



Denver Indian Family Resource Center

Research Report



Robin Leake, PhD

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ABOUT RMQIC

The **Rocky Mountain Quality Improvement Center** (Grant # 90-CA-1699), one of six Quality Improvement Centers funded by the Children’s Bureau of the US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, addressed the significant need in this region for strengthening families at the front end of Child Protection Services (CPS) that are struggling with child maltreatment and substance abuse. Through a competitive proposal process, RMQIC chose to fund four programs, which operated during 2003 – 2005. Two Colorado programs were community based; of these one (The Recovering Together Program, Cortez, Colorado) developed an intervention based on gender-specific treatment and skill-building for women with their children, while the other (The Denver Family Resource Center) served urban American Indians. The Idaho Department of Health and Welfare (in the PreTreatment Program) served parents or caregivers who had been referred to CPS and were waiting for substance abuse treatment, and the Ada County Family Violence Court implemented a collaborative approach by the courts and CPS in Ada County, Idaho, in which families reported to a central court to receive a consistent, accurate, and coordinated court response through the Supreme Court. All four programs provided intensive case management and either provided or brokered substance abuse treatment services to their client families. This present publication forms part of an array of materials designed to disseminate findings and recommendations from each of the four programs.

DISCLAIMER

This document was made possible by grant # 90-CA-1699 from the Children’s Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services. The contents are solely the responsibility of the authors and do not represent the official views or policies of the funding agency. Publication does not in any way constitute endorsement by the U.S. Department of Health and Human Services.

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INTRODUCTION

Initial problem statement

Urban American Indian families that are involved in the child welfare system and also have substance abuse issues often face seemingly insurmountable challenges. In the experience of the Denver Indian Family Resource Center (DIFRC), these families are among the most vulnerable and multi-problematic in public child welfare systems. Few educational and job training programs in the human services arena provide workers with adequate understanding of Native people's cultures, their value systems, and the contemporary contexts of their lives. This understanding, however, is a critical piece of working effectively with American Indians.



Description of the program

The purpose of the DIFRC's Rocky Mountain Quality Improvement Center (RMQIC) project is to prevent removal and out-of-home placement, or to promote timely return home of Indian children who have become involved with the child welfare system due to parental substance abuse *and* child neglect or maltreatment. The underlying assumption driving the program is that by implementing and strengthening culturally appropriate services for Indian families referred by county departments of human services, families will be strengthened and out-of-home placements will be avoided. In cases in which children have been placed out of home, culturally appropriate substance abuse and case management services will assist in expediting family reunification.

The primary goals of the DIFRC RMQIC project are:

- Improve child well-being by preventing removal of American Indian children from their homes due to abuse and neglect and, if removed, to expedite reunification.
- Accelerate the willingness of parents or caregivers with substance abuse issues to engage in treatment to improve child safety.
- Reduce or eliminate parent or caregiver substance use to improve family functioning.
- Engage an extended, culturally appropriate network of support for families to improve family and child well-being and increase child safety.

American Indian families appropriate for this program are referred from the child welfare departments in the seven-county metropolitan Denver area (i.e., Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, and Jefferson counties) and have been identified as having both parental substance abuse issues *and* child protection concerns. County departments of human services have an active case with these families, are working with them on a voluntary basis, or have elected not to open a case as long as families participate in the program. Some children have remained in parental homes, while others have been placed temporarily with kinship providers or are in short-term out-of-home care with the intention of an expedited reunification.

Partnering agencies supporting the DIFRC RMQIC project include DIFRC's formal partners, Denver Indian Health and Family Services, the Denver Indian Center, Native American Counseling, and Casey Family Programs. In addition, DIFRC collaborates

with the seven county departments of human services and with substance abuse treatment agencies that serve the target counties or are affiliated with tribes and Indian Health Services. Several American Indian mental health and substance abuse providers partner with DIFRC to provide individual and family counseling to program participants. Finally, DIFRC partners with American Indian community members to provide cultural connectedness and support for family members.

DIFRC's RMIQIC project is a new approach to improve child and family outcomes for urban American Indian families with substance abuse and child protection challenges. The program expands upon DIFRC's ongoing Indian Child Welfare efforts in the areas of family reunification, family preservation, and family support services.

Literature Review

American Indian families have a history of difficult and unfortunate interactions with child welfare systems. A survey by the Association on American Indian Affairs found that by the 1970s, 25% to 35% of all American Indian children born in the 20th century had been separated from their families and adopted by non-Indian families (Fischler, 1980; Mannes, 1995). More than 25 years after the passage of the ICWA, American Indian children remain overrepresented in the child welfare system, especially in out-of-home, non-kinship foster placements. High rates of removals of American Indian children have continued in many U.S. communities despite the requirements of the ICWA (Bussey & Lucero, 2005).



Group memories of widespread loss of children and other historical traumas remain strong in tribal groups and American Indian communities (Brave Heart, 1999; Horejsi, Craig & Pablo, 1992) and have resulted in many contemporary families being unable to trust and engage with their child welfare workers in ways necessary to reunify with their children (Halverson, Puig & Byers, 2002). Years of oppression have damaged many American Indian parents' capacities to trust and accept help from CPS workers, and other parents become so frightened and intimidated that they flee in terror and seemingly abandon their children (Horejsi Craig & Pablo, 1992). This mistrust and fear is exacerbated by the child welfare system's ignorance of American Indian cultural values and practices, the imposition of dominant culture norms as the standard of child well-being, and the lack of knowledge of resources and strengths of American Indian communities (Cross, 1986).

Evaluation Design and Approach

The evaluation design for DIFRC's RMIQIC project built upon an earlier program evaluation design for the work of DIFRC as a whole. This design included examination of outcomes using quantitative pre-post measures (North Carolina Family Assessment Scale-American Indian version), documentation of consumer input (American Indian Family Survey [AIFS] and satisfaction survey), and measurement of safety and permanency outcomes gathered from DIFRC administrative and case records (presence/absence of child maltreatment, number of families with termination of parental rights, and number of children reunified or placed with relatives or tribes versus in non-relative, non-tribal settings). In the original design, these measures were gathered on 100% of cases. In addition, qualitative interviews were done with a sample

of outside collaborating agency personnel (i.e., DHS caseworkers, legal personnel, partner agencies, and American Indian community members), with case record review to document service use, client participation, and progress toward outcomes done on a random sample of open cases.

The original evaluation design for the RMQIC project proposed keeping all these elements, increasing the coverage of some, and adding new elements:

- The quantitative pre-post measurements (NCFAS-AI) and consumer input (AIFS and satisfaction surveys) continued to be done on all new cases. Likewise, data on safety and permanency were gathered on all new cases.
- Three existing elements were expanded: For RMQIC participants, 100% of case records, rather than a random sample, were reviewed for service use, client participation, and progress toward outcomes. Because these participants were expected to receive more intensive substance abuse evaluation, the case record review also covered all materials sent by DHS and by substance abuse evaluators and service providers. In addition, caseworkers for RMQIC participants were contacted for interviews. Finally, DIFRC staff collected and documented biological measurement results by substance abuse providers as an indicator of parental substance use reduction or elimination.

There was a focus to strengthen communication and collaboration among DIFRC, county departments of human services, and other key providers.

Formulation of research questions

Initially, the key program interventions of the project were identified as:

- 1) conducting a safety planning conference followed by a family group decision making (FGDM) meeting for service planning;
- 2) conducting family assessment and planning through strengths-based processes;
- 3) using a case management approach to assess needs and facilitate receipt of needed services/treatment; and
- 4) ensuring that services are culturally appropriate, either by referrals or by providing services in-house such as parenting classes.

