getting referrals, getting background information.

Language is a huge challenge—there are few non-English classes taught in Snohomish County. Participants are often referred to King and Skagit Counties.

Q36. Please add additional comments

Q9: I transport clients when there is no other transportation or emergency. Q35: I accept referrals for families that I can get in within two weeks. I don't feel ok about maintaining a long waiting list in a time sensitive situation. I have the ability to offer a variety of services that can be tailored to meet individual family needs. Supervised visitation/hands on parenting is a modality that I am proud to offer. Visiting in a safe, clean, homelike environment with trained staff has been exceedingly helpful. I would be interested in providing additional information.

Question 4: Does your agency provide parenting classes was answered as yes with the caveat that the contract was terminated earlier this year. Question 19: What transportation does DSHS provide to your agency was answered with social workers, but this happens rarely.

We provide child care to the community, including families on DSHS. I do not know why we would receive this survey otherwise.

Question 13: What are your agency's scheduled hours? 9 am to 9 pm Monday, Tuesday, Wednesday and Thursday. On Friday our hours change to 9 to 5.

BSM Creative Change Counseling Center Written Rules attached.

The DCFS office in this area black lists any providers who publicly disagree with their recommendations in court or in staffings. They believe that their funding for services buys support for their clinical position. As a result, the local DCFS office no longer refer to me. I do see some state kids who are referred through other channels. DCFS should be razed to the ground and restarted under the auspices of another agency such as Juvenile Services to juvenile criminals or another well run agency. The most unethical behavior I have seen involves stacking the deck in court by deliberately biasing the information presented to judges, evaluators, and supposedly independent decisions in cases such as CPTs.

Question 26: Upon initial referral does the caseworker provide you with a case summary? Yes, but only in about half of the cases.

Question 15: Are there written rules and policies for participation in services at your agency? No, those fall under state or private agency contract.

There is little collaboration between DSHS and other agencies. Case workers do not follow up, do not return phone calls and do not seek or receive information readily.

CPS refers people to our parenting classes. People attend because they have to. Especially for African/American, Latino and refugee immigrant populations, virtually NO adequate services exist to supplement parenting classes. A few parents change, but most have other issues: drugs, alcohol, mental health, racism, cultural barriers-differences, and post traumatic stress issues from their own lives. Question 20 asks about how we serve non-English speaking clients—we don't use interpreters—we have a Latino parenting class taught in Spanish. Question 29 asks about how many DSHS clients successfully complete services. Do you mean change or complete the class? Question 30 asked for an estimate of DSHS clients who complete the services—less than 25%. Question 35 asked about funding—we don't get money.

Question 15: Disclosure Statement enclosed.

See enclosed newsletter and brochure. Question 2: Does your agency provide psychological evaluations? Yes, Brainwave evaluation and TOUA test for attention issues. Question 4: Does your agency provide parenting classes? Yes, in conjunction with neurofeedback treatment. Question 17: Estimate the percentage of your clients who are referred by DSHS in child abuse and neglect cases: Range between ten and thirty percent. Question 20: How does your agency serve non-English speaking clients? Occasionally Spanish speaking. Question 28: If you receive summaries from DSHS caseworkers, are they accurate, fair and complete? Never received one. Question 35: Funding for services? Do not know.

Thank you. Question 13 asks about our agency's hours of operation. We are open Monday thru Friday from 8 am to 4:30 pm. Question 15 asks about written rules and policies to participate in our services. Eligible for First Step Service. Anyone needing a public health nurse regardless of income. Contracts at CPS like Early Intervention and Alternative Response Depends on referrals and client needs.

Question 26 asks if we are usually provided a case summary by the parent. This depends—sometimes the parent supplies an oral account. Question 28 asks about the quality of the summaries received from the DSHS caseworkers. This depends greatly on the social worker.

[Our center] provides a home to twenty health and human service organizations many of whom (or some of whom) provide these services. See attached information for all service questions. Excerpt of info: "On-campus services include medical and dental care, emergency food and shelter, youth activities, low-income housing assistance, mental health counseling, disability support and referral, therapeutic programs for at risk youth and much more."

Question 30: Estimating your agency's experience with DSHS clients who complete services and correct their problem: Less than 25%. No box to mark.

