Florida

An Analysis of Preferred Practice Approaches in Substance Abuse and Child Welfare - Comparative Practice Elements

An Analysis of Preferred Practice Approaches in Substance Abuse and Child Welfare, 3/11/04

Values or Principles?	Preferred Substance Abuse Approach	Preferred Child Welfare Approach
Practice Element: Prevention Prevention works! There are many interventions now widely used that have been verified scientifically to produce positive outcomes in a wide range of field environments. Understanding the underlying factors (including risk and protective factors) that increase or decrease the risk for substance abuse and/or child abuse within a target population is a pre-requisite for change. Risk and protective factors can affect children at different stages of their lives. At each stage, risks occur that can be changed through prevention interventions. Intervening with families is critical as a child's earliest interactions occur in the family, and sometimes family situations heighten a child's risk for later drug abuse when there is:	***Practice Element: Prevention of Substance Use/Abuse*** Prevention interventions and programs should be tailored to address risks specific to population or cultural characteristics, such as age, gender, and ethnicity, to improve program effectiveness. Prevention interventions should be based upon the latest scientific evidence of success – ones that have consistently demonstrated successful outcomes over time, in a variety of settings and with multiple target populations. Risk and protective factors should be the primary targets of effective prevention programs used in family, school, and community settings. The goals of these programs is to build new and strengthen existing protective factors and reverse or reduce risk factors.[1]	***Practice Element: Prevention of Child Abuse and Neglect*** Education and support programs need to be available to parents of all age groups. They need to be tailored to address cultural differences.[2] Lacking a support network in times of crises puts families at significantly greater risk for abuse or neglect. To provide immediate assistance to parents in times of stress, crisis care programs should be available on a 24-hour basis and should include the following services: telephone hot line, crisis caretakers, crisis baby-sitters, crisis nurseries, and crisis counseling. In terms of providing prevention services to at-risk families, home visitation programs have thus far proven to be the most effective method for educating and assisting families. Comprehensive home visiting programs provide an array of services, including nurse visitation to monitor the

[1] NIDA, Preventing Drug Use among Children and Adolescents, A Research-Based Guide for Parents, Educators, and Community Leaders, Second Edition, National Institute on Drug Abuse, 2003.
[2] Cohn Donnelly, A. (1997) *An Approach to Preventing Child Abuse, Chicago, IL:* National Committee to Prevent Child Abuse.

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● a lack of attachment and nurturing by parents or caregivers; ● ineffective parenting; and ● a caregiver who abuses drugs. Prevention is the first line of defense. Identification of persons at risk for abusing alcohol and other drugs should be an important component of pre-natal care. Children of substance abusers are at increased risk of abusing alcohol and other drugs as they get older. Once a parent is identified as a substance abuser, appropriate prevention services for the child should be initiated. Abusive behavior is known to be passed on from generation to generation. Child maltreatment may result in, or be more likely to occur, when children have health or developmental problems. It is important to identify any behavioral, educational, and/or psycho-emotional problems in children who have maltreated. Early detection of such problems should occur and lead to appropriate health, mental health, or other services that will best protect these	Prevention programs should address all forms of drug abuse, alone or in combination, including the underage use of legal drugs (e.g., tobacco or alcohol); the use of illegal drugs (e.g., marijuana or heroin); and the inappropriate use of legally obtained substances (e.g., inhalants), prescription medications, or over-the-counter drugs.[1] ***Prevention programs should be designed to intervene as early as preschool to address risk factors for drug abuse, such as aggressive behavior, poor social skills, and academic difficulties.*** [1] Prevention programs should be designed to enhance family protective factors for children by teaching parents better family communication skills, appropriate discipline styles, firm and consistent rule enforcement, and other family management approaches. Family-based prevention programs should also enhance family bonding and relationships. [1] ***Prevention programs should be long-term with repeated interventions (i.e., booster programs) to reinforce the original prevention goals.***	health of an infant and mother, in-home parenting education and mentoring. Home visitation programs strive to create social networks for new parents. Social isolation is a proven risk factor for child abuse (see footnote 2).

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children from becoming abusive parents. Older children who have been victims of maltreatment should have every opportunity to receive life skills training that will be valuable in adulthood. Such life skills training should include information about the parenting role, as well as the skills needed to protect themselves from abuse (adult domestic violence).		