In addition, there was a focus on to strengthen communication and collaboration among DIFRC, county departments of human services, and other key providers. At the end of the first year, programming was adjusted to better meet the needs of families (Figure 1). It was hypothesized that these four interventions would lead to the following key long-term client outcomes:

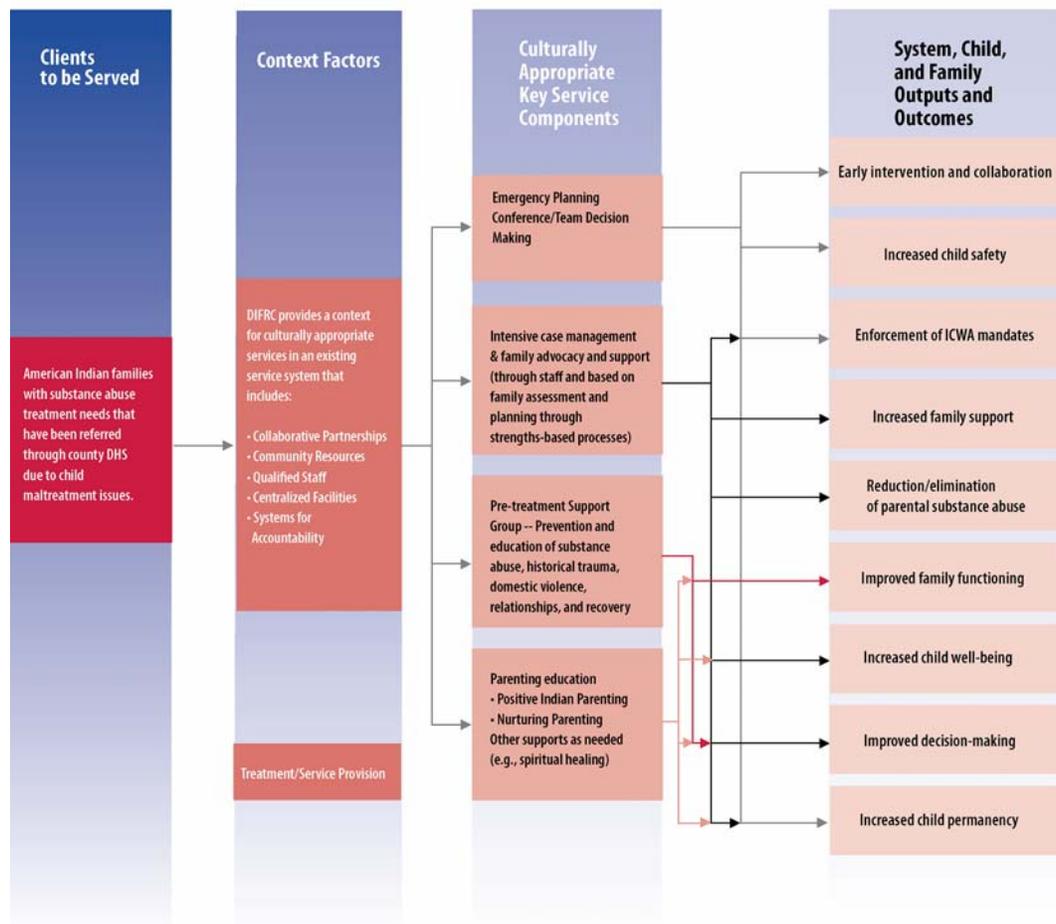
- 1) child safety;
- 2) child well-being;
- 3) reduction/elimination of parental substance abuse;
- 4) increased child permanency; and
- 5) improved family functioning, along with specified system improvements.

After the first year, the use of family conferences as a follow-up meeting (after 30 days of enrollment) was discontinued. The program team made that decision after hosting two and attempting one additional family conference. The reasons identified by project

staff included: participants had intentionally left their reservations and moved to an urban area in an attempt to free themselves from the “interference” of family or community members who pressured them to stop their substance use; family conferences were organized with invited family members who agreed to attend but ultimately did not show; some family members whom the client considered supportive refused to participate; or no supportive family members could be identified, often due to extreme levels of intra-family violence or substance use severing connections to nuclear and/or extended family.

The project did, however, continue to use an emergency planning meeting or Team Decision Making (TDM) meetings hosted by county child welfare systems. The team also decided, based on their experience, that families would best be served by creating and implementing a pre-treatment substance abuse support group to increase participants’ readiness to address their substance abuse issues and/or enter treatment. In addition, the team decided to adjust the case management approach to be intensive and to include the services of a family advocate. Figure 1 is an adjusted logic model that illustrates key program elements and the connected outputs and hypothesized outcomes.

Figure 1: PROJECT LOGIC MODEL



EVALUATION APPROACH AND ACTIVITIES

Overview of approach

The program evaluation design for the RMQIC project included both quantitative and qualitative elements to provide as much information as possible to document the effectiveness and impact of the program. Quantitative methods included caseworker and client surveys, biological drug testing (urinalysis), and a review of case files for child outcome data (safety and permanency). Qualitative methods included case record reviews, observations, interviews, and focus groups with clients, staff, and county caseworkers. In addition, a time-methods study was done to gather data on the dosage of intervention required in intensive case management to clients. Table 1 provides a summary of activities to illustrate the project’s interventions after the first year adjustment.

TABLE 1
DIFRC RMQIC PROJECT—KEY PROGRAM INTERVENTIONS

Intervention	Description	Participants	Purpose	Short Intermediate Outcomes
Decision making meetings	<ul style="list-style-type: none"> An Emergency Planning Conference for safety planning and initial needs identification held within 72 hours of referral to DIFRC A family conference held at a later date to develop a plan (e.g., identify needed services, engage a support system, support the client's entry into appropriate substance abuse treatment) 	<ul style="list-style-type: none"> Client Family members DIFRC social worker County case worker Substance abuse treatment provider Other service providers (e.g., mental health) Community support people 	<ul style="list-style-type: none"> Ensure child safety Further engage client, extended family members, and service providers in case planning and identification of family needs, strengths, and supports Support client's entry into appropriate substance abuse treatment 	<ul style="list-style-type: none"> Client feels supported by family Client is involved in case planning and feels plans meets his or her needs Extended family members take a role in helping family heal
Pre-treatment support group	<ul style="list-style-type: none"> Allows client to identify issues underlying his or her use of substances Designed around a group-therapy model that is participant-driven and includes topics relevant to client's current needs Topic areas represent issues that impact client's abilities to fully engage in substance abuse treatment, such as childhood physical and sexual abuse, abandonment, interpersonal conflicts, and unresolved trauma, grief and loss 	<ul style="list-style-type: none"> All individuals who are not participating in appropriate substance abuse treatment Participation begins upon entry into program Participants who have completed treatment may attend for additional support 	<ul style="list-style-type: none"> Increase client's readiness to address his or her substance abuse issues in an appropriate type of treatment 	<ul style="list-style-type: none"> Client attends the group and completes appropriate substance abuse treatment
Intensive case management	<ul style="list-style-type: none"> Intensive case management services that begin at referral to program and continue through completion 	<ul style="list-style-type: none"> All program participants 	<ul style="list-style-type: none"> Improve identification of client's service needs and development of individualized service plans that include culturally appropriate services 	<ul style="list-style-type: none"> Client accesses services that are identified in his or her service plan and that are culturally appropriate
Strengthened communication and collaboration among DIFRC and public child welfare agencies	<ul style="list-style-type: none"> Outreach efforts to key county child welfare staff Training for county child welfare caseworkers and supervisors in culturally appropriate services 	<ul style="list-style-type: none"> DIFRC Program Development Manager DIFRC Clinical Services Supervisor Key county child welfare staff 	<ul style="list-style-type: none"> Improve early identification of American Indian families entering child welfare systems Increase referrals to DIFRC services 	<ul style="list-style-type: none"> Heightened culturally appropriate service delivery to American Indian families Increased county caseworkers' awareness of client's cultural needs

Description of tools and data gathering processes

The following quantitative tools were used to measure process and outcomes for the RMQIC program:

- Pre-post tests of client functioning—The Social Worker filled out the North Carolina Family Assessment Scale, which was modified for American Indian families (NCFAS-AI), at intake, every six months, and at case closure. T-tests were used to look at the differences in functioning between intake and the first six months re-assessment. When enough families were assessed at three or more time points, Repeated Measures were used to look at the progression in scores longitudinally.

The NCFAS-AI was used to assess families' environment, caregiver capabilities (including items on substance use and mental and physical health), family interactions, child and family safety, and child well-being. The instrument thus addresses all four long-term program outcomes: child safety; child well-being; reduction or elimination of caregiver substance use; and improved family functioning.

The modifications to the NCFAS-AI made for the American Indian population did not change the structure of the instrument, the number of items, or the scale values, but they did affect the wording of the scale values, and of some items and anchors for those items. In addition, the instrument was modified to include separate ratings for two caregivers, if appropriate, to track progress on substance abuse, mental health, and parenting abilities. The modified version has been shared with the original NCFAS scale authors. Reliability analyses described in more detail in the results section indicate good reliability for the total NCFAS-AI (Alpha = .91) and for each of the subscales.



- Since the ultimate goals of the program include child safety, case record reviews were used to assess recurrence of substantiated maltreatment for families.
- All clients were administered periodic random biological drug testing in the form of urinalysis as a measure of substance use.
- Client satisfaction surveys—As part of DIFRC's regular follow-up with former clients, client satisfaction surveys were administered after case closure by mail and by telephone (using social work student interns).
- Positive Indian Parenting (PIP) Class surveys—RMQIC participants who chose to take the PIP classes filled out pre-, midway-, and post-surveys on attitudes, parenting behaviors, and satisfaction with the classes.
- Stages of Change surveys—Participants in the pre-treatment group were asked about their readiness to change as they began the sessions, during Week 1, and at the end of the group.

