DANSR

Dependency and Neglect System Reform

COLORADO

Department of Human Services

DANSR Pilot Practice Guidelines

DRAFT 04-15-16

"CHANGE THE WAY YOU LOOK AT THINGS AND THE THINGS YOU LOOK AT CHANGE."
– Wayne Dyer

"SYSTEM REFORM MEANS, ABOVE ALL, CREATING A POSITIVE, SUPPORTIVE ENVIRONMENT NOT ONLY THROUGH ADEQUATE TREATMENT SERVICES BUT THROUGH CLIENT ADVOCACY THAT IS DRIVEN […] BY STAKEHOLDERS ENGAGED IN CONTINUOUS TRAINING AND SUPPORT [WHO ARE] SENSITIVE TO THE IMPACT THE D&N HAS […] ON CLIENTS."

– C.J. Montoya
Problem Solving Court Coordinator II
Huerfano County DANSR Pilot Site

EXECUTIVE SUMMARY

What are the practice guidelines?

This document provides guidelines for the pilot phase of the DANSR project: May 2016 – September 2017. These practice guidelines were developed, in part, by DANSR teams in Fremont County, Huerfano County, Jefferson County, and Montezuma County. We hypothesize that the practices listed here will immediately impact how pilot sites serve these families and rapidly impact outcomes. The development and piloting of the guidelines will be evaluated by the National Center for State Courts [NCSC] to assess identified barriers, needs met, unmet needs, existing resources that are leveraged, resources that do not exist, and successes and failures. This evaluation will inform the implementation phase of the program (October 2017 – September 2020). During implementation, the goal is for all judicial districts and stakeholders to receive training and use a revised version of these guidelines.

Which families should be given access to DANSR?

At the very least, any family with a new dependency and neglect case managed according to EPP (Expedited Permanency Planning) timeframes.[1]

What is DANSR?

In October 2014, Colorado became one of five states to receive an Office of Juvenile Justice and Delinquency Prevention Statewide System Reform Program (SSRP) award. Now known as Colorado's Dependency and Neglect System Reform Program (DANSR), this federal initiative (three years of planning with a subsequent three year implementation phase) will support the infusion of effective family treatment drug court strategies into our dependency and neglect cases across the state. This effort will involve "systems change" for Colorado's Judicial Department, CDHS-Division of Child Welfare, and CDHS-Office of Behavioral Health, supported by a nationally-recognized substance abuse and child welfare research agency, Children and Family Futures.

What problem is DANSR trying to solve?

Research shows that:

- The child welfare and treatment (mental health and substance abuse) systems – as well as the court system - have an overlapping population, but these systems don't always coordinate efforts to serve that population effectively.
- Most families involved in a dependency and neglect case have a substance use disorder and sometimes have a co-occurring mental health disorder. The dependency court's treatment orders are not sufficiently responsive to substance abuse and any corresponding co-occurring mental health assessments.
- Parents in child welfare with substance use disorders and, if applicable, co-occurring mental health disorders, are less likely to reunify with their children than parents who do not face these challenges.

[1] Expedited Permanency Planning procedures are followed for all dependency and neglect cases involving a child six years old or younger (and their siblings even if they are older). § 19-1-123(1)(a) (2015).

What is DANSR's proposed solution?

Research shows that family treatment drug court strategies work for families involved in multiple systems. Parents in family treatment drug court are significantly more likely to complete treatment, be reunified with their children, and their children spend considerably fewer days in out-of-home care.

DANSR is informed by six effective family drug court strategies identified by our funders [*see Appendix A*]. It is also informed by the following definition of well-being: Each family's well-being exists in the context of a dependency and neglect case. In this context, a DANSR-informed approach to creating well-being for children and families supports meaningful connections for a child or youth leading to permanent and protective relationships that foster his/her capacity for resiliency and growth in the face of adversity and trauma.

Within that framework, DANSR proposes to create a family-well-being focused, trauma-informed, front-loaded, and individualized service-provision process for families that includes:

1. Providing universal screening for substance abuse and mental health;
2. Shorten timeframes between screening and assessment for substance use disorder and mental health;
3. Use a multidisciplinary team staffing to integrate substance use disorder and mental health assessments and to consider, simultaneously, the child's safety and risk assessments; and
4. Make the court's case management responsive to treatment needs.