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Practice Element: Screening for Substance Use/Abuse Substance abuse screening should be available in health care settings, mental health programs and other portals of entry into the service system. Treatment needs to be readily available once needs are identified.[3] Families in crisis must have quick access to appropriate treatment, not a spot on a waiting list. Relationships and collaboration between systems are what will ensure that the appropriate information is gathered and shared in order to benefit families.	***Practice Element: Screening for Substance Use/Abuse*** Screening should be conducted for the evaluation of a possible presence of substance abuse and other particular problems, and to determine if a more detailed assessment is warranted. Screening should be conducted using a brief, inexpensive and standardized screening tool. There are a number of standardized screening tools available for use by persons not specifically trained in addictions assessment and counseling. Screening for substance abuse typically includes gathering data about: current and lifetime use, risk-related behaviors, the immediacy of intervention needed for substance toxicity, intoxication and withdrawal symptoms; aggression or danger to others; potential for self-inflicted harm or suicide; and co-existing mental health problems. Persons conducting screenings should be aware	***Practice Element: Screening for Substance Use/Abuse*** The identification of a substance abuse issue that is impairing a caregiver's ability to care for their children should be determined during the child protection investigation/intake process. There are many repeat investigations of maltreatment resulting from insufficient identification of underlying substance abuse problems. The identification of family dynamics that might indicate an underlying substance abuse problem should result from further information gathering from the person who made the report and collateral contacts with persons who are likely to know the caregivers. The investigator should share substance use/abuse concerns with the caregiver, and seek a voluntary substance abuse evaluation from a substance abuse professional. If the caregiver is unwilling to voluntarily seek an assessment, a court order should be obtained. In all cases, all information gathered by the protective investigator should be fully shared with the substance abuse professional conducting the assessment.

[3] *Principles of Drug Addiction Treatment,* National Institute on Drug Abuse, 2000.

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	that some screens that perform well for one population might not be as optimal in others. The focus should be on identification of problematic use of alcohol and other drugs before use interferes with child safety. Workers in these arenas should receive training in signs and symptoms of substance abuse and in use of basic screening instruments. For pregnant women, screens need to be conducted for "risky drinking" and other types of substance misuse or abuse that may harm the fetus. Safety screening should be conducted for both women and children. ***Care should be taken when using urinalysis as a screening tool. A thorough history to identify possible legal prescription use that can affect urinalysis should be completed.***	65-12.006 requires investigators and service counselors to screen all children and their families for substance abuse problems.

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Practice Element: Screening for Child Maltreatment that requires state intervention Child safety and protection is an exception to general confidentiality protections. Many of the risk factors associated with risk for child maltreatment are common to those dependent on alcohol or other drugs: poor impulse control; impaired judgment; poorly developed interpersonal skills; behaviors that place children at risk (such as drug dealing and leaving children unattended to acquire or use substances); social isolation; and lack of interpersonal supports.[4]	***Practice Element: Screening for Child Maltreatment that requires state intervention*** Substance abuse counselors are mandated to report suspected child abuse or neglect. This should be clearly communicated to clients receiving treatment. Prompt reporting of suspected abuse or neglect should take place, even when such reporting may damage the therapeutic alliance between counselor and client. Screening for child maltreatment risk factors to detect possible problem areas should be a part of the substance abuse screening and assessment protocol after informing the client of regulations concerning mandatory reporting. ***Treatment plans for substance abuse clients who are parents should include provisions for monitoring client safety.***	***Practice Element: Screening for Child Maltreatment that requires state intervention*** The child abuse investigation/intake's primary responsibility is to determine whether or not a child's caregiver is protecting their child from risks of harm which are created by acts or omissions on the part of the caretaker, and what interventions are needed. Each state statute defines harm to children. Florida's statutory definitions are provided in F.S. 39.01. *Systems should respond promptly to reports of abuse/neglect.*[5] *The response to reports of abuse and neglect and requests for assistance should be met with an offer of help.* The intake assessment must include a determination as to when a child is in need of the protection and supervision of the court, and when immediate safety plans must be made to ensure child safety as well as caregiver safety when domestic violence is occurring The investigation/intake must determine the protective, treatment, and ameliorative services necessary to safeguard and ensure the child's safety and well being and development. In the absence of

[4] Hoffman, N., Shulman, G., and Young, N. Addition and Child Welfare Professionals: The Makings of a Healthy Partnership, *Addiction Professional,* NAADAC, Vol. 2. No. 2,, March 2004
[5] All italicized text in the Child Welfare column is from "Framework for Individualized, Needs Based Child Welfare Practice" produced by Child Welfare Policy and Practice Group, Inc.