The qualitative design used a variety of methods to provide more context and further understanding of the quantitative findings as well as to contact external project partners:

- Case record review—All RMQIC client charts were reviewed to document the client demographics, types of initial problems, types of services received (both from DIFRC and from other agencies), notes on client participation in comparison to recommended services and orientation toward change, formal assessments from DHS and outside substance providers, and court reports. The paper and computer database case records provide an initial framework for constructing case narratives about client progress. Case records also contain the documentation of any safety issues, re-reports to DHS, and records of biological testing for substance use.

One successful element to the evaluation was the use of the NCFAS-AI as an outcome measure.

- Caseworker interviews regarding the process and progress of RMQIC project participants—The Social Worker who works directly with the families has a wealth of knowledge about the family dynamics and background in addition to the history or summaries of contacts found in the agency case record.
- Observation/documentation of EPC/TDM meetings—Information about meetings initially was obtained from the facilitator’s reports of the meetings. Wherever possible, evaluators attended a sample of EPC/TDM meetings.
- Observation of formal outreach trainings—Evaluators attended and documented the training process with community partners and DHS agencies.
- Interviews with partner agencies, referral sources, and collaborating agencies—DHS caseworkers for each RMQIC case were surveyed annually to document their perceptions of the collaboration. The partner agencies and substance abuse provider agencies involved with these cases also were interviewed.
- Time and Effort Study—This component used a mix of quantitative methods documenting the frequency and duration of case management/direct client service activities, as well as the “intensity” of the work, with the more subjective perceptions of the Social Worker about the nature of the client contact, emotional tone of the contact, and coping skills needed for multifaceted client life challenges.

Database development and data storage

All quantitative data, including client demographics, NCFAS-AI, and self-report survey results were entered into an Excel file by DIFRC case managers. Project evaluators cleaned the data files and exported the files to SPSS for analysis. All client data were stored in password-protected secure network files with the client names removed from the files to ensure further protection.

Challenges and successful strategies

There were several challenges to the evaluation methodology. First, the program activities changed significantly during the first year, impacting the evaluation methods. For example, DIFRC discontinued FGDM meetings after convening two and attempting to coordinate a third, and hosted a limited number of EPCs or attended a limited number of TDMs organized by the county CPS agency. Therefore, qualitative data about the content of these meetings were limited. There also were limited data from partner agencies despite attempts by evaluators at several points to schedule interviews. One successful element to the evaluation was the use of the NCFAS-AI as an outcome measure. This modified tool was shown to be a valid and reliable measure of family functioning for American Indian participants.

PROCESS EVALUATION RESULTS

Program startup

DIFRC began program implementation in January 2003. The agency had been providing Indian Child Welfare services to families and collaborating with county departments of human services on Indian Child Welfare (ICW) cases since July 2000. The RMQIC project was designed to build upon DIFRC's efforts to bring about systemic change and break new ground in ICW services for urban Indian children. The RMQIC project was implemented to test a service model with a specific segment of DIFRC's ICW population—families with both substance abuse and child protection issues.

Changes and adjustments to program elements

To address immediate challenges, program elements were modified during the first year and new interventions were implemented in the second year of the grant. Intensive case management was added as a program intervention to support participants in connecting with additional services to meet their needs. A pre-treatment support group was developed to increase participants' readiness to address their substance abuse issues in appropriate treatment. The pre-treatment group began in Spring 2004 and met weekly for two hours per session.

All participants entering the program were encouraged to attend the pre-treatment group. The group allowed individuals to identify issues underlying their use of substances and used a curriculum designed around a group-therapy model that incorporates Prochaska and DiClemente's Stages of Change framework. Included also within group discussions were topics relevant to the issues underlying participants' use of substances. These topic areas represent issues that impact participants' abilities to fully engage in working on their substance abuse such as childhood physical and sexual abuse, abandonment, sexual assault, interpersonal conflicts, and unresolved trauma, grief, and loss.

In DIFRC's original RMQIC proposal, participants were to progress through a series of steps, from an initial EPC/TDM; to case planning, substance abuse evaluation, a family group conference, and substance abuse treatment; and then to culturally appropriate parenting classes, substance abuse prevention classes, and cultural and spiritual strengthening classes. Early in the implementation phase, it became apparent that participants entering the program had intensive challenges just managing day-to-day life issues. At the same time, most also were at the pre-contemplation stage of change, thus lacking readiness to begin addressing their substance abuse issues. As a result of these two factors, participants remained for a long time at a stage where intensive work was necessary to increase their readiness to change.

As a result, DIFRC's project model eliminated the program elements of substance abuse prevention classes and cultural and spiritual strengthening, and replaced them with a focus on intensive and individualized case management services. Positive Indian Parenting classes still were offered to participants who wished to attend the bi-weekly classes. However, if attending the classes seemed overwhelming or prohibitive to

participants, the Social Worker or Family Advocate was able to assist by teaching parenting skills as part of the ongoing clinical and case management contact with participants. Opportunities to strengthen families' cultural ties also were incorporated into the intensive case management services. In addition, parenting skills and cultural connectedness were addressed in discussions within the pre-treatment support group.

Program timeframes

DIFRC served its first family in the RMQIC project in late January 2003. A second family entered the project in early March 2003. Recruitment of families through the first year of the project was difficult and referrals were affected by budgetary cuts and restructuring in county departments of human services, most notably at Denver Department of Human Services (DDHS). At the end of the first year of the grant, six families were participating in the project. The final participant entered the program in March 2006. In total, 49 families were served during the program funding period.



Building partnerships

DIFRC was created in 2000 through a collaborative partnership of agencies serving American Indians in the Denver-metro area. These formal agency partners are the Denver Indian Center, Denver Indian Health and Family Services, Native American Counseling, and Casey Family Programs. The DIFRC Board of Directors comprises representatives from each agency, along with at-large community representatives. DIFRC's formal partners supported the RMQIC project, and Denver Indian Health and Family Services and Native American Counseling agreed to provide services to project participants.

Since its inception, DIFRC focused on efforts to establish and maintain collaborative working partnerships with the six county departments of human services in its target service area. A new county, Broomfield, was incorporated in the Denver-metro area in 2001 and was included in DIFRC's service area. The counties in DIFRC's service area are Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, and Jefferson.

In its working relationships with these county departments of human services, DIFRC stressed the importance of early identification of American Indian families that become involved with the child welfare system; encouraged and facilitated tribal notification on ICWA cases; provided consultation and training on ICWA and culturally responsive services; worked collaboratively with caseworkers and families to ensure the provision of culturally appropriate services, and when possible, the quick reunification of children with parents or kin; and assisted county DHSs in identifying and supporting kinship placements.

A formal Memorandum of Agreement existed between DIFRC and DDHS at the beginning of the RMQIC project. This MOA subsequently was refined and revised to support the RMQIC project with specific protocols for referring families from DDHS to DIFRC. Efforts at establishing similar agreements with the additional county departments of human services have been undertaken since DIFRC's inception. Jefferson County DHS established a fee-for-services contract with DIFRC, and initial

discussions regarding a formal agreement with Adams County DHS began in December 2004. Despite the lack of formalized agreements in most counties, DIFRC continues to work informally with them on the same elements as those listed earlier.

The RMQIC project added a refined and focused service for families with both substance abuse and child protection concerns that were involved with the county DHS. However, it became clear early in the project that it was confusing and difficult for county DHS referral systems to determine whether families should be referred to the RMQIC project or to DIFRC's other child welfare services. As a result, DIFRC decided to focus recruitment efforts with the counties on the message that all American Indian families should be referred to DIFRC, and the agency then would work with families and determine the most appropriate services, including enrollment in the RMQIC project, if families consented.

Building community awareness and involvement

Public education efforts of the RMQIC project were most appropriately targeted at county DHS systems. DIFRC's efforts in this area focused on the importance of early identification of American Indian families involved with the child welfare system, timely referral to DIFRC, and culturally appropriate services for these families. DIFRC conducted trainings for caseworkers, supervisors, and administrators at DDHS, Adams County DHS, and the annual Colorado Child Welfare Conference regarding the provision of culturally responsive services for American Indian families. These trainings were one strategy for educating public child welfare systems on how to better serve American Indian families as well as inform them of the RMQIC project. In addition, all workers at Savio House, a contract provider for DDHS and El Paso County DHS, received the same training in culturally responsive service delivery.

Several of the counties in DIFRC's service area remained somewhat closed to DIFRC's efforts to educate them about working with American Indian families. To meet this challenge, DIFRC staff requested meetings to build relationships with county staff and to educate them on the importance of incorporating culturally appropriate services into family service plans. DIFRC attempted to gain deeper cooperation by stressing to county DHS staff that collaboration with the agency can make caseworkers' jobs easier and can ease the burden in areas traditionally difficult for DHS workers, such as bridging with tribes and engaging with families.

DIFRC was supported by a Service Delivery Advisory Council (SDAC) comprising representatives of agency partners, other service providers from the Denver Indian Community, and providers from agencies that serve American Indians. These representatives met on a monthly basis to share information and support the ongoing development of DIFRC's ICW services. The proposal for the RMQIC project was initially presented to the SDAC, and the group was updated regularly on the progress of the project. Several SDAC representatives are formal partners in the RMQIC project, such as Denver Indian Health and Family Services and Native American Counseling.