TABLE OF CONTENTS

WHAT DOES A DANSR PILOT SITE DO?

I. PROVIDE UNIVERSAL SCREENING FOR SUBSTANCE ABUSE AND MENTAL HEALTH

A. IDEALLY, WHAT DOES A DANSR PROCESS LOOK LIKE?

1. Screening and assessment for substance abuse and co-occurring mental health issues are front-loaded in all cases.[2]
2. All custodial parents and other parents present at the initial hearing are screened by child welfare professionals for substance abuse and co-occurring mental health issues as early as the initial social services contact but no later than 14 days after the initial hearing.
3. Treatment plans that incorporate substance abuse treatment and any co-occurring mental health treatments are individualized and developed with the input of the family.[3]

B. HOW DO WE CREATE A DANSR PROCESS?

CHILD WELFARE

1. Incorporate a substance abuse screen into all dependency and neglect cases by either:
   - Incorporating it into the county's child welfare social history questions. [*For Jefferson County's model, see Appendix B*]; or
   - Use a separate UNCOPE screen **no later than** 14 days after the filing of a new EPP Dependency and Neglect Petition. [*For the UNCOPE questions, see Appendix C*]
2. Work with substance abuse and mental health treatment providers to make case planning after initial assessments sensitive to whether or not a child's well-being is impacted by any substance use and, if applicable, co-occurring mental health disorder.
3. Use a trauma screen for children and adults. Share the screening results with substance abuse treatment providers and mental health treatment providers.

SUBSTANCE ABUSE TREATMENT PROVIDERS

1. Screen for mental health issues in clients seeking admission to substance abuse treatment using either:
   - The MENTAL HEALTH SCREENING FORM – III (Carol and McGinley), which is available to the public and is free of charge. [*For a complete copy of the Mental Health Screening Form – III, see* http://store.samhsa.gov/shin/content//SMA13-3992/SMA13-3992.pdf (p. 500-01)*, Appendix D*], or
   - Another comparable screening tool.
2. Determine whether to administer another trauma screen if one has already been administered; if one has not yet been administered, use a trauma screen for adults.

[2] CJD 98-02, Case Processing Procedures (1).
[3] *See* C.R.S. § 19-3-209. (2015)

MENTAL HEALTH TREATMENT PROVIDERS

1. Screen for co-occurring disorders and trauma within 30 calendar days of the temporary custody hearing.
2. Determine whether to administer another trauma screen if one has already been administered; if one has not yet been administered, use a trauma screen for adults.
3. Coordinate any urine screen requirements with child welfare's use of urine screens for child-safety monitoring.

COURTS

1. Attend trainings on child development, addiction, recovery, and identification of significant alcohol and/or drug-related disorders in children. *You can begin at the Convening!*
2. Use court progress reports to support the inclusion of substance abuse treatment and mental health perspectives in case management.
3. Judicial officers should check to see that trauma screen has been done – **but not in open court.**

NON-MANDATORY PRACTICE TIPS FOR UNIVERSAL SCREENING

1. Local Mental Health Providers will need to be brought into to agree with the specific requests made of them under this action step.
2. In Fremont County, substance abuse assessments occur at the first appointment (intake) which occurs within 24 hours of child welfare's referral.
3. Montezuma County created a court report form. [*See Appendix E*]
4. In Huerfano County, Judicial, the Department, and treatment providers collaborate to ensure that client evaluations are scheduled prior to the temporary custody hearing so that Judge Appel can order the client to attend the evaluation at the scheduled date and time.
5. In El Paso County, prior to the shelter hearing, parents can agree to participate in an "expedited assessment." Generally, it is the caseworker and respondent parent counsel discuss this option with the parent. The caseworker contacts one of the partnering treatment providers (local providers there commit a block of time each week to any expedited assessments) and gets a date/time for the expedited assessment within the next 72 hours. The parent gets a form with the date, time, and location of the appointment and a map. The caseworker also sends (electronically) case summary to the treatment provider directly from the courthouse so they have collateral information before coming to court. The treatment provider agrees to provide a written report to the caseworker within ten days of the assessment. The caseworker then files the report with the court.
6. Review your judicial district plan, established after *CJD 98-02*, as a team. What procedures does your county already have established to get families' needs identified more quickly? [*Locate your judicial district's plan at www.coloradocip.com. Go to "District Plans for Handling Dependency & Neglect Cases" under "Best Practices."*]