Values	Preferred Substance Abuse Approach	Preferred Child Welfare Approach
	SAFERR: Ensure that data are consistently collected regarding the number and status of children, both in and out of their care Be aware of children's needs and make connections to experts to assess and address those needs Link children of substance abusing parents to supportive services as necessary, to improve well-being of children Ensure that supervisors consistently monitor cases for clinical implications for children ***Routinely share with CWS and court staff the information collected regarding children***	egregious abuse or neglect, there must be efforts to provide the caregivers with the support, treatment and assistance needed to be able to provide their children with adequate care and safety. There must be a determination of whether the child can remain with his caregivers, with or without special in-home services and assistance. SAFERR: Train staff to consistently make observations and ask key questions regarding the substance use of all persons living in the household, have the knowledge of what to do with this information, and engage/motivate individuals—this includes males in mother's life, extended family members, foster parents and kinship arrangements Routinely record the results of observations and questions in the case record Ensure that supervisor staff consistently monitor case records for substance use notations Know the current status of each child's biological/psychological/social needs and connect to appropriate services Routinely share with ADS and court staff the information collected regarding children and potential parental substance use disorders

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Practice Element: Engaging clients, significant others, parents, children and other caregivers (foster parents, relative caregivers) Promoting client/family readiness to change increases the likelihood of successful outcomes. Engagement of client/family/significant others means acknowledging and practicing acceptance of (though not acquiescence to) a broad range of concerns, opinions, preferences, beliefs, emotions, styles, and motivations. Families, children and clients must be viewed within the context of the support systems that can be brought to bear upon the success of the case.	***Practice Element: Engaging clients and significant others*** The client and significant others in the client's life should be actively involved in examining their options for treatment, understanding their rights, and selecting treatment strategies based on needs and preferences (where possible). The level of the client's interest in making specific changes should be explored. Continual facilitation of the client's participation in the treatment and recovery process should be achieved through: the establishment of a helping relationship characterized by warmth, respect, genuineness, concreteness and empathy; the use of counseling strategies that value individual differences including culturally appropriateness; the promotion of client knowledge, skills and attitudes that contribute to a positive change in substance use behaviors.[6] Family engagement is recognized as a critical	***Practice Element: Engaging parents, children and other caregivers (foster parents, relative caregivers)*** The child and family should feel a sense of personal ownership in the plan and the decision process. Children and families are more likely to enter into a helping relationship when the worker or supporter has developed a trusting relationship with them. The quality of this relationship is the single most important foundation for engaging the child and family in a process of change. Children and families are more likely to pursue a plan or course of action that they have a key role in designing. The assessment and planning process should engage the caregivers in an ongoing team process. The team should include persons in the extended family and/or friends of the caregivers, with the agreement of the caregivers. Based on the family's goals and the challenges that need to be addressed in order to meet those goals, involved professionals and other key

[6] US Department of Health and Human Services, SAMHSA, Center for Substance Abuse Treatment. *Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice. Technical Assistance Publication Series, #21(2002)*

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	element in successful substance abuse treatment. Family dynamics and history are often contributing or precipitating factors that complicate substance abuse treatment. ***The substance abusing parent is generally the identified client whose problems are targeted in the treatment plan. It is unlikely that the affected child will make significant contributions to treatment decisions, but the child welfare worker should be a part of the treatment team when appropriate so that expectations for behavioral change that affect child custody and placement are clear to all parties.***	support persons need to be members of the team. When children are placed in alternative living arrangements, including foster care, the substitute caregivers also need to be members of the team.

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Practice Element: Strength- based intervention. Focusing on client strengths is a primary goal of treatment. Treatment plans should be individualized, behavior-focused, outcome-oriented and formulated with mutually agreed upon (by client/family/staff) actions/outcomes. Respect must be given for the family/client's individual pace toward change, allowing for incremental achievements toward goals	***Practice Element: Strength-based intervention.*** Motivation to change is a critical element of substance abuse treatment. Identifying strengths can assist the client in maintaining motivation by establishing a track record of success in early treatment engagement. Resistance and denial are recognized as part of the addictive process. Strategies for overcoming resistance/ambivalence and breaking through denial are routinely incorporated into substance abuse treatment. Focusing on strengths rather than problems can be an important strategy for overcoming resistance and increasing motivation.	***Practice Element: Strength-based intervention.*** When children and families see that their strengths are recognized, respected and affirmed, they are more likely to rely on them as a foundation for taking the risks of change. For caregivers, interventions are primarily oriented to assist them in making difficult changes. The stages of change that persons experience are predictable and normal. Most adults have gone through difficult times and have developed their own successful strategies for surviving and coping. The identification of a person's past successful coping strategies is an important way to assist them in planning for the new challenges they face. For children, interventions are oriented to helping them overcome the emotional and developmental problems that have resulted from past maltreatment, including the trauma of separation from their caregivers and other family members who may be important to them. The special interests and talents of children need to be identified and cultivated.