Summary of project startup challenges and successful strategies

In the initial proposal for the project, DIFRC had planned on using its formal partner, Denver Indian Health and Family Services (DIHFS), to provide substance abuse evaluations and treatment to program participants. DIHFS receives its funding from Indian Health Services (IHS) and follows IHS guidelines regarding patient eligibility, specifically that patients be enrolled members of federally recognized tribes and show verifiable proof of tribal enrollment at the time of services.

One unexpected challenge was the high number of participants in the RMQIC project who had difficulty meeting the tribal enrollment requirement for service. Participants either did not complete their tribal enrollment or did not have the documentation required by DIHFS and were delayed in receiving services until documents could be obtained from their tribes. Since DIFRC understood that many program participants came into the project without their tribal enrollment in order and were unable to use DIHFS services, the project sought other providers for substance abuse evaluations and/or treatment. SIGNAL, the evaluation provider for DDHS, and an individual practitioner were added as partners to expand the options for substance abuse evaluations for program participants. DIFRC's Clinical Supervisor, a certified CAC III, also conducted some of the evaluations.



Additionally, it was determined that many program participants were coming into the project with chronic, and often untreated, mental health problems. To address this issue, DIFRC partnered with several American Indian mental health clinicians for mental health services for participants.

PROGRAM IMPLEMENTATION

Clients and their characteristics

Implementing the program as planned was challenging due to unanticipated characteristics of the client population. Participants came into the program with numerous and very challenging issues of daily living, such as homelessness, serious and chronic mental health problems and domestic violence issues, and criminal/legal involvement. These issues appeared to prevent participants from addressing their substance abuse issues (e.g., participating in a substance abuse evaluation, entering appropriate treatment). Commonly, participants reported to the Social Worker that they would be able to address their substance abuse once these other issues became more manageable. As a result, the Social Worker spent a great deal of time with each family in intensive case management activities, as well as doing clinical family work and teaching parenting skills. The intensity and duration of time with each family was much greater than originally anticipated, and families did not move through the steps of the program as quickly as expected.

Referrals

Receiving program referrals was an ongoing challenge in implementing the grant. During the first three months of Year 1, referral protocols were developed with DDHS. At the same time, however, DDHS and other county departments underwent major budgetary cuts and restructuring that affected their ability to collaborate with DIFRC

on this project. DIFRC's presumption that the number of Indian families referred to the agency would increase in 2003 was not supported; overall referrals to the agency dropped more than 50% in the first three quarters of 2003 as compared to the same period in 2002.

In mid-2004, a second round of layoffs and program restructuring affected the county departments with whom DIFRC collaborates. A subsequent drop in the number of families referred to the agency was seen again. The ability of DIFRC staff to engage in intensive outreach efforts with key staff within the county departments was limited. These DHS staff focused instead on internal issues such as staff cuts, program restructuring, and increased workloads, and thus had less time and energy to engage with community agencies. By the end of Year 2, the county departments had regained some internal stability and staff consistency. Concurrently, DIFRC noted that community outreach efforts and referrals of families increased, especially with DDHS, and to a lesser extent, Adams County DHS.

Another significant challenge during the first year was that few of the referrals by DDHS met the criteria for the project. Meeting the expectation that referrals be voluntary cases with DDHS with children remaining in the home with their parents was especially challenging. As a result, it was proposed to the RMQIC that DIFRC expand the project to include families in the other counties in the Denver-metro area that are part of DIFRC's service area. The RMQIC agreed that DIFRC could expand its service area for the project, and that families could participate if children were placed in kinship care or other out-of-home care for two months or less with a permanency goal of reunification with the parents.

DDHS initially agreed to serve as the referral agency for the project prior to the submission of the application to RMQIC. At the time DIFRC's proposal was developed, it was believed that the MOA in place between DIFRC and DDHS would adequately address the referral process. However, DDHS did not actively participate in the planning for the project proposal. In retrospect, it would have been beneficial to include the input of an intake supervisor and/or administrator from DDHS in the development of the proposal.

Program elements and considerations

Program Staffing. DIFRC's original staffing was adjusted at the end of the first year and remained as described for the remainder of the project:

- The Social Worker was the primary clinician for all program families. In addition to being responsible for developing and implementing the ongoing treatment plan for each family and collaborating with county DHS staff, the Social Worker also provided intensive case management services to each family. The Social Worker continued to participate in Emergency Planning Conferences and co-facilitated the weekly Pre-treatment Support Group.
- The Project Director oversaw the administrative and service development aspects of the project. Although funded as a half-time position, the responsibilities of the

Project Director required additional hours to fulfill. The Project Director supervised the Family Caseworker.

- The Family Caseworker worked two to three hours per week to provide culturally specific services to youth and assisted the Social Worker in providing cultural strengthening for families. Funding for this position ended with the completion of Year 2.
- The Clinical Services Supervisor supervised the Social Worker and took the lead in facilitating the Pre-treatment Support Group during Year 2. The Clinical Services Supervisor also provided individual substance abuse treatment to program participants who were appropriate for this level of treatment. This position was not funded through the RMQIC project and was included in the 10% match for this grant.
- A Coordinator was hired on a contract basis in June 2004 to coordinate and facilitate the Emergency Planning Conferences.
- A Parent Training Family Advocate was hired in the second half of Year 2. This staff person worked with selected families to strengthen parenting skills, particularly for very young and early school-age children. While the position's salary was paid through other DIFRC sources, the Family Advocate worked regularly with those RMQIC families needing assistance with parenting skills.

All program positions required demonstrated knowledge of American Indian culture; experience in working with American Indian families; and sensitivity to the social, cultural, and economic issues faced by children, families, and communities served by the DIFRC. Additional requirements for project positions included:

- Social Worker—MSW with experience in case management and working with clients with substance abuse issues and families involved with the child welfare system.
- Clinical Services Supervisor—Licensed Clinical Social Worker with Addictions Certification (i.e., CAC II/III) with three to five years of combined clinical practice and supervisory experience related to substance abuse and child welfare.
- Program Development Manager—Licensed Clinical Social Worker with four to seven years of combined clinical practice and supervisory experience and experience managing program goals and objectives and assisting in program monitoring and evaluation.
- Family Caseworker—Associate's Degree in Human Services-related field and experience in providing case management and supportive services to families and youth.
- Parent Training Family Advocate—Associate's Degree in Human Services-related field and experience in working with parents in early childhood development and parenting skills enhancement.

System issues

Most clients in the population that had both child protection and substance abuse challenges also had histories of severe trauma, chronic—and often untreated—mental health problems, current involvement with the legal system and/or incarceration, and a lack of readiness to address substance abuse issues. These characteristics required intensive work on the part of the Social Worker to move the client to the point of being ready to engage in a substance abuse evaluation, as well as to ensure continued child safety and family well-being. To support the increased family and individual work required to serve this population, both a full-time Social Worker and at least a half-time Family Advocate were recommended to help clients with intensive in-home and case management services. The addition of a Family Advocate to assist with case management activities gave the Social Worker more time to provide critical clinical services to families, such as individual counseling, increasing readiness to address substance abuse issues and enhancing parents' skills in working with their children.

External factors

At the same time the RMQIC project began, DDHS became a site of the Annie E. Casey “Family to Family Initiative.” DIFRC joined the initiative as one of its first community partners and was designated by the department to be the community representative at the table for all Indian families involved with DDHS. Included in the initiative were Team Decision-making Meetings (TDMs), a decision-making process aimed at safety planning and resource identification to which DIFRC representatives were invited. At TDMs, families learned of DIFRC services and were assessed for their appropriateness for the RMQIC project. This formalized method of communication and collaboration between DIFRC and DDHS facilitated referrals and allowed DIFRC to begin serving families at the very initial stage of their involvement with the child welfare system.

PROGRAM AND CLIENT OUTCOME EVALUATION RESULTS

Services provided and number served, including intensity of services

Tables 2 and 3 summarize the Service Outputs of the DIFRC RMQIC project for the first, second, and third years. Table 2 is divided into Client and Direct Service Efforts and Case Management Activities. Table 3 presents community service outputs such as Collaboration and Information Efforts, and written materials.

The section on Client and Direct Service Efforts documents the number of participating families and their children served, and the types of services participants received while in the program. Emergency conferences (i.e., EPCs or TDMs) to address safety issues and immediate case needs were held with 23 families, and DIFRC attended 15 of these meetings. If families had an open case with the county prior to program enrollment and the county had already done its own safety planning process, another meeting was not held and the information was gathered from DHS and the client. The Pre-treatment group was added in Year 2. The section on case management is a quantitative approximation of the amount of case management resources needed by and provided to participating families.