II. SHORTEN TIMEFRAMES BETWEEN SCREENING AND ASSESSMENT FOR SUBSTANCE USE DISORDER AND MENTAL HEALTH

A. IDEALLY, WHAT DOES A DANSR PROCESS LOOK LIKE?

1. Information from the child welfare safety and risk assessment is shared by child welfare with treatment providers (both mental health and substance abuse) in time for that information to inform the provider's assessment processes.
2. Initial treatment assessment reports (oral or written) and/or evaluations are completed (for both substance abuse and mental health, as well as for co-occurring disorders) no later than 30 calendar days after the temporary custody hearing / initial hearing.

B. HOW DO WE CREATE A DANSR PROCESS?

CHILD WELFARE

1. Incorporate information from substance abuse and mental health treatment provider assessment reports into the child welfare safety and risk analyses and into initial and ongoing treatment planning/case management.

SUBSTANCE ABUSE TREATMENT PROVIDERS

1. When the client participates in the assessment process within this timeframe, complete the initial assessment and share all reports within 30 calendar days of the temporary custody hearing / initial hearing for all custodial parents and parents present at initial hearing.
2. Screen clients for child welfare involvement and seek appropriate releases of information so that the client can share information about case issues with professionals working on their case.

MENTAL HEALTH TREATMENT PROVIDERS

1. When screening indicates a possible mental health concern, complete the initial assessment and share all reports within 30 calendar days of the temporary custody hearing / initial hearing for all custodial parents and parents present at the initial hearing.

COURTS

1. Ensure respondent parent counsel are appointed within ten business days of a temporary custody hearing/ initial hearing. Note: Fremont County holds first hearings on days when the whole team of GAL and RPC are present for other cases to match counsel to clients "on the fly". Some jurisdictions may not be able to accommodate that practice – consider appointing counsel remotely (i.e. by phone).

2. Collaborate with local departments of social services, county attorneys, guardians ad litem, and respondent parent counsel to develop procedures to ensure that petitions are filed at the first hearing conducted.[4]

NON-MANDATORY PRACTICE TIPS FOR SHORTENED TIME TO ASSESSMENT

1. DANSR teams can consider using a Substance Abuse Specialist or recovery coach/peer mentor. Recovery coaches provide advocacy, service planning, outreach, and case management to parents throughout the case. The use of recovery coaches is one strategy that, according to research, has a positive impact on family outcomes. [*For more information on substance abuse specialists/peer recovery mentors, see Appendix G; also consider reaching out to Jefferson County, who has worked on developing a substance abuse specialist position.*]
2. Substance abuse treatment providers should review their contracts with their Managed Service Organization (MSO) and county. Assessments can involve the Addiction Severity Index (ASI) or GAIN; are there other contractual guidelines? Within the contractually-required framework, what strategies have the jurisdiction's treatment providers developed to get the most informative clinical evaluation? Please share this insight with the team (*and with the DANSR Liaison – Sarah Felsen, sarah.felsen@judicial.state.co.us*).
3. In Fremont County, Solvista (Mental Health Provider) is starting to include referral documentation in intake folders for more comprehensive assessment.
4. In Fremont County, Rocky Mountain Behavioral Health's substance abuse treatment providers bring a tablet to initial Family Engagement Meetings (immediately preceding shelter hearings) to set times for initial appointments for assessment.
5. Consider using Montezuma County's standardized referral form to help substance abuse treatment providers get the information they need from their initial assessment appointment. [*Appendix I*]

[4] CJD 96-08 (2)(a).