I provided IFPS, FPS & FRS to DCFS for two and a half years. I hope that when my current dispute is resolved that I will provide these services again. FRS is generally not enough hours to realistically help a family. I consider the time funded IFPS and FPS to be about right. However, at times a family is making gains, funding runs out, and there is no real provision for extending services. I believe that CPS social workers should have to undergo the same process that a licensed mental health counselor, licensed clinical social worker, or licensed marriage and family therapist have to complete to be licensed. Lack of professional standards for CPS, social worker is problematic. Question 3B asks about the duration of Mental Health Treatment. Mental Health becomes an integral part of family counseling as needed. Question 4B asks about the duration of Parenting Classes. It also becomes an integral part of family counseling. Question 7A and 8A I answered yes to, but these services have not been provided this year. On Question 15 regarding written rules and policies please note: Service plans include a clause that services are voluntary and excessive no shows will result in termination of services. Question 21 asking how long after a DSHS referral is made do clients contact your agency: Clients rarely contact me, I contact them within twenty-four hours. Question 29 asks about how many clients successfully complete services? More than 75% complete services, but not successfully. Question 30 asks, of the clients who complete the services, what proportion correct their problem? Almost all make some improvement, but sometimes it is minimal.

Payment for experienced therapist is too low. Tremendous number of conversations with caseworker for DSHS which is appropriate, but financial compensation and/or payment for individual summons does not help to cover all of the costs. Though I continue to see a number of DSHS referred clients I can no longer afford to due to the intense case management and my business is a private practice, not an agency, which has more ability to cost off meetings, numerous calls, etc.

Too many organizational loopholes and inexperienced or misinformed workers. Workload for state caseworkers and supervisors is too heavy, which affects all other persons and agencies involved in cases. Too many changes, lack of information being relayed to providers. Not enough respect given to providers for involvement and work commitment on cases, no consultations regarding progress and concerns. Too much control and clout given to state workers, who are often overburdened and uninformed, but make major decisions concerning people's lives. Not enough services in community to work with parents on parenting skills. Hotlines need to be available for immediate crisis intervention and those numbers need to be published. Expertise and experience by individuals who are paid, rather than volunteer workers. More programs through schools should be offered to help parents. Thanks for the opportunity to vent! Question 16A: This question is vague, I'm assuming that you mean any parent including guardians, foster parents, adoptive parents who are involved with abused or neglected children. Question 16B: Was answered yes as to foster parents.

I very rarely see DSHS patients because their payments do not cover counseling by independent psychologists. Psychologists provide only testing or must work for a mental health clinic to provide services. I have been referred a few clients who are foster families. The referring social worker felt that I was an especially good fit to counsel a particular family. Somehow, the social worker found funding for my services.

Emergency Support Shelter Policy attached.

Question 15 asks if there are written rules and policies for participation in our agency service. Our administrative plan is about two inches thick and we have separate plans for each of our sites. If you want me to forward these, please give me a call.

We provide child care referral services to anyone who calls. We also work with child care providers to access needed services. We function more as an ancillary service than direct.

I had been in private practice for several years. In May of this year I retired, so I am not providing any service.

Question 16A & B ask if our agency provides services or treatment to parents in child abuse and neglect cases. It is possible that we have. Our programs are open and promoted by CPS. We do not ask, so are unaware if they are directed to us by CPS. Washington State 4-H Youth Development Program Policy #EM0758 enclosed.

Question 21 asks how long after a DSHS referral is made do clients contact our agency. They don't, we contact clients.

Question 13 is about our agency's scheduled hours. Open Monday thru Thursday 7 am to 5 pm and available weeknights for on-call crisis basis. Mental Health Services Treatment Consent Form enclosed.

I don't serve parents in abuse and neglect cases.

Purposed reduction in Mental Health Services in medically underserved areas like Yakima County will limit parents and children's chances to be reconciled due to poor assessments of their needs by overworked and stressed child welfare social workers.

I have a solo private practice. My office hours are Monday thru Thursday. Question 17 asks me to estimate the percentage of clients referred by DSHS in child abuse and neglect cases. "I had 1 or 2 in the past and one recent referral, but client never called back after I left a message for her at a message phone." Questions 28, 29, 30 and 34: I have just had too few cases to comment on.