TABLE 2: DIFRC RMQIC PROJECT CLIENT-SPECIFIC SERVICE OUTPUTS

CLIENT AND DIRECT SERVICE EFFORTS	TOTALS
Number of families served	49
Number of children served	106
Number of EPC and TDMs attended at DHS offices	23
Number of FGDM meetings held	2
Number of pre-treatment sessions held (average of four mothers per session)	48
Number of Positive Indian Parenting sessions held/ Number of RMQIC participants beginning group	91 sessions held/26 RMQIC participants

CASE MANAGEMENT ACTIVITIES (PERCENTAGE OF RMQIC FAMILIES THAT ENTERED THE PROGRAM AND RECEIVED EACH TYPE OF CASE MANAGEMENT SUPPORT FROM THE DIFRC SOCIAL WORKER)	TOTALS
Housing resources	41% (n=20)
Transportation resources	53% (n=26)
Food/clothing/furnishings resources	45% (n=22)
Case manager supported parents to enter parenting classes	47% (n=23)
Employment/job-readiness activities	35% (n=17)
Substance abuse provider linkage activities (Case manager supported client entry)	63% (n=31)
Family linkage activities	53% (n=26)
Legal/court advocacy	61% (n=30)
Mental health (Case manager supported entry to treatment)	49% (n=24)
Child resources: Child Find or Head Start	25% (n=9)
Health referrals (Case manager supported access to physical health services)	39% (n=19)
Contacts with tribes	45% (n=22)

Table 3's Collaboration and Information Efforts section shows major community education and outreach efforts. There were extensive efforts to reach and train DHS staff (primarily in Denver but also two trainings in Adams County) about the program and increase their understanding of cultural competence issues in working with American Indian families. A total of 312 participants—both DHS and non-DHS groups such as youth residential centers, Catholic Charities, and foster care providers—participated. In addition, DIFRC's monthly Service Delivery Advisory Council (SDAC) meetings provided a forum to communicate updates on the program to DIFRC's partners and other community agencies.

TABLE 3: DIFRC RMQIC PROJECT COMMUNITY SPECIFIC SERVICE OUTPUTS

COLLABORATION AND INFORMATION EFFORTS	TOTAL
Number of County DHS trainings done and number of participants attending	18 trainings 312 participants
Substance abuse treatment provider contacts made (percentage of families with Social Worker contact)	100%
Service Delivery Advisory Council meetings	30
Guidelines/Curricula Used or Developed	
DHS referral protocols/MOAs (commitment to refer American Indian families from DDHS)	Year 1
ICWA Compliance Checklist/Native Heritage Assessment Forms for DHS (developed for use by county DHS statewide)	Year 1
DHS Cultural Competence Guidelines (curriculum used for county DHS trainings)	Year 1
Pre-treatment Group Curriculum (curriculum based on Stages of Change principles)	Year 2

Program completion rates and factors impacting completion

A total of 49 participants were served by the RMQIC project between January 1, 2003, and June 30, 2006. Services included:

- **Pre-treatment support groups** were available for participants with substance abuse issues who were waiting for treatment, were receiving treatment, or had completed treatment. The pre-treatment group met once a week for 90 minutes to motivate and/or increase participants’ readiness to enter treatment, as well as to address issues related to trauma. It was an open group so that participants could join at any time. Twenty participants attended the pre-treatment group, which averaged four participants per week with the number of sessions attended by each participant ranging from one to eight.
- **Intensive case management** services formed the foundation of the treatment plan and included referrals, advocacy, and linkages in areas such as housing, food, transportation, medical care, mental health assessments or treatment, childcare, school-related concerns, and legal issues. Also included in the treatment plan were regular home visits from the project’s Social Worker that provided time to develop a therapeutic relationship with participants.
- **Positive Indian Parenting Classes** were offered bi-weekly to all participants. Twenty-six parents participated in the Positive Indian Parenting classes, with 11 finishing all sessions. Other parents received help with parenting skills via home visits by the Social Worker or Family Advocate.
- A total of 38 participants had **substance abuse evaluations** through community-based originations (e.g., Signa, Arapahoe House, ARTS Potomac, Jefferson County Department of Health and Environment, New Directions, Mile High Council, Native

American Counseling) by private providers who were culturally trained and by a DIFRC clinical supervisor. All but two of the evaluations completed indicated that participants would benefit from outpatient care. Two participants needed the intensive services provided by inpatient treatment but neither enrolled until two others completed inpatient treatment.

Thirty-seven participants were *referred for substance abuse treatment*.

As noted, 49 families were enrolled in the project. Table 4 summarizes their activities and levels of engagement.

TABLE 4: SUMMARY OF DIFRC RMQIC FAMILY PARTICIPATION

	TOTAL
Re-opening of a closed RMQIC case	3
Participants completing substance abuse evaluations	38
Participants beginning in pre-treatment group	20
Participants beginning substance abuse treatment	37
Participants completing inpatient substance abuse treatment	2
Participants completing outpatient substance abuse treatment	16
Participants completing DIFRC RMQIC program	16
RMQIC DIFRC cases closed	28
CPS cases closed	18

Of the 28 participants with closing dates, 14 dropped out of services with DIFRC and discontinued their substance abuse treatment, and DIFRC closed their cases. Another two cases were closed at clients' request but with clients continuing their substance abuse treatment at two local providers. Six other cases closed because they reached a successful outcome (i.e., four reunifications, one tribal placement supported by the parent, one voluntary case closed). The remaining six closed for a variety of reasons.

Client Factors and Outcomes

This section presents findings linked to the four main program objectives in the DIFRC RMQIC project Logic Model, as well as additional information about project participants and county caseworker perceptions of working with DIFRC. The program served a total of 49 families at conclusion of enrollment on March 31, 2006. Ages of participants ranged from 20 to 54, with an average age of 32.5. Most participants (83.7%) were unemployed at intake, and just two of those clients were on other regular sources of income (e.g., TANF, SSI Disability). Participants' educational level ranged from finishing sixth grade to two years of college, with an average of finishing 11th grade.

There were fairly high levels of domestic violence (DV) in these families; 67% experienced DV in current relationship prior to intake, and 80% had experienced DV in prior relationships. For all families, regardless of timeframes, 88% had or had had DV as part of experience. Children had witnessed DV in 69% of all cases. Social workers

reported that in 25% of cases, there were new instances of DV since intake, and in 18% of cases, children had witnessed the recent DV.

Of the cases referred, 66% came via county DHS staff; 18% by self or family, and 16% by project partner agencies. In 74% of cases served by the program, families were involved in a formal case with DHS; 8% had a case referred for services but had no court involvement; and 18% had a voluntary case with DHS.

Of the DHS cases, 78% were substantiated, 2% were unsubstantiated reports, 18% were assessed to be “at-risk,” and 2% youth in conflict. Maltreatment by type were as follows:

- 86% involved neglect
- 8% involved physical abuse
- 2% involved sexual abuse
- 4% showed “none”

Charts 1 through 3 illustrate these and more factors of program participants.