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		Children need developmentally appropriate information to understand what is happening in their lives and why, and what to expect. For caregivers and children, the ongoing feedback and praise for progress made and achievements, however small, needs to be ample and continuous. Adequate support from the family's team requires ongoing positive reinforcement and encouragement, as well as honest feedback about expectations not yet fulfilled

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Practice Element: Functional assessment The caregiver who abuses substances is part of a larger family system that is impacted by the substance abuse in many ways. The impact on family members of the substance abuse as well as the impact of the caregiver entering treatment needs to understood and addressed. Other unmet special needs of children need to be addressed in order to assist the family achieve success over the long term. Treatment recommendations must be based on an accurate assessment and the needs of the specific individual.	***Practice Element: Functional assessment*** Assessment is an ongoing process through which the counselor collaborates with the client and other to gather and interpret information necessary for planning treatment and evaluating client progress. A number of valid and reliable quantitative instruments, such as the Addiction Severity Index, may be used. However, in general practice, standardized instruments are supplemented with a clinical interview. Assessment may also include review of clinical records from prior treatment or service episodes or interviews with collateral information sources (with appropriate releases). A comprehensive assessment process must be sensitive to age, gender, cultural issues and disabilities and include, at a minimum, the following domains: ● History of alcohol and other drug use ● Physical health history and current status ● Mental Health history and	***Practice Element: Functional assessment*** "Do we know what we need to know about this family in order to do what we need to do?" At a minimum, this includes: ● The child's immediate safety, and whether in-home interventions will assure safety. ● An understanding of the situations that surround the caregiver's substance abuse, including motivators and barriers to change. This will serve as a roadmap of a caregiver's interpersonal, intrapersonal and environmental triggers. ● An understanding of the caregiver's level of motivation to enter treatment (Stage 1) and whether motivational interventions are needed. ● The impact of the substance abuse on other family members, providing a foundation for understanding their needs as the caregiver enters treatment. For children, an understanding of their

[7] US Department of Health and Human Services, SAMHSA, Center for Substance Abuse Treatment. *Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice. Technical Assistance Publication Series, #21(2002)*
[8]National Center on Substance Abuse and Child Welfare (2002), *Screening and Assessment for Family Engagement, Retention and Recovery* (SAFERR), Prepublication Draft.

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	current status ● Addiction and mental health treatment history ● Family Issues ● Work and career history ● Physical, emotional and world view concerns ● History of criminality ● Spirituality ● Education and functional literacy ● Socio-economic status ● Current legal status ● Living situation / Housing status ● Support networks ● Connection to community resources.[7] SAFERR Fundamentals[8]:In determining the nature of an issue, share diagnostic information with CWS within 7 days of assessment, using a standardized form to make information sharing uniform—Was the screen validated by assessment determination of substance abuse or dependency? ***In determining the extent of an issue, conduct a multi-dimensional assessment within 30 days and share results with CWS within 7 days. The written report is delivered to CWS and information is shared using standardized forms that include:*** ● Frequency of use ● Impact of drug toxicity ● How does alcohol and drug use affect parent (e.g. blackouts)	strengths and opportunities for building their resiliency. ● Who are persons (family, friends) that are important to the child and family and are they safe individuals for the child and family to interact with? Are there other persons who can serve on the family's team? ● Whether other important issues are present, such as domestic violence, mental illness, and/or other special needs of the caregivers. The Comprehensive Behavioral Assessment that is required for all children entering care should provide much of the above information. The child and family team should review all available assessment information and agree upon the implications for planning. SAFERR Fundamentals: In determining the nature of an issue, share the nature of the case with ADS agency upon referral using standardized forms ● Signed consents for disclosure are executed in compliance with 42 CFR, Part II ● Precipitating incidents in the CWS case ● Results of CWS

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	● Level of impairment—is parent functioning in a way that impairs his/her ability to meet child's basic needs ● Family connections, strengths, extended family ● Employment/education status ● Parent's trauma history ● Assessment of motivation and engagement level ● Who is caring for child during parental alcohol/drug use or substance seeking behavior ● What is child witnessing or being exposed to during parental alcohol/drug use or substance seeking behavior ● Statement of parent's perception of relationship between their substance abuse/dependency problem and their parenting abilities ● Treatment recommendation—level of care, length of time in treatment, can children be with parents and/or visit in treatment ● Other family events going on (marriages, deaths, moves, etc.) ● Does Inter-state compact apply? ● Any additional service needs **Re-assessment information is shared with CWS agency as warranted** **SAFERR Model Practice:** **ADS, CWS and court staff and family meet to discuss assessment results and to develop case plans; meetings should conducted in a manner that is comfortable for families in regards to**	observations and screens ***Directly refer individuals with positive results on alcohol and drug screens and/or observation of substance abuse for assessment*** ***In determining the extent of an issue, Family Assessment information is shared with ADS agency within 30 days using standardized forms that include:*** ● Criminal and civil court history ● Prior child abuse/neglect cases ● Use by significant others and other adults in home ● Information about home environment—including past and/or present violence in the home ● Was parent a CWS dependent ● Does parent have a history of mental illness (results of psych evaluation) ● Does the Indian Child Welfare Act (ICWA) and/or Inter-state Compact on Placement of Children (ICPC) apply ● CWS drug testing requirements ● Parents perception of issue ● Extended Family, Family Strengths, Connections to Community and Resources