Only problem I've had in several years was DCFS trying to micro-manage my private practice. 1. You will carry certain forms of insurance. 2. Your records belong to DCFS (yet when I close my practice and ask DCFS where they want me to put their records, they said "oh no, those are your records and you have to keep them for six years in a place DCFS has access to"). I very much enjoyed working with DCFS kids, foster parents and workers. Effectiveness disintegrates at regional and state level. Disclosure and Informed Consent form enclosed.

Question 30 asks for an estimation of DSHS clients who complete the services and correct their targeted problem: 20%.

I have serviced many children, adolescents and parents in this county. We are a rural county with a lot of poverty. It is a shame that funding has been cut for services to very needy families and the most vulnerable single parent families. Indeed, we have a lot of drug abuse in our county, the children are the one's that suffer. Now they are placed in foster care, but no services to foster parents, because of cut funding. Besides being a therapist, I am also a therapeutic foster parent. I see first hand how our children and family services suffer at the expense of financial stress.

Historically, few clients have been referred by DSHS (two in the last ten years).

There has been a definite change in attitude/perspective at DCFS during the six years I have been a contracted provider. The tone has become much more punitive rather than supportive and encouraging. Expectations are often unreasonable and mental health issues are minimized. The standard of "good enough" (meeting baseline standards) has been blurred. Not being able to bill for transportation/travel time, all-provider meetings, phone calls and reports is not fair professional practice.

In the past couple of years, our relationship with CPS has eroded. There have been several changes in management.

DSHS, primarily CPS in my county, are extremely resistant to working with the focus of reconciliation for families. Consequently my relationship with CPS is strained. I have seen many families in conflict that could with investment and time heal their conflicts and return to

more appropriate family life. Instead the Department displays behavior of divide and conquer mentality, splitting families that are devastated already. Many not able to repair for extended length of time, sometimes throughout many years. It is my belief that this display is not encouraging for "Family Preservation" rather "Family Devastation." I'm sure from these descriptions it becomes obvious why my locals resist wanting to use my services, as much as possible, and when they do it is generally only by court order. CPS has a valid and necessary role they should play in all communities, and I don't begrudge this. Its only when they move to "NAZI" type behavior that I believe (and a great deal of other individual professionals also) their value drops to completely inappropriate.

We have been over budget in Yakima County on our 3235 psych- psych funds. The local DCFS administrators have asked workers to use only therapists who can take medical coupons. This limits social workers to only three options in Yakima. These three agencies have enormous waiting lists. They also have therapists who do not write quarterly reports and do not show up to testify when needed. This situation is hurting clients, jeopardizing cases and leaving social workers in a difficult position as they try to prove that all necessary services have been provided. This trend has been slowly developing over the last six months. I predict the state will lose more termination trials over the next year than it has in the last five years. They will also be more likely to lose on appeal. No Show Policy enclosed.

DSHS has terminated the contracts that it had with me because of a discipline process with the Board of Psychology Examiners.

16B: Parent may bring children to see me. I go to court in some cases. 28: Have only had minimal cases where, at some point, I received via parent the paperwork.

Our agency provides visitation (court ordered) services for children and parents. It is our role to be neutral, unbiased providers. We don't determine whether or not services are completed, but rather this is determined by the social worker. Question 29: Some services are terminated for No Show at Visits, or social worker cancels service if parent non compliant with court order. Question 21: We contact them usually. Visitation Guidelines enclosed.

You will notice that several of the answers were changed. I initially answered not realizing you were referring to court ordered services. Our agency receives ARS referrals, but clients are not court ordered. We also provide foster care and adoption related services.

Parenting Assessments play an important role in providing information to the courts in determining services and the potential for a family to be reunited. Question 20: No non-English speaking clients, but would request DSHS supplied interpreter if a non-English speaking client was referred.