CHART 1: REFERRAL SOURCES

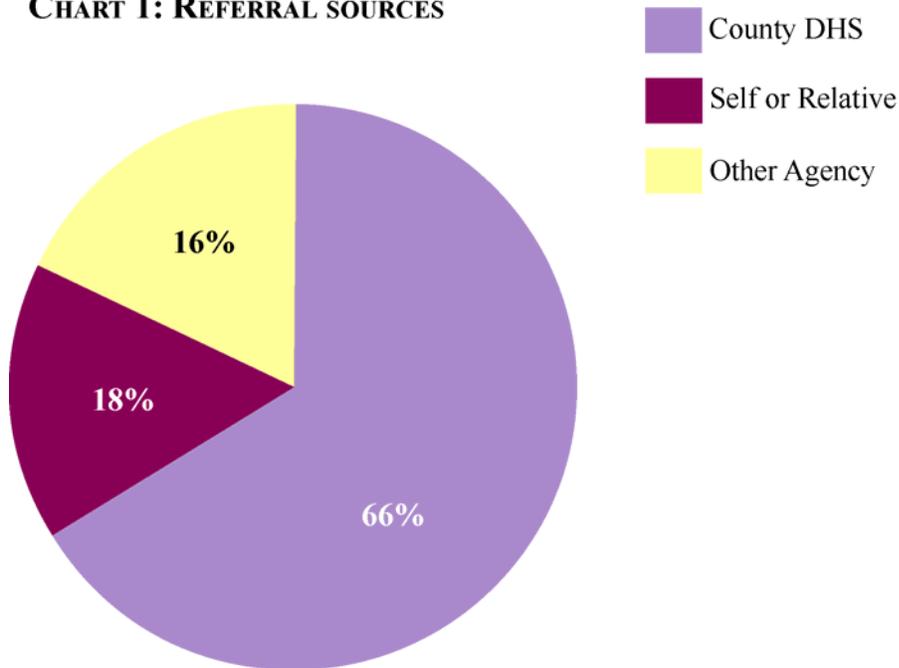


CHART 2: MALTREATMENT TYPE

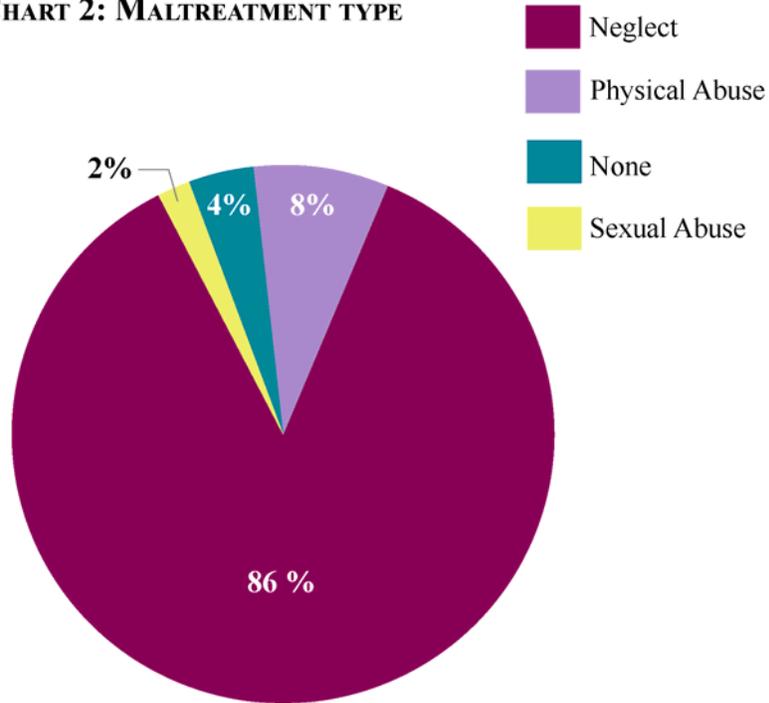
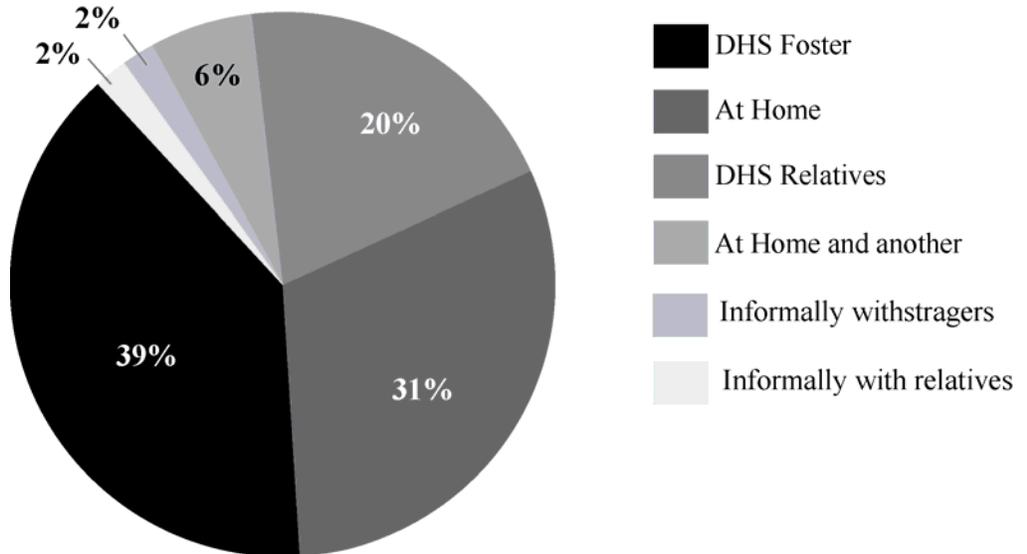


CHART 3: CHILD PLACEMENT AT BEGINNING OF PROGRAM



Child safety

There have been no new reports on any of the RMQIC project families while their cases were open for services with DIFRC. This rate is far lower than other data. The national average for new substantiated reports within six months of a first substantiated report was 8.1% for all groups (using National Child Abuse and Neglect Data Systems [NCANDS] data from 2004, the latest year available). The same national data set differentiated by race/ethnicity and showed a substantiated rate of 15.5% for American Indian/Alaska Native children. Colorado's recurrence rate for substantiated reports within six months for all groups in Colorado was lower than the national average—4.1%.



State data from the CWEST system, an administrative database, indicate the number of new cases opened and whether the reported maltreatment was substantiated. Using data from that source, 15.6% of cases statewide, across all ethnicities, have a second case reported within six months of the closing date of the prior case. These data span a five-year period, from 1995-2000. The rate of second case opening for American Indian cases by the counties within six months was the highest for any race/ethnicity—17.5%.

It also is possible to look at these same statistics for Denver County, where the average rate of recurrence of a second case is 20%. Again, the rate of second case openings within six months during the five-year period from 1995 to 2000 was highest for American Indian families in Denver County at 28.8%. Since the NCANDS data only present on substantiated cases, whereas the Colorado CWEST data contain all reports that result in a case being opened, DIFRC's recurrence rate of 0% for a new report within six months of a prior report is substantially better than the state rate of 17.5% for new cases for American Indian families or the Denver County rate of 28.8% for new cases for American Indian families.

Improvements in levels of safety and risk

Repeated measures analysis was conducted to determine whether there were changes in any of the NCFAS-AI domains, including environment, caregiver capabilities, family interactions, family safety, and child well-being across the three time-point measures: baseline, 180 days, and case closure. Results showed significant positive improvements from baseline to case closure in only one domain, caregiver capabilities ($p < .05$). Results were almost significant for family safety ($p = .59$), and additional Paired-t-test analyses showed that family safety significantly improved from baseline to 180 days, but these changes were not sustained at the final assessment of the NCFAS-AI administered at case closure. Thus, gains in child safety seem to be short-term.

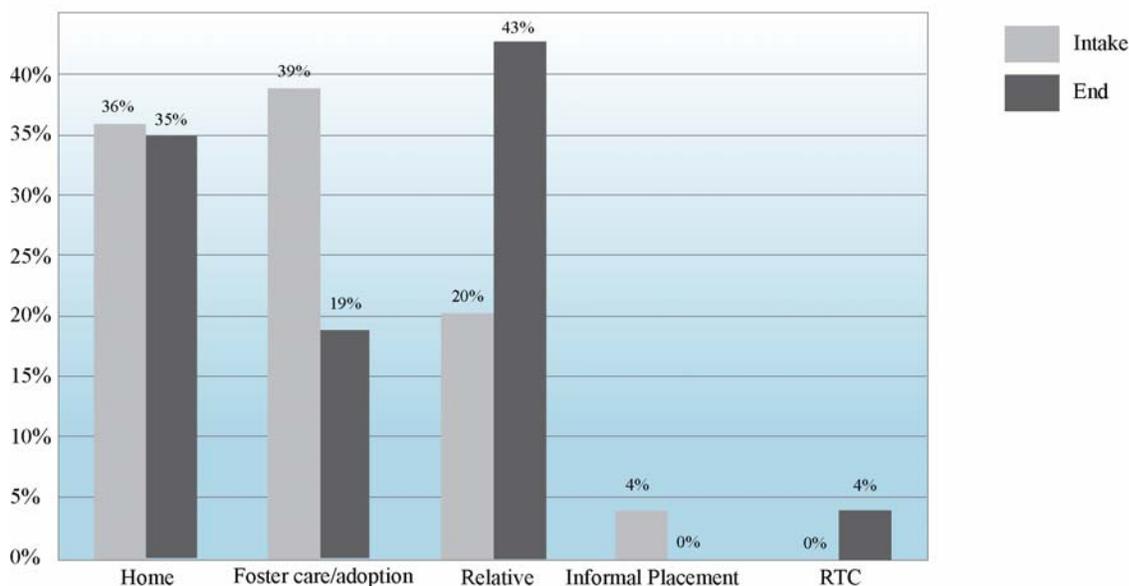
Child permanence

Nearly all RMQIC project cases' placement goal was reunification, with most children being placed out of the caregiver's home at case opening. For those cases where the children remained in the home, two teens were placed subsequently while in the program (due to Youth in Conflict issues). Three families saw a reunification with parents, and while children in 19 families were placed with strangers at the outset, children in only 8 families were placed with strangers at project end. In one

reunification case, an infant was returned home but then placed again after the parents tested positive for drugs. In the cases that were closed due to lack of compliance with treatment, children were placed primarily with relatives or in a home chosen by the Tribe, so there has been little use of permanent non-relative, non-Tribal homes for project families. In one case, however, the participant had her parental rights terminated and her child was placed for adoption in a non-Indian and non-relative home.