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	language, culture, etc. **Multi-disciplinary team should complete assessment, level of care determination and diagnosis within 30 days or soon after the preliminary protective hearing in court involved cases**	● Assessment of How Children are Doing ● Results of alternative dispute resolution Conduct on-going assessment at each decision making point in case and share re-assessment information with ADS agency as warranted updated at least 30 days **SAFERR Model Practice:** **ADS, CWS and court staff and family meet to discuss assessment results and to develop case plans; meetings should conducted in a manner that is comfortable for families in regards to language, culture, etc.** **Multi-disciplinary team should complete assessment, level of care determination and diagnosis within 30 days or soon after the preliminary protective hearing in court involved cases**

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Practice Element: Child and family service planning process An individual's treatment and services pan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.[9] Understanding and recognizing the stages of change and other signs of progress toward case/treatment goals are critical elements that should be used to reinforce positive change and demonstrate therapeutic optimism. For women, many clinical, developmental, and economic issues are intertwined and impact service planning and outcomes: ● Psychological stressors for women, including sexual and physical abuse, violence, and victimization; ● Social and cultural role issues for women, which pertain to stigma,	***Practice Element: Service planning process*** The client is an active participant in treatment planning and outcome monitoring. This is a collaborative process in which the counselor and the client identify desired treatment outcomes and identify the strategies for achieving them. Client-identified goals are as important as legal requirements in achieving treatment success. Because substance abuse incorporates denial, objective measures such as urinalysis can be used to help clients realistically and honestly view their situation. Feedback from significant others should also be incorporated into the treatment process. The data derived from the screening and assessment processes form the basis of a treatment plan. At a minimum the treatment plan addresses the identified substance use disorder(s), as well as issues related to treatment progress, including relationships with family and significant others, employment, education,	***Practice Element: Child and family service planning process*** Children and their families should receive individualized services based on their unique strengths and needs. Children and parents should be encouraged and assisted to articulate their own strengths and needs, the goals they are seeking for themselves and what services they think are required to meet these goals. The mix of services provided should be responsive to the strengths and needs of the child and his/her family. Conceptualizing the needs based plan should not be constrained by the availability of services. Where needed services are unavailable, appropriate services should be created. Services to children and their families should be planned and delivered through an individualized service plan crafted by the child and family team. Children, their parents, the family's informal support network, caregivers and foster parents should be full participants in this team. The

[9] *Principles of Drug Addiction Treatment,* National Institute on Drug Abuse, 2000.

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self-esteem, under-education, and economic deficits; ● Centrality of women's relationships as an organizing principle in their lives, particularly their relationships with children and families; ● Loss of image and personal empowerment; and ● Vulnerability in health and high risk behaviors, with frequent medical problems and a high rate of HIV/AIDS and sexually transmitted diseases.	spirituality, health concerns, and legal needs.[10] Parenting issues should be addressed as part of the treatment plan and access to appropriate parenting training should be available, either within the treatment program or by referral. SAFERR Fundamentals: Develop an individualized treatment plan with the participant, incorporating objectives related to child safety, permanency, and well-being Integrate treatment plan activities and objectives with the activities and goals in the CWS case plan Develop treatment plans that incorporate awareness of the family's CWS case plan and other timetables and prioritize activities as possible Jointly review treatment plan with CWS staff and the family Share treatment plan activities and goals with CWS staff Monitor treatment compliance by frequently sharing of information about: ● Number of drug tests required and results of drug tests ● Progress in	family's informal helping system and natural allies are central to supporting the family's capacity to change. Their involvement in the planning process provides sustaining supports over time. Involvement should include regular participation in family team meetings as a point for engagement, assessment, planning intervention and assessment of progress. Children, parents and foster parents should be accurately and timely informed, in language understandable to them of their rights, the goal for the child/family and individualized service plans. SAFERR Fundamentals: Develop a case plan that incorporates objectives related to parents treatment and recovery Incorporate needed treatment interventions for children's issues in case plans Ensure that case plan activities, objectives, and service strategies do not conflict with the alcohol and drug treatment plan as possible Jointly review case plan with ADS staff and the family Share case plan activities, objectives, and service

[10] US Department of Health and Human Services, SAMHSA, Center for Substance Abuse Treatment. *Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice. Technical Assistance Publication Series, #21(2002)*