My "agency" isn't an office as such. I am a private contractor of FPS & FRS services, have three sub contractors, a home office and a one day a week office in Colville. Stevens County goes from near the Canadian border, south to Spokane, so is a long county. The long distance takes a lot of contract monies in the form of travel hours and miles for clients who are at the extreme ends or up mountain roads. I believe that we meet the needs of the clients in our county to a high level considering our small amount of funding. Many parents embrace our services, really work on their issues and grow considerably to become better parents heading more functional families. One of my subcontractors works in Pend Oreille County. Question

15 regarding written rules for participation—"The contracts have policies we follow for FRS & FPS."

I most recently have seen the child as a client in an abuse/neglect case. The Department of Child and Family Services locally has been extremely difficult to work with in terms of establishing a contract as a private provider. The process has been bogged down in "lost paperwork." I will likely not provide further services to the Department as a result.

Question 15 regarding written rules for participation in services: There is an entire level of care manual for the agency. Nothing specifically goes to client other than client rights.

I work with a male therapist who is also an MSW. He is African-American and can provide anger management, and diversity work. He is excellent at working with high risk minority youth and their families. Together, we focus on short term (brief therapy) work with individuals, couples and families. Mostly chemical dependency and mental health work. Changes in Action Client Responsibilities, Client Rights and Program Rules list enclosed.

Our parenting program primarily serves court ordered; in the past DSHS referred clients who undergo a 2nd phase process. 1. An initial intake. Screen for domestic violence, substance abuse, sexual deviancy, mental health, cognitive abilities, health issues. 2. Phase I—a 4-week anger management program derived from our history of doing domestic violence, cognitive behavioral, psycho-educational process. It addresses beliefs, behaviors and provides parents with the tools to collect themselves prior to parenting their child. 3. Phase II is a 12-week bi-monthly process that provides the model of the parent as teacher and then aids the parent in developing specific parenting skills based on time, energy, attitude at that moment. The time between allows parents to practice the skills through homework assignments that enhance their life skills as parents. All groups are open ended meaning that a parent can enter the learning process at any time. Our DV program for men provides five monthly classes on the effects of domestic violence on their child. This course is at the end of the domestic violence program.

Length of stay agreement family shelter contract and information enclosed.

Community Mental Health Services Statement of Client Rights, Consent for Treatment, Counseling or Hypnotherapy Client pamphlet enclosed.

We are a proactive probation department that wants to do all we can to provide our clients and community with offender accountability community protection and innovative prevention-based activities.

All social workers need to provide the PHN a parenting plan, developed by parent and social worker. The one approved by the court. PHN has to request this. It is not readily shared. Weekly staffings at CPS regarding cases that PHN serves. Question 28 asks about summaries received from DSHS caseworkers. Never receive them, PHN uses CAMIS. Client Disclosure Information packet enclosed.

Question 20 asks how our agency serves non-English speaking clients. We have a separate Spanish speaking program, which I supervise.

Agency rarely admits children. Has admission rate of about 7 adolescents per year. They stay less than one week. Question 15 asks about written rules for participation in services—RCW 71:05.

I am not aware as to why DSHS no longer refers clients to me.

Washington State University Clinic Policies enclosed.

We provide services to children. Question 2 and Question 13B and C are handled through a different department.

YWCA Child and Family Care Program Authorization for Provision of Program Services, and Updated CFCP Policies enclosed.

I have never worked in a state where mental health for poor people is held by a monopoly. I believe the mental health services would increase if the state Medicaid was opened up to licensed professionals.

Q15: Our participation is monitored by the DCFS worker. Q20A: Contracted on an as-needed basis. Q21: We contact them! Q26C: At times. Q28: To that date, they are complete. Q35B: Referrals go up and down. Q36: Would like to see CPS workers get cases that they are specifically trained in. For instance, if physical abuse is the problem then the worker with the most knowledge should be the worker. I know that is difficult at times; however, workers with little or no knowledge about sexual abuse can do more damage to a child. Not knowing the effects of abuse of children and their psychological being harms children more. Would also like to see a better match with children and foster parents. Workers need to be aware of which homes are skilled to work with certain children.