Chart 4 compares child placement at the beginning and end of the program. At the end of the program, 17 (35%) families had children who remained at home, compared with 18 (36%) of the families at intake. The number of families with children placed in foster care or with adoptive non-Indian parents decreased from 19 (39%) at intake to 9 (19%) at case closure, and the number of families with formal placements with Indian relatives increased from 10 (20%) to 21 (43%). Although the number of children who were at home did not increase, an overall positive outcome, as shown in Chart 4, is that placements with strangers decreased while placements with relatives increased over the course of the program. The connections of the children to their culture were strengthened.

CHART 4: CHILD PLACEMENT AT PROGRAM BEGINNING AND END



Child and Family Well-Being

Caregiver Substance Use: Many participants used more than one drug; the two most common combinations of substances were: 1) alcohol and marijuana, and 2) alcohol, marijuana, and cocaine. Substances used by clients were: alcohol (80%), marijuana (43%), cocaine (35%), methamphetamines (27%), and heroin (2%).

Reduction/Elimination Based on Urinary Analysis (US) results upon program completion and at six-month follow-up: A total of 19 clients were administered UA or breathalyzer tests. Twelve of these tests showed positive use of substances, while six assessments showed no substance use. One participant's UA showed dilution. Another participant insisted that a UA that showed positive for methamphetamines was actually due to pain medication she was taking. Thus, there was a 32% rate of elimination for the 19 participants tested. This is promising data.

Self-reports of usage and treatment provider reports indicated reduction of usage. The self-reports of usage largely matched the evidence from the UA reports. All but one of the project participants with positive UA also admitted to relapsing. However, some of the participants not providing UAs did admit to relapsing.

Eight clients who entered the program prior to 2005 were unable to maintain sobriety and essentially had zero sober months. The remaining 15 clients who were in the program long enough to measure sobriety were sober between two and six months. Ten participants remained drug- and alcohol-free (sober for nine or more months). What these 10 participants had in common was that they attended substance abuse treatment and were in regular contact with the DIFRC Social Worker. Several also were voluntary cases with the counties. Two of them had attended PIP parenting classes. The Social Worker noted that some of the successful cases were ones for which she had arranged extra team meetings that brought caseworkers, therapists, and DIFRC staff together with the client. She believed that the participant felt supported by the group of professionals and could not triangulate among agencies, and therefore heard a consistent message from everyone involved.

Overall, clients had varying degrees of stability in sobriety, ranging from 0 months (a recent relapse) to 16 months. The median length of sobriety was 3 months, with a mean of 4.4 months. (Two participants began their sobriety prior to program enrollment, but their length of sobriety was calculated from time of enrollment to case closure.) One reasons for participants' success might be the intensive case management they received as part of the program.

RESEARCH QUESTIONS

1. What family and child characteristics are associated with successful outcomes of family strengthening efforts?

Composition, degree of connection to, and use of support networks: Qualitative interviews with six RMQIC participants suggest that the most successful participants use their treatment team (across agencies) as a source of support or have made a strong commitment to a substance abuse program. Some participants reported distrust of the county DSS system and felt the DIFRC caseworkers played an important advocate role, helping them "navigate" the system and connect with culturally based treatment. However, two participants also reported there had been

turnover among the caseworkers at DIFRC, and that sometimes they had difficulty connecting with their caseworkers when they needed help with time-sensitive issues such as documentation for court. Linking with family for support was difficult for many participants due to family involvement with substance use and, in an opposite fashion, the tendency of some family members to cease all relationships with parents who had abused substances and broken many cultural norms and expectations.

2. *What intensive specialized services for families that struggle with substance abuse and child maltreatment are most likely to affect outcomes for clients (i.e., child safety, child permanency, child well-being, family well-being, and other outcomes specific to the proposed project)?*

DIFRC learned early in the project that providing the services necessary to support change in the lives of American Indian participants who have child protection and substance abuse issues required a much more intensive level of clinical intervention than originally anticipated. Identified factors underlying the need for more intensive work with this population were:

- Severity of substance use
- Chronicity of use
- Intra-familial substance use, often spanning several generations
- High levels of unresolved grief, loss, and trauma, including both historical and contemporary trauma
- Undiagnosed and/or untreated mental illness
- Inability of participants to pay for affordable substance abuse treatment services

It was discovered that many of these issues negatively impacted RMQIC project participants' readiness to address their substance use and their abilities to participate in family preservation or reunification activities. In addition, participants with these issues often led extremely chaotic lives in which it was difficult to meet basic needs such as food or stable housing. Serious problems with interpersonal relationships, domestic violence, involvement with the criminal justice system, and disruptions in family support networks also have been identified as areas requiring intensive intervention.

To address the extra efforts needed to assist this population, DIFRC incorporated intensive and clinically based case management services into the RMQIC project. These services were focused on helping participants meet issues of daily living that they reported as being "overwhelming" or which were too difficult to handle alone. Case management also helped participants find services to meet challenges such as mental health concerns. This intervention also was added as a result of participant feedback that indicated that if participants felt more in control of these life issues, their readiness to address substance abuse issues in treatment would increase.

APPRAISAL OF SUSTAINABILITY AND REPLICATION

1. *What efforts are needed to support initiative sustainability and successful project replication?*

The goals of the RMQIC project are consistent with DIFRC's mission and values. The inclusion of substance abuse assessment and treatment has added a new dimension to the agency's service delivery. DIFRC considered information from the agency's experience with the RMQIC project in updating its strategic plan in August 2004 and incorporated substance abuse-related services as part of the new plan. DIFRC's updated strategic plan serves as the foundation for a long-term fundraising plan with strategies focused on sustainability.



Financially, and prior to the RMQIC grant, DIFRC received funding for start-up costs through a decreasing multiyear grant from Casey Family Programs. The RMQIC funding has served as leverage for other funding. In 2003, DIFRC developed and implemented a comprehensive local fundraising plan with the assistance of JVA Consulting and funding support from the Rose Community Foundation. JVA facilitated a process with board members, fundraising committee members, and staff to develop a plan to diversify DIFRC's funding base. The process included extensive research to identify potential funding sources compatible with DIFRC's goals and objectives. The result of these efforts was a fundraising plan for 2003 that included multiple strategies.

DIFRC's efforts at diversifying its funding sources are being realized. Foundation and government proposals are being submitted consistently. Sources of funding now include federal and state government grants, county service contracts, national and local foundations, churches, direct mail appeals, a memorial endowment fund, and training fees. The 2003 fundraising goal was achieved at 90%. The fundraising plan was updated in 2004 and achieved 100% of its goal.

JVA Consulting began a second phase of planning for sustainability in Fall 2004. Additional research on potential funding sources was conducted and a long-term diversified fundraising plan was developed. Proposal writing for major federal and/or national foundation funding was included. In 2006, DIFRC received a SAMHSA Circle of Care planning grant to conduct a community-wide assessment to identify needs and describe the current delivery system for services for youth with severe emotional and behavioral disorders. The RMQIC effort was an important event, as it helped shape planning and supported building organizational capability and community awareness.

2. What systemic changes in the communities, in the lead organizations, if community based, in the CPS agency, or in the court has the project brought about?

The following systemic changes have occurred as a result of the RMQIC project:

Increased/enhanced education training with county DHS agencies and community substance abuse providers

DIFRC staff conducted 18 trainings in Denver, Jefferson, and Adams counties, reaching a total of 312 county workers, since the inception of the RMQIC project. Project staff met with the following substance abuse providers in the Denver-metro area to educate them about participant needs and the project: SIGNAL, Arapahoe House, Eagle Lodge outpatient program, Native American Counseling, Kayt Schneider, and Verla Howell.

Increased program referrals from county DHS

As of June 2006, the program received 21 (43%) referrals from Denver County, 17 (35%) from Jefferson County, five from Arapahoe County (10%), five from Adams County (10%), and one (2%) from Boulder County. There were proportionally more referrals from Jefferson and Arapahoe Counties in this mix than the prior proportions referred to DIFRC's general services. It is not known how many of the prior referrals would have met eligibility criteria for the RMQIC program, but numbers of referrals in general decreased between 2002 and 2003 because all county departments suffered extensive budget cuts just as the RMQIC project was implemented. Data obtained from Denver County, however, showed that the department was referring all eligible American Indian families seen to DIFRC.

Improved understanding of and commitment to project goals and methods from all project partners

DIFRC's partner organizations were aware of the RMQIC project goals and services through presentations about the project at the monthly SDAC meetings. Additional links have been made with Native American Counseling to provide needed substance abuse and mental health counseling. DIHFS has made an adjustment in its commitment to the project goals by arranging substance abuse treatment with other providers for tribally enrolled program participants.

There is now a formal commitment from DDHS to work with American Indian families, including those with substance abuse issues. Adams County has asked for the development of a formal process and commitment. Jefferson County includes DIFRC in some of its planning processes and has committed to doing TDMs that include American Indian families. Arapahoe and Boulder Counties are aware of the project and refer clients but have not made a formal commitment to the project.