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	obtaining/maintaining abstinence ● Number of group and individual sessions required and attended ● Treatment goals and progress toward treatment goals Continually assess movement through stages of change Share qualitative and quantitative information about compliance with court orders, meeting treatment plan objectives, and parenting responsibilities with CWS and court at standardized intervals and at critical incidents Provide progress reports to CWS staff and courts at agreed upon intervals Ensure that aftercare incorporates child welfare goals and supports optimal long-term family connections Include changes in family functioning and children's status in outcome measures Routinely monitor and share outcome data with CWS and court staff SAFERR Model Practice: Team development of family driven case plans with shared objectives Court interventions are used therapeutically with families Outcome results are used for community-wide planning and	strategies with ADS staff Share qualitative and quantitative information about meeting case plan objectives ADS agency at standardized intervals and at the time of critical incidents Provide progress reports to ADS workers and the courts in a timely fashion Share new information with ADS when: ● Visitation schedules are being changed ● Changes in service plans are being considered ● There is a case transfer to a new CWS worker or unit ● When the child is moved to a new placement Include indicators of capacity of families with substance use disorders to meet the needs of their children regarding safety, permanency, and well-being in outcome measure Routinely monitor and share outcome data with ADS services SAFERR Model Practice: Team development of family driven case plans with shared objectives Court interventions are used therapeutically with families Outcome results are used for community-wide planning and prevention efforts Cross agency and

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	prevention efforts Cross agency and community-wide funding strategies are employed to sustain programs	community-wide funding strategies are employed to sustain programs

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		The involvement of other service systems is often required. Communication and interaction with the court should reflect timeliness, preparation, knowledge, respect and accuracy. The system should take an active role in seeking to ensure that local education agencies recognize children's education rights and provide children with educational services in accord with those rights. The system should include probation or parole officers on the family team when they are involved with any family members.

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Practice Element: Out-of-home placement of children Parents do better in treatment when they are able to remain with their children or have frequent contact and visitation. *Children experience trauma when they are separated from their families. When children must be removed to be protected, their trauma is lessened when they can remain in their own neighborhoods and maintain existing connections with families, schools, friends and other informal supports*	***Practice Element: Out-of-home placement of children*** Whenever possible, parents in residential treatment should be allowed to bring their children with them into treatment. The treatment program may provide a safe place to discuss family placement issues. Substance abuse treatment should be offered in the least restrictive setting appropriate to the severity of the substance abuse problem.	***Practice Element: Out-of-home placement of children*** Removal of children from their homes causes additional trauma. Every effort should be made, when safety can be assured, to plan out-of-home care with the parents, including their involvement in the child's transition. When children cannot live safely with their families, the first considerations for placement should be with kinship connections capable of offering and demonstrating the resources for a safe, stable and appropriate home. Siblings should be placed together. Placements should be made in the least restrictive, most normalized setting responsive to the child's needs. Temporary, interim placements should be avoided. Children should be placed in settings that could reasonable be expected to deliver long term care if necessary. To this end, the use of congregate shelter placements should be avoided in favor of family based settings. Children younger than six should not be placed in congregate settings unless it is necessary to maintain connections with siblings placed in the same setting. When

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		shelter is used, the placement should be short terms. The system should forbid summary discharges of children from placement. The system should develop a policy that describes steps that should be taken prior to a child's discharge from a placement. The system should be based on the philosophy that the disruption of a placement is a failure of the system, not a failure of the child. AFSA Timeframes: When children have been removed from their homes, federal law now requires that a permanency plan be established no later than twelve months after the child's entry into care. This means that a parent must be making reasonable **progress toward recovery** and reunification within 12 months.

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Practice Element: Special Supports to Children/Clients in Care The special needs of the child need to be addressed in order to ensure that they able to interact with their peers and family in age-appropriate and safe ways, and to succeed in school. Findings from enhanced versus standard women's substance abuse treatment contrasts suggest that enriching women's treatment with additional components specifically oriented toward meeting women's needs adds value above and beyond the expected effects of standard programs.[13]	***Practice Element: Special Supports to Clients in Care*** To promote healing and support for clients receiving substance abuse services, especially women, a healing environment should include attention to the physical, emotional, spiritual and safety needs of individuals. Support to clients in treatment must also attend to practical issues such as child care, housing support and transportation. Addicted or drug-abusing individuals with co-existing mental disorders should have both disorders treated in an integrated way. Medications should be viewed as a potential extension of treatment for patients, especially when combined with counseling and other behavioral therapies. Treatment medications offer help in suppressing the withdrawal syndrome and drug craving and in blocking the effects of drugs.	***Practice Element: Special Supports to Children in Care*** Children should receive prompt and appropriate attention to their health care needs. Mental health needs should be addressed as developmentally appropriate. Children should have freedom from excessive medication, unnecessary seclusion and restraint. The system should vigorously seek to assure that children, when in foster care or custody, are integrated to the maximum extent feasible into normalized school settings and activities and achieve success in school. Visitation between children in care and their parents and among siblings should be addressed in each child's individualized service plan. The frequency and circumstances of visiting should depend on age and need. Visiting should be viewed as an essential ingredient of family reunification services. Hence, when the goal is for the child to return home or live with a family member, visiting should be actively encouraged. Visiting plans that require agency