Q5C: 20 families. This whole system has major flaws that need to change. My current status with DSHS is typical of what providers of services face when the department allows power and control tactics to dictate what services will be given to clients and who tells what to the court. There are many excellent and hard working case workers who are overloaded and still doing their jobs. It takes only one incompetent or vindictive person in the department to go after a provider and end their ability to provide services. This situation is particularly difficult because there is little to no effective safeguard against this. The attorneys for the client and the AG's continually act in a manner that damages the courts ability to accurately assess clients. When the findings are not what they want, they attempt to damage the evaluator and often as not, not just in the court room. In three years of providing evaluations, the attorneys obtained second opinion evaluations a number of times. I was never overturned by those second opinions, but I found it incredible that in none of those cases was I summoned to testify verbally on the stand. Last, but not least, other providers who disagree with findings will resort to defamation and unfounded complaints to the licensing board to act out their anger or agenda. Clients who have negative evaluations are too easily involved in making false and misleading allegations that can take months, if not years, to respond to and seek remedy. Service provided in questions 1–14 are juvenile offender services, youth-at-risk and truancy court services. We do not provide child abuse and/or neglect services other than providing the assistance to the court for hearings in our facility.

[After several years in practice with private-pay clients], I am newly reacquainting with DSHS. I am currently seeing a DSHS family. I have been very pleased with the DSHS case worker and the collaboration we have; this is a complicated family situation. The team effort in this case has been essential. I just received a second DSHS case. I look forward to renewed relationship with DSHS.

We'd like to know what data you're looking for with regards to this survey and the outcome of same. Question 35 asks about Federal, State, County and Municipal funding. [This agency] does not receive funding. [We] receive referrals funded by DCFS-DSHS.

Some of the difficulties are the individual client's needs, and parenting can be at the bottom of their list, above drugs/alcohol, mental illness, development disability, severe poverty. Funding is unpredictable-difficult to know what is available and how to staff. If DCFS has already planned on termination of rights, our services become a formality in their mind, a "hoop" that needs to be jumped through by the client. This is an extremely difficult situation for our staff and feels unfair to the client.

We receive referrals for conflict management and inter family mediation from a variety of sources. Parents are always encouraged to participate in an effort to preserve families and have healthy families in the county.

Responses based on three clients, unclear how representative these responses will be. Office policy enclosed.

I find Okanogan County DSHS to work very well and closely with providers.

The continued additions to insurance necessary for counseling for disordered eating.

Additional challenges—lack of a theoretical framework driving practice. Timelines are not real. Lack of clinical supervision resulting in some acting out on part of social workers. Lack of common understanding which would allow the judicial system and the child welfare system to operate in the best interest of children. Lack of honest presentation of concerns resulting in parents feeling victimized could promote anger at the system rather than solve the problem. Lack of supervision and support of foster parents. Lack of understanding of developmental psychology and the impact of decisions on children. Inadequate assessments of needs of parents and children resulting in cookie cutter. Lack of adequate theoretically driven intervention services based on the needs of the child. The system needs a common understanding of what children need and the services designed to respond to those needs. House Rules Contract and Protocol attached to survey.

We work with children and families in which child abuse and neglect is, or has been, an issue, but these services are provided only as RSN funded, Title 19, contracted services. Consent to Treatment form enclosed, our policy and procedure manual is 200 + pages.

Our agency provides CPS and CWS services with referral out to other agencies for services.

A definition of DSHS referred cases would help this survey. In private practice there's a lot of overlapping services, but very few to no direct state referrals. Question 17 asks the percentage of my clients that are referred by DSHS. None. Families who are involved with

DCFS come to me. Client disclosure statement and informed consent and fee agreement forms enclosed.

The DCFS system is very political and case workers/supervisors refer to favored therapists and agencies. Referrals are not necessarily based on a good fit or counselor expertise. There are current agendas to reduce the adequate level of service delivery for the children and families due to budget cuts. This will result in more costly services (e.g. prisons, welfare, etc.) down the road. Caseworkers often do not ask for or listen to input from the therapist. There needs to be improved team approach with respect and validation for all recommendations, more involvement from caseworkers would be helpful. There appears to be budget driven agendas to prematurely terminate or transfer services. Client no-shows without notification to the therapist, e.g., transport workers not notified, etc. There is concern all CPS reporting will be filtered through intake workers in Western Washington delaying investigations and compromising the well being of children. There is no current list of DCFS workers and phone numbers given to providers. Recently a DCFS worker told me not to work so hard coordinating services for a courtesy case where the caseworker lives in another county and has not met the child or guardian. I am the constant stable person for this situation, that is complex. Recently I was told they wanted to reduce services to once a month due to budget cuts.