III. USE A MULTIDISCIPLINARY TEAM STAFFING TO INTEGRATE SUBSTANCE USE DISORDER AND MENTAL HEALTH ASSESSMENTS AND TO CONSIDER, SIMULTANEOUSLY, THE CHILD'S SAFETY AND RISK ASSESSMENTS

A. IDEALLY, WHAT DOES A DANSR PROCESS LOOK LIKE?

1. Assessment reports (oral or written) for substance abuse and, if applicable, a co-occurring mental health disorder, are shared (with releases) by treatment providers to child welfare professionals and parent's attorney in time for all parties to make informed decisions about the treatment plan.
2. Treatment plan recommendations and orders are directly related to a continuous joint assessment process involving treatment and child welfare.
3. **Multidisciplinary team staffing of case occurs based on FTDC staffings.** Staffings in FTDC are used to integrate the results of SUD and MH assessments into the level of care placement, to monitor progress in SUD/MH treatment, to monitor progress in auxiliary services, to discuss drug test results, to discuss sanctions and incentives, and to establish the appropriate level of judicial supervision and oversight of the case. The FTDC model generally does not include the attendance of parents, children, relatives and friends at staffings. The staffing provides an opportunity for the professionals assigned to the case to speak about the needs of the case and to formulate recommendations for the court. The participation of the judicial officer is permitted but is not required. However, staffings must include the attorneys, case worker, assessors and therapists assigned to the case whenever possible to ensure the most accurate and timely information can be considered during the event. Pilots may consider adapting or combining other multi-disciplinary staffings or meeting such FEM, TDM, pre-court staffing, IIST to function as MDT staffing.

TYPES OF MULTIDISCIPLINARY STAFFINGS
Family Engagement Meetings
Team Decision-Making Meetings
Treatment Support Meetings
Pre-Court Staffings
Individualized Service and Support Team (ISST) Meetings
Permanency Round Tables
Other: *What type of multidisciplinary team staffing will your jurisdiction create to best serve your families at this DANSR stage?*

B. HOW DO WE CREATE A DANSR PROCESS?

CHILD WELFARE

1. Caseworkers participate in a multidisciplinary team staffing in advance of any treatment order.

2. Document any multidisciplinary team staffings created/used to discuss initial treatment plan in advance of disposition in the state automated management system in the same way/a similar way as family engagement meetings.[5]
3. Incorporate information from multidisciplinary team staffings regarding treatment orders, into the child welfare safety and risk analyses and into initial and ongoing treatment planning/case management.
4. Transmit received substance abuse and mental health assessment information, in the appropriate manner, to all professionals (including RPC, GALs, Court).

SUBSTANCE ABUSE TREATMENT PROVIDERS

1. Providers participate in a multidisciplinary team staffing in advance of any treatment order.
2. Use the ASAM (American Society of Addiction Medicine) criteria to develop the treatment level of care recommendation post-assessment; document the treatment level of care determination.[6]
3. Share the assessment report and substance abuse treatment level of care determination during the first multidisciplinary team staffing. [*For resources on Information Sharing, see Appendix F*]

MENTAL HEALTH TREATMENT PROVIDERS

1. Providers participate in a multi-disciplinary team staffing in advance of any treatment order.

COURTS

1. Determine whether a voluntary waiver has been signed for information exchange within the multidisciplinary team staffing. .
2. The multidisciplinary team uses the child welfare safety and risk assessments, as well as a/each parent's substance use disorder and, if applicable, co-occurring mental health disorder assessment reports to gauge/monitor child well-being, and develop recommendations for the permanency orders. [Note: "Severity" of addictive disorder does not uniformly translate to "severity" of risk for child maltreatment, nor to the child safety issues necessitating placement.]
3. Hold a multidisciplinary team staffing before any interim treatment orders are set or dispositional orders made. [7]
4. Hold a multidisciplinary team staffing before the first permanency planning hearing.

[5] Vol. 7: 7.107.24(B).
[6] 2 CCR 502-1, 21.210.43(A): "Agencies shall use the American Society of Addiction Medicine Patient Placement Criteria as a guide for assessing and placing individuals in the appropriate level of care."
[7] "Any interim treatment plans that are entered must be available 30 days after the child's removal or the filing of the petition, whichever is earlier." CJD 96-08 (1)(d).