[13] National Evaluation Data Services (NEDS). *Effectiveness of Women's Substance Abuse Treatment Programs: A Meta-Analysis.* Batelle Centers for Public Health, Arlington, VA. May 2001.
[14] *Principles of Drug Addiction Treatment,* National Institute on Drug Abuse, 2000 (for all 3 substance abuse practice elements on this page)

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	For women who are pregnant, services need to be focused on helping the woman have safer pregnancies and healthier babies, with appropriate support to infants. Links between Medicaid, substance abuse, and health agencies at the state level, and between prenatal care and substance abuse treatment agencies at the local level need to be cultivated and maximized. Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, tuberculosis and other infectious diseases and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.[14]	oversight or participation should take into account the work, education and other obligations on the part of the parents. After hours and weekend visits should be options to permit parents to meet necessary obligations. Visiting may be arranged by the child, the child's parents or family, or the foster parents, as well as by staff and the staff of residential facilities in accordance with the individualized service plan. Supervision of visiting should be required only when there is a danger that the parent or family member with whom the child is visiting will harm the child unless the visit is supervised.

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Practice Element: Formal Services Alcohol and other drug addiction is a treatable disorder. Support for an individual's or a family's physical, mental emotional and spiritual needs should be incorporated into treatment. Individuals have the right and the responsibility to fully participate in all decisions related to their health care, including addiction treatment. Health differs by gender as well as by race and ethnicity requiring specialized care. Among women, however, alcohol and drug abuse may progress differently, and may require different treatment approaches. Recovery from the disease of alcohol and drug addiction is often a long-term process, involving multiple relapses before a patient achieves prolonged abstinence.	***Practice Element: Formal Services*** Culturally competent programming needs to be factored into the design and delivery of addiction services (addressing such issues as race, ethnicity, culture, sexual orientation, age, criminal justice status, disability status). Treatment services are based upon the client's needs, in accordance with the appropriate level of care, and with the active participation of the client in determining the course of care. Treatment services should be provided in the most effective dosage and intensity levels to achieve success (i.e. at least 3 months for outpatient and residential services). A variety of treatment services need to be available, such as individual, group and family counseling, as well as alternative therapies based on client needs and desires. Therapeutic approaches need to be based on the latest scientific evidence of effectiveness and delivered by	***Practice Element: Formal Services*** AFSA Timeframes: When children have been removed from their homes, federal law now requires that a permanency plan be established no later than twelve months after the child's entry into care. This means that a parent must be making reasonable **progress toward recovery** and reunification within 12 months. *The system should be sensitive to cultural differences and the special needs of minority ethnic and racial groups. Services should be provided in a manner that respects these differences and attends to these special needs. These differences and special needs should not be used as an excuse for failing to provide services.* *The service array should be sufficiently flexible to be adapted to the unique needs of each child and family. Services and supports best meet child and family needs when they are* ***provided in the family's natural setting or for children in custody, the child's current***

[15] *Principles of Drug Addiction Treatment,* National Institute on Drug Abuse, 2000
[16] Covington, S. S. *Helping Women Recover: A Program for Treating Addiction*. San Francisco: Jossey-Bass, 1999.

Values	Preferred Substance Abuse Approach	Preferred Child Welfare Approach
Combining prison- and community-based treatment for drug-addicted offenders reduces the risk of both recidivism to drug-related criminal behavior and relapse to drug use.[15]	counselors who are skilled in delivering specific therapeutic protocols. For women in treatment, providers of services need to provide comprehensive, *trauma-informed* services that address women's multiple roles, complex psychological identity, and the cultural and social realities in which they live and work.[16] Self-help groups (AA, NA, etc) can be used to complement and extend the effects of professional treatment. Relapse prevention strategies need to be incorporated into all therapeutic protocols to facilitate abstinence as well as provide help for individuals who experience relapse. Substance abuse treatment programs should have staff members who are knowledgeable about local resources that can be used to augment services they do not provide. Case management and referral to appropriate services, both during treatment and after discharge, should be incorporated into the treatment process.	*Children and their families should have access to a comprehensive array of services, including intensive home-based services, designed to enable children to live with their families or to achieve timely permanency placement.* ***If services are limited to delivery in a particular place, children often have to move to receive them. Services should be flexible enough to be delivered where the child and family reside. Children and families should not be expected to adapt to ineffective services.***

Values	Preferred Substance Abuse Approach	Preferred Child Welfare Approach
	Addiction treatment programs should be available to incarcerated persons to help them succeed in preventing a return to criminal and drug abusing behaviors. Linkages need to be made with to community-based programs that continue treatment when the individual leaves prison.	