Client case plans reflect culturally appropriate, individualized plans

Case planning at intake now includes input from participants about services needed and desired, as well as incorporates needs and mandates from county departments of human services. These voluntary, and sometimes involuntary, goals are reflected on the intake sheet under services requested. In addition, after doing the initial family assessment within the first 30 days, the Social Worker may add additional services or plans arising from new information. While all RMQIC participants had some common case services (e.g., intensive case management, pre-treatment group, substance abuse treatment, parenting classes) and shared goals (e.g., child safety, permanence, increased family functioning, reduction/elimination of substance use), the plan to sequence all these services and the provision and timing of the intensive case management was individualized for each family.



DIFRC worked with provider agencies and clients to improve access to services

This has been an area of program growth since Year 1. At that time, some participants waited weeks for a substance abuse assessment, primarily due to a DIHFS policy regarding the need for documentation of tribal enrollment status, and in some cases, low client motivation levels. After hiring a clinical supervisor licensed to provide substance abuse counseling, arranging with Native American Counseling to work with a trained substance abuse counselor there, and networking with SIGNAL and Arapahoe House (two of the primary substance abuse evaluators/providers in the area), participants in Years 2 and 3 increasingly were able to arrange for a substance abuse evaluation soon after intake. In addition, all willing participants then were able to begin substance abuse services with no major delays after evaluation.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

Project outputs

Collaboration between DIFRC and other Indian-serving organizations improved as a result of this project. While DIHFS has traditionally been the conduit for substance abuse services for Denver’s American Indian community and was assumed at the beginning of the project to be the primary substance abuse provider, they were unable to serve many of the American Indian clients in this project. This is because of an Indian Health Services mandate that the agency can provide services only to enrolled tribal members. As a result, DIFRC had to seek additional referral sources for project participants who are not tribally enrolled.

Collaboration with county departments of human services also was strengthened, particularly in Denver, the county with the largest percentage of American Indian families. DIFRC staff and DDHS administrators and caseworkers worked together to accomplish several goals:

- 1) formalize the referral process so that all American Indian families that come into contact with DDHS are referred to DIFRC;
- 2) ensure that DIFRC Case Coordinators are notified of all TDMs with American Indian families;

- 3) participate in monthly meetings of the Promoting Safe and Stable Families Initiative; and
- 4) provide trainings to the department on the ICWA and the provision of culturally appropriate services to American Indian families.

This success hopefully will provide a template for DIFRC to build partnerships with other county agencies that will lead to formal Memorandums of Understanding for the most effective ways to serve American Indians/Alaskan Natives with open child welfare cases.

The DIFRC RMQIC program served 49 families over three years that struggled with substance abuse and child welfare issues. A majority of project participants had been dually diagnosed with substance abuse and mental health issues. A great deal of effort was required of the Clinical Supervisor and Social Worker to refer participants with mental health problems to culturally appropriate providers who could conduct evaluations, prescribe medication, and provide necessary care. Mean scores on the NCFAS-AI indicate that these clients experienced greater severity of issues than other DIFRC clients.

Project outcomes

At project end, client outcomes were very positive:

Child Safety

Throughout the project period, there were no new reports thus no new substantiated or re-substantiated reports of child maltreatment.

Child Placement (including cultural and family connection)

Efforts to achieve the goal of keeping American Indian children from being placed outside the cultural and family community were successful. The number of children placed in foster care with strangers decreased from 39% to 19%, while the number of these children placed with relatives increased from 20% to 43%.

Parental Substance Use, Treatment, and Sobriety

As presented, many participants presented with severe substance abuse issues; 37 participants received treatment, and the median length of sobriety was three months, with a mean of 4.4 months.

Family Well-being

As for measures of family well-being, since the project evaluator adapted the NCFAS for use in this context, reliability analyses had to be conducted. These reliability analyses conducted for the NCFAS-AI showed that Cronbach's alpha for the 31 questions was .91, suggesting that the overall measure is a highly reliable tool. Reliability analyses for each of the five subscales to determine the internal consistency of the items showed that all the subscales were reliable, with Cronbach's alphas ranging from .73 to .91.

Repeated measures analyses were conducted to determine whether there were changes in any of the NCFAS-AI domains, including environment, caregiver capabilities, family interactions, family safety, and child well-being across the three time-point measures: baseline, 180 days, and case closure. Results showed significant positive improvements from baseline to case closure in only one domain, caregiver capabilities ($p < .05$). Results were almost significant for family safety ($p = .59$), and additional Paired t-test analyses showed that family safety significantly improved from baseline to 180 days, but these changes were not sustained at the final assessment. No changes were found over time for the other domains, including environment, family interactions, and child well-being.

Recommendations

A comprehensive set of recommendations based on the results of the DIFRC RMQIC project can be found in the *Replication Guide*. Following is a summary of the recommendations presented in that report:

Forming Partnerships

Efforts to develop working partnerships between public child welfare and private ICWA agencies are essential to growing and to maintain awareness of programs to serve families. In addition, partnering with other initiatives promoting similar interventions, such as the “Family to Family Initiative,” can strengthen both programs.

Techniques of Outreach

In the absence of a legislative or executive mandate for CPS to refer clients to American Indian agencies or service providers, the agencies may use networking, formal outreach, a formal memorandum of agreement, and a fee-for-services approach to publicize its services and emphasize the role agencies could play in helping CPS work with American Indian families.

Ongoing Collaborations

Agencies or service providers should focus on strengthening measures to identify American Indian families at first contact with CPS and to develop protocols for referring those families. Agency staff could provide training to child welfare workers (including administrators and supervisors) on the ICWA and on providing culturally responsive services. The training could cover basic information on American Indian culture, worldview, values, history, and experiences with child welfare, as well as provide workers with practical skills in cultural responsiveness.

Partnerships and Resources

It is important to identify and form working relationships and resource understanding with Indian and tribal providers, and to establish similar relationships and partnerships with other providers who understand and can furnish culturally appropriate services for Indians who may have difficulty registering with their tribe.

Promoting Community Awareness

Agencies or service providers may want to actively participate in conferences and offer trainings for social workers in early identification, timely referral, and culturally appropriate services; training provides information and practical means to incorporate these areas into their casework.

Family Engagement

It is important to identify kinship relationships and assist CPS caseworkers in kinship placements and to educate others about the value in thinking and acting more broadly with their definitions of family.

Staffing for Intensive Case Management

Most of the client population suffers from histories that include severe trauma, chronic (and often untreated) mental health problems, current involvement with the legal system and/or incarceration, and a lack of readiness to address their substance use. These characteristics require exhaustive work on the part of workers as they attempt to move participants to the point of being ready to engage therapeutically in regard to their substance use, as well as to ensure continued child safety and family well-being.

Access to Culturally Appropriate Services

Even though most of the project participants were dealing with severe substance abuse and mental health diagnosis there was a lack of culturally appropriate treatment services to enable families to become higher functioning in any aspect of their lives. The community was forced to access services through mainstream programs that may not be sensitive to culture and historical implications that affect the entire family.

Staffing for Growing Caseloads

Since participants move toward recovery slowly, there is potential for a large caseload buildup. Steps to prevent worker burnout, including options for staff expansion, should be incorporated into programs serving this population.

Staffing Recommendations

It is recommended that both a full-time social worker and at least a half-time Family Advocate be used to assist clients with intensive in-home and case management services. The family advocate assists with case management activities, allowing the Social Worker more time to provide families with critical clinical services, such as individual counseling, increasing readiness to address substance use issues, and enhancing participants' abilities to attend to daily living challenges. Caseloads of 10 to 12 families appear to be ideal.

Director Allocation and Involvement

A full-time project director should be hired to oversee program development, implementation, reporting, data collection, and collaboration with the program evaluator, and maintaining collaborative relationships with public welfare agencies. Those activities normally require a significant amount of a project director's time.

Skill Sets

In making hiring decisions, it is important to seek workers who not only represent the tribal diversity of their urban American Indian population, but also are flexible and knowledgeable in working with the diverse cultural connectedness and social and contextual realities of the families served.

Recommendations concerning RMQIC activities

Being part of a collaborative of grantees with oversight by a local intermediary conferred several benefits in the DIFRC RMQIC project. First, the American Humane Association provided technical assistance and support, which was particularly helpful during project implementation. American Humane also was accommodating of program changes that occurred early during implementation. Finally, American Humane provided opportunities for grantees to share ideas, challenges, and successes through telephone contact and annual meetings. In fact, learning about the program design of another RMQIC program instigated the development of the pre-treatment group for the DIFRC project to help clients improve their stage of readiness for substance abuse treatment.

One recommendation for improvement is to communicate clear and consistent expectations to grantees about all aspects of the project, including design, outcomes and measurement, and accounting.

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