NON-MANDATORY PRACTICE TIPS FOR MULTIDISCIPLINARY TEAM STAFFING & INFORMATION SHARING

1. All case professionals are trained to rely on the treatment provider's treatment level of care recommendation (not solely their own judgment or solely the family's decision).
2. Attorneys can advocate for multidisciplinary team staffings as part of reasonable efforts.
3. Local Mental Health providers will need to be brought into to agree with the specific requests made of them under this action step.
4. Huerfano County developed a shortened, verbal report system for caseworkers to complete and circulate with their multidisciplinary team staffings..
5. Huerfano County organized their multidisciplinary team staffing schedule to accommodate GAL's caseload, but the same system could not effectively serve RPC

IV. MAKE THE COURT'S CASE MANAGEMENT RESPONSIVE TO TREATMENT NEEDS

A. IDEALLY, WHAT DOES A DANSR SYSTEM LOOK LIKE?

1. Substance use testing is random, frequent, and trauma-informed, and the results are prompt and reliable.
2. Judicial officer can modify frequency of hearings to accommodate family's demonstrated, treatment-related need for oversight.
3. A judicial officer interacts with a client directly, as in drug court.

B. HOW DO WE CREATE A DANSR PROCESS?

CHILD WELFARE

1. Track DANSR families' abstinence monitoring information (i.e. # and date of urine analysis screening ("UAs"), # and date of hair follicle tests, etc.)

COURTS

1. Hold hearings in response to issues brought up during multidisciplinary team staffings.

NON-MANDATORY PRACTICE TIPS FOR JUDICIAL RESPONSIVITY

1. Judicial officers should spend at least 3-7 minutes of time with families per hearing. Moving from under three minutes to just over three minutes effectively doubled the reduction in recidivism for adult drug court participants, while spending seven minutes or more effectively triples the positive outcome. This time should be spent in meaningful discussion regarding the family's needs and progress.
2. Treatment providers (substance abuse and mental health) should be trained to give effective court testimony.
3. Child welfare reviews their contracts with urine analysis monitoring companies – is your system reliable, random, and frequent? What are the barriers preventing it from being that?
4. Regardless of frequency of court hearings, the court should be available to hear motions or schedule hearings on short notice.
5. Consider reviewing the following policy document to better understand drug testing Best practices[*https://ncsacw.samhsa.gov/files/DrugTestinginChildWelfare.pdf*]

DANSR PILOT DESCRIPTION[8]

How is the county's DANSR steering team set up?

DANSR steering team members should have administrative authority so that decisions can be made during meetings and acted upon immediately thereafter, but also close enough to program operations to have a real understanding of practice issues and concerns. This group must include:

1. Judicial Officer
2. Representative(s) from your county's child welfare agency (*include front line and administration-level staff, when possible*)
3. Substance Abuse Treatment Provider representative(s) (*include front line and administration-level staff, when possible*)
4. Mental Health Treatment Provider representatives(s) agency (*include front line and administration-level staff, when possible*)
5. Attorneys – GALs, RPC, and County Attorneys

How often should the DANSR steering team meet per month?

1. Meet at least once every other month as a full team – including the team's judicial officer.
2. You may need to develop subcommittees with different meeting schedules.
3. If your DANSR team is the same as your multidisciplinary team participants (see below), you may be able to coordinate your policy-level discussions with your multidisciplinary team staffings.

*Who staffs a DANSR steering team?**

Choose a central person who (1) schedules meetings, (2) updates team members with meeting summaries and substantive issues, (3) is the point person for communication with the statewide Core Planning Team.

**While you can choose who staffs your team, the Judicial Department is the lead agency for the DANSR Program.*

How is DANSR measuring impact in the pilot sites?

Your identification of system barriers. This information will be gathered through:

1. *Monthly pilot calls* – Learn what your peers across the state are doing and how it's going! Your feedback will be used to improve the process outlined here.
2. *Site visits* – Core Planning Team members will visit you to learn about your work and support you. Children and Family Futures will also be available for site visits and technical support.
3. *Complete a Survey* – Periodically, pilot sites will complete surveys on their experience/progress. Your feedback will be used to improve the process outlined here.