Most of our funding comes from grants. We are a small, rural, isolated community with limited resources. This causes us to work closely together, to share our resources, to collaborate on work with individual families and to provide individualized and tailored wrap-around services to our clients. As stated elsewhere, when the courts order mandatory treatments or visitation plans (or other services), the courts should fund these services. Thank you for the opportunity to respond. Request for service and acknowledgement of conditions form enclosed.

Our program's services are voluntary and we have very strict confidentiality laws, which can come into conflict with DSHS mandated services/clients. Shelter Rules and Regulations enclosed.

[This agency] has two District Programs. 1. [Our] response center provides outpatient support and mental health services to victims of violence, mostly children. We get a large number of referrals from DCFS for services, but often the communication is poor. 2. Child Welfare provides therapeutic Foster Care, Intensive Home Based Services, and Sexually Reactive/Aggressive Youth Services.

Question 29 asks for an estimate of how many DSHS clients successfully complete services. Our agency has had too few clients referred to tell.

Disclosure Information Education, Training and Education: MA Psychotherapy/Counseling. Practicing since 1987 treating individual adults, couples and families. Post MA training in: Domestic Violence, Dissociate Disorders, Affective Disorders, Post Traumatic Stress Disorder, EMDR (Eye Movement Desensitization and Reprocessing), Mind/Body Medicine and Hypnosis. Licensed Marriage and Family Therapist. Methods and techniques used by counselor: Family Systems, Object Relations, Cognitive Therapy, Conflict Resolution, Stress Management, Hypnotherapy, EMDR. Confidentiality is an ethical principal that protects privacy of communication between the clinician and the client. It may permit: 1. the ability to consult with clinical peers and other providers as necessary to provide quality care, and 2. the

communication of information for necessary record keeping and accounting purposes. However information will be released under the following circumstances. 1. When there is reason to suspect the occurrence of adult or child abuse or neglect. 2. When the consumer presents a clear threat to do serious bodily harm to self or others. 3. When under court order. 4. With a legally valid signed release of information. Sessions are 50 minutes. Clients will be billed for no shows or cancellations with less than 24 hours notice.

Our agency is a dual agency, DV/SA. Our grant that provided C/AN victims with counseling, legal advocacy, etc., will end October 1, 2002, but the DV/SA finding is still available and we provide those services.

We don't provide any services for court orders. Counseling cannot be court ordered. We cannot provide any documentation to courts, attorneys, CPS, etc. Question 5 asks if our agency provides subsidized housing or housing referral services. No, not through counseling program, but through Catholic Charities Housing Program.

Question 15 asks if there are any written rules or policies to participate in services. Yes, "all of my clients are sex offenders. Rules may be per court order." SSOSA Treatment Plan, Treatment Rules, Sexual Offender Treatment Program Contract, Program Policies enclosed.

Our parenting classes may/may not be suitable for court orders/DSHS referrals. Our classes repeat themselves quarterly. Longest class = 7 weeks at once per week. Under Family Support Principles (attached) participant takes full responsibility for making appointment and attending class. We require no paperwork and classes are free to low income participants. We send a letter of confirmation to agency ordering classes.

Question 8 asks if I provided family preservation services. Am licensed for this service, but have never received a referral.

We get occasional referrals from CPS.

At the present time I am tutoring one child for which I am paid by the state. Three other children I tutor I am providing the services for free due to cutbacks in funding for DSHS. My goal is to help these children gain confidence and feel good about their academic abilities. This foster care mother has never asked for anything else for her children, while others are receiving money for dance lessons etc. I am wondering why academics is not being made a priority? I have worked with these children for two years and will continue to do so despite the cutbacks in funding.

DSHS accesses my service very inconsistently. I have a large contract which is not utilized. Foster care families frequently request my services. It is my understanding that my work for the agency has been [exemplary]. I receive very positive feed back from both caseworkers and clients. Therefore, I am unclear about the under-utilization of services. I also, have outstanding bills that I'm having difficulty collecting from the old TANF WorkFirst Program.

APPENDIX

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.