Values	Preferred Substance Abuse Approach	Preferred Child Welfare Approach
Practice Element: Informal Supports One of the keys to helping persons with substance abuse disorders during the recovery process is to encourage healthy connections and relationships.	***Practice Element: Informal Supports*** Programs should be sensitive to the relational issues that an individual brings into treatment, taking full advantage of those that provide positive connections and support. Neighborhood and community resources and institutions should be identified as assets in the client's treatment planning. Linking clients with community-based, self-help groups during treatment and after discharge should occur to create a network that can support the services provided by professional counselors.	***Practice Element: Informal Supports*** Through a family team process, every family should be assisted with including/developing their own informal support system of family members and/or friends. The team process is a way to develop the capacity of the family's informal support system in terms of understanding the family's challenges, goals, and needs for support and assistance. The team process provides an important means for mobilizing the resources of the family's informal support system. Neighborhood and community resources and institutions should be treated as key partners in serving children and families, both in planning for individual families and as a partner in system design and operations. Many of the services and resources that children and families find most accessible and responsive are those found in their own community, provided within their own neighborhoods and culture. Relative and foster caregivers should be provided with the formal and informal supports they need to successfully care for the children placed with them.

Values	Preferred Substance Abuse Approach	Preferred Child Welfare Approach
Practice Element: Tracking and Adaptation An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.[17]	***Practice Element: Tracking and Adaptation*** The treatment team meeting provides an appropriate forum for review of the client's and children's status. Progress toward identified goals is documented and discussed with the client.	***Practice Element: Tracking and Adaptation*** The status of children and their families is routinely checked as well as the results of services and supports that are being provided. Evaluating the efficacy of services and supports should occur primarily at family team meetings, with the family assisted in providing honest feedback to the team as to what is working or not working to move them successfully toward their goals. The family team meeting is also the forum for other team members to provide reinforcement to the family about progress being made as well as any potential opportunities for improving intervention. The team, with the family's input, should develop consensus as to needed changes in the child/family's plan and the steps needed to effect those changes.

[17] *Principles of Drug Addiction Treatment,* National Institute on Drug Abuse, 2000.

Values	Preferred Substance Abuse Approach	Preferred Child Welfare Approach
Practice Element: Long-term View (Recovery) The system is responsible for ensuring that caregivers are able to transition successfully from formal services provided and sustain the progress they have made over the long term. When a long-term view has not been adequately envisioned and planned for, the likelihood of relapse and re-abuse of children remains high. Recognizing craving and relapse as an integral part of addiction has tremendous importance for developing strategies, which must encompass ways to enable the client to deal with continued exposure to the cues that are associated with drug abuse long after formal treatment is completed.	***Practice Element: Long-term View (Recovery)*** ***There needs to be a system of monitoring and aftercare that assures sustained disease management. Post-treatment support services need to be of sufficient scope and duration to assist in sustaining recovery.*** ***Relapse prevention plans need to be in place for all clients leaving primary treatment services.***	***Practice Element: Long-term View (Recovery)*** The family's case plan should include an explicit plan for the child and family that enables them to live safely and independently from the child welfare system. The plan should provide direction and support for making smooth transitions across settings, providers and levels of service.

Values	Preferred Substance Abuse Approach	<u>Preferred Child Welfare Approach</u>
Practice Element: Effective Results The system is responsible for producing effective results. When parents are not yet motivated to enter treatment, the system is responsible for making every effort to motivate and encourage parents to obtain treatment. The ultimate goal of all addiction treatment is to enable the individual to achieve lasting abstinence, but the achievement of immediate goals (to reduce drug use, improve the patient's ability to function, and minimize the medical and social complications of drug abuse) are also very important.	***Practice Element: Effective Results*** Substance use is reduced or eliminated. Client refrains from criminal involvement. Social functioning and relationships are improved. ***Stable, gainful employment or educational enrollment is maintained.***	***Practice Element: Effective Results*** Children are protected from abuse and neglect. Children are provided with stability and permanency in their lives within timeframes appropriate to their developmental needs. Where possible, children remain with their families or are reunified through the provision of services that strengthen the capacity and skills of their caregivers. Children achieve success in school and become stable, gainfully employed adults. Families are engaged and satisfied with the services and supports they receive.