Through the Project Plan

[8] DANSR Pilot jurisdictions should sign the MOU from April 2015 [see Appendix H] and these draft guidelines.

Pilots' work (May 2016 – September 2017) will be evaluated using the following project plan. In the Project Plan, below, all pilots will collect/track the data listed under "Data Collected" until instructed otherwise. If your jurisdiction does not currently track the data required, we will work with you to devise and support a system to collect this data.

The quarters identified below are intended to begin October 1, 2016 (this corresponds to our target date for the circulation of a database to hold all of your jurisdiction's data for each practice.

Before October 1st, consider the following:

- Convene your steering committee frequently – do you have all the participants you need to make the Project Plan tasks a reality?
- Develop action steps around the project plan – who will do what by when? Try to give your team some "lead time" on each practice.

DANSR PROJECT PLAN

	PRACTICE	STANDARD	DATA COLLECTED
1	*Identification of DANSR families for pilot/data collection purposes*	By end of QT 1 (3 months into piloting), each pilot site will: - Universally screen for MH and SUD - Identify an appropriate and expandable caseload for piloting purposes → document the steps you took to achieve this in a protocol	-# of cases appropriate for DANSR-informed intervention - # of cases not tracked during the pilot period, but appropriate for DANSR-informed intervention -copy of protocol submitted to DANSR liaison
2	*Integrating level of care recommendations and identifying barriers to enrollment to recommended treatment*	By end of QT 1, each pilot will provide/coordinate data submissions for identified monitoring elements (a.k.a. the information under "data collected" in this document) for access to treatment.	[Some elements collected at the state level] - date of substance abuse treatment level of care recommendation[9] -substance abuse treatment level of care recommendation -substance abuse treatment level of care placement -documentation of discrepancy between substance abuse treatment level of care recommendation and placement -drug/alcohol test date -drug/alcohol test result - co-occurring mental health screen date[10] -#of substance abuse treatment episodes that ended with a referral to a different level of care

[9] There are a number of ways that the treatment level of care recommendation and treatment level of care placement can be tracked. DANSR will look to our pilots to determine the best possible way of documenting this information.
[10] DANSR also aspires to collect co-occurring mental health assessment report date, but it is not in the pilot practice guidelines at this time.

3	*Increase % of cases given DANSR-informed intervention – 6 months*	By the end of QT 2 (6 months into piloting), each pilot site will have at least 25% of cases appropriate for DANSR-informed intervention (according to pilot site's protocol) managed according to DANSR pilot practice guidelines	-# of cases appropriate for DANSR-informed intervention -# of cases not tracked during the pilot period, but appropriate for DANSR-informed intervention
4	*Data Practice Change to create coordinated care and reporting*	By QT 2, your jurisdiction will have developed releases to allow for the sharing of relevant information amongst stakeholders	-copy of data-sharing protocol sent to DANSR liaison
5	*Multidisciplinary team staffings and court attendance*	By QT 3 (9 months into piloting), all attorneys (GAL, RPC, ACA), and all treatment providers[11] (SUD and MH), and caseworker are present at 50% or more of your DANSR multidisciplinary team staffings and hearings.	-documentation of barriers to attendance at team staffings[12]
6	*Increase % of cases given DANSR-informed intervention -12 months*	By the end of QT 4 (12 months into piloting), each pilot site will have 50% of cases appropriate for DANSR-informed intervention (as defined by the pilot site's protocol) managed according to DANSR pilot practice guidelines.	-# of cases appropriate for DANSR-informed intervention -# of cases not tracked during the pilot period, but appropriate for DANSR-informed intervention
7	*Timely Access to Substance Abuse Treatment – Time to Initial Assessment*	By end of QT 4, DANSR consumers will receive their initial substance abuse treatment assessment report (oral or written) within 30 calendar days of the temporary custody hearing/ initial hearing	-[Some elements collected at the state level] -Local courts (track receipt of the assessment report -date of temporary protective custody hearing / initial hearing.

[11] This could create a funding challenge; try to document your barriers specifically. In some jurisdictions, this is a representative from an agency that is informed about all cases to be discussed.

[12] There are cost barriers to allowing providers time to be present at court hearings and in multidisciplinary team meetings. Please document what barriers you face as a pilot jurisdiction.

8	*Parent treatment received*	By the end of QT 4, each pilot site will provide/coordinate data submissions for identified monitoring elements for appropriate placement to treatment	-length of substance abuse treatment[13]
9	*Determine appropriate level of court supervision*	By end of QT 4, each pilot jurisdiction will use a protocol to determine appropriate risk and need for each parent in order to accurately determine the level of judicial responsivity necessary.	-Copy of signed protocol sent to DANSR liaison -Pilots will provide a narrative for determining appropriate level of court supervision (this should include discussion around the appropriateness of parent's current treatment level of care).
10	*Maintain Parental Sobriety*	By end of QT 4, DANSR consumers who received treatment will see a reduction in use of primary substance use in the last 30 days at intake and at treatment discharge.[14]	- Use in last 30 days (at intake, discharge of treatment)
11	*Tracking co-occurring disorder presentation in DANSR population*	If possible, pilots will provide the following data elements to help DANSR look at the co-occurring disorder prevalence in the population	Co-occurring mental health screening date # of positive screens -MH diagnosis, if known -MH assessment date

Who do we contact if we have questions or need help?

Please contact the DANSR Liaison anytime:
Sarah Felsen, sarah.felsen@judicial.state.co.us (720-625-5968)

[13] In future development of DANSR's work, we will look to measure and investigate changes in levels of care in treatment.
[14] Benchmark is set to be higher than the OBH Contractual Reduction in use %.

COURT PERSPECTIVE: DESIRED EXPECTATIONS FOR DANSR-INFORMED CASELOAD

Two multidisciplinary meetings are listed below. These multidisciplinary team staffings may be combined when dispositional orders and permanency orders are combined. The days listed are draft reports from state-level data for the year 2015.

CASE EVENT	OUTPUT MEASURE	COMMENT
Filing of Petition	100% within 10 business days of temporary custody hearing / initial hearing[15]	Consistent with Colorado Rules of Juvenile Procedure, Rule 4 *The average number of days between temporary custody hearing and petition filing will be tracked.*
Appointment of Respondent Parent Counsel for custodial parent and for any other parent present at initial hearing	100% within 10 business days of temporary custody hearing / initial hearing	Respondent "parents have a right to be represented by counsel at *every stage of the proceedings*, and the right to seek appointment of counsel if the party is unable financially to secure counsel on his own." C.R.S. §19-3-202 (emphasis added). *The average number of days between temporary custody hearing and appointment of respondent parent counsel will be tracked.*
Adjudication of the custodial parent and for any other parent present at initial hearing (from case file date) **DN Mean: 54 days** **DN Median: 31 days** **EP Mean: 43 days** **EP Median: 25 days**	100% within 60 calendar days of case file date when no jury trial is demanded/ordered. 85% within 45 calendar days of case file date	Compare: "The adjudicatory hearing must be held within 60 days of service of the petition unless the court finds the delay will serve the best interests of the child." §19-3-505(3). Consistent with NCJFCJ Resource Guidelines (http://www.courtsandchildren.org/key_measures/time_key_m2.html)
Multi-disciplinary team staffing (tx)	100% of cases have one multidisciplinary team staffing **before** any interim treatment order or dispositional order	Determination of treatment level of care (both for substance use disorder for child and parent shared with Multi-Disciplinary Team and recommendations for Treatment and Permanency Orders formulated during

[15] Each district "shall . . . ensure that petitions are filed at the first hearing conducted in all or most actions." CJD 96-08.

		team staffing. Note: failure to match substance use disorder treatment level of care placement to patient need is a high risk factor that requires concurrent planning.
Disposition of the custodial parent and for any other parent present at initial hearing (from case file date) **DN Mean: 86 days** **DN Median: 50 days** **EP Mean: 69 days** **EP Median: 42 days**	100% within 90 calendar days of case file date, 85% within 50 calendar days of case file date	Substance use disorder treatment orders (and, when applicable, mental health treatment orders) for children and parent are consistent with the assessment process's recommended treatment level of care EPP requirements include that the court must enter a decree of disposition within 30 days of adjudication unless good cause is shown and the court finds delay will serve the best interests of the child. § 19-3-508(1). For individualized treatment plan requirements, see C.R.S. § 19-3-702(1)(2015).
Multidisciplinary Team staffing (permanency)	100% of cases have one multidisciplinary team staffing before permanency orders	The appropriateness of parent's treatment level of care, and progress in treatment, are shared at a multidisciplinary team staffing. This information provides a basis for recommendations for revised treatment orders and permanency orders formulated during the team staffing.
Permanency Planning Order (from case file date) **DN Mean: 150 d.** **DN Median: 127 d.** **EP Mean: 121 d.** **EP Median: 112 d.**	100% within 120 calendar days of case file date	Permanency planning must be combined with treatment planning in all DANSR cases

CASE EVENT	OUTPUT MEASURE	COMMENT
Substance Abuse and Mental Health Assessment	100% of respondents and children who have screened positive for potential issues with substance abuse and, when applicable, mental health, have completed an initial assessment process within 30 calendar days of the temporary custody hearing / initial hearing, 25% of respondents and children who have screened positive for potential issues with substance abuse and, when applicable, mental health, have completed an initial assessment process within 21 days of the temporary custody hearing / initial hearing	Treatment providers will screen for a client's involvement with child welfare system Treatment providers will seek appropriate releases so they can share information with other case professionals. Biopsychosocial assessment of substance use disorder treatment needs is conducted within 30 days of parent's contact with the treatment provider, and results are reported to assist the Court in finding that the treatment plan is reasonable and capable of success. Interim or temporary orders requiring treatment may be entered prior to adjudication upon notice and a finding that such orders are in the best interests of the child. §§ 19-1-104(3)(a), 19-1-114. The department must provide a set of services as determined necessary by an assessment and a case plan. §19-3-208.
Multi-disciplinary team staffing (tx)	100% of cases have one multidisciplinary team staffing **before** any interim treatment order or dispositional order.	This requirement applies to parents present at the initial hearing and custodial parents. Determination of treatment level of care (both for substance use disorder for child and parent shared with Multi-Disciplinary Team and recommendations for Treatment and Permanency Orders formulated during team staffing. Note: failure to match substance use disorder treatment level of care placement to patient need is a high risk factor that requires concurrent planning. team staffing
Multidisciplinary Team staffing (permanency)	100% of cases have one multidisciplinary team staffing before permanency orders	Determination of treatment level of care (both for substance use disorder for child and parent shared with Multi-Disciplinary Team and recommendations for Treatment and Permanency Orders formulated during team staffing. Note: failure to match substance use disorder treatment level of care placement to patient need is a high risk factor that requires concurrent planning.

CHILD WELFARE PERSPECTIVE: DESIRED EXPECTATIONS FOR A DANSR-INFORMED CASELOAD

CASE EVENT	OUTPUT MEASURE	COMMENT
Substance Abuse and Mental Health Screening	100% of cases have completed a substance abuse and mental health screen within 14 days of the temporary custody hearing / initial hearing; 50% of cases have a substance abuse and mental health screen within 7 days of temporary custody hearing / initial hearing	This requirement applies to parents present at the initial hearing and custodial parents.
Multi-disciplinary team staffing (tx)	100% of cases have one multidisciplinary team staffing **before** any interim treatment order or dispositional order	This requirement applies to parents present at the initial hearing and custodial parents. Determination of treatment level of care (both for substance use disorder for child and parent shared with Multi-Disciplinary Team and recommendations for Treatment and Permanency Orders formulated during team staffing. Note: failure to match substance use disorder treatment level of care placement to patient need is a high risk factor that requires concurrent planning.
Multidisciplinary Team staffing (permanency)	100% of cases have one multidisciplinary team staffing before permanency orders	Determination of treatment level of care (both for substance use disorder for child and parent shared with Multi-Disciplinary Team and recommendations for Treatment and Permanency Orders formulated during team staffing. Note: failure to match substance use disorder treatment level of care placement to patient need is a high risk factor that requires concurrent planning.