

# SCREENING AND ASSESSMENT FOR FAMILY ENGAGEMENT, RETENTION, AND RECOVERY (SAFERR)



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## SECTION III: COLLABORATIVE PRACTICE AT THE FRONTLINE

Section I of this guidebook makes the case for collaboration and presents a framework for establishing a governance structure including an Oversight Committee, Steering Committee, and Subcommittees charged with creating policies and protocols that allow staff and systems to work together. Section II outlines some of the individual and shared responsibilities of the child welfare, alcohol and drug service, and court systems in creating and sustaining effective relationships. This section focuses on frontline practices, providing information to help staff implement policies and procedures that have been developed and approved by subcommittees and the Steering Committee. It is preferable that child welfare, alcohol and drug services, and court staff in local offices participate on Subcommittees and therefore identify and recommend the screening and assessment protocols they will use in their offices. The Steering Committee and relevant Subcommittees should guide, oversee, and evaluate the activities described below and should use local experiences to revise State policies and procedures where required.

The terms “screening” and “assessment” are widely used by staff from child welfare, alcohol and drug, and court systems. They are sometimes used interchangeably, and they often mean different things to different systems. For example, when calls come in to the child welfare hotline, the worker asks a series of brief screening questions to determine whether a report of abuse or neglect will be accepted for an in-person response, and if accepted, whether the situation requires an immediate visit to the home. When reports are accepted and workers visit the home, they quickly assess the home situation to determine whether children are safe or whether they are at imminent risk and must be removed, at least until further assessments have been completed. After an initial determination has been made that children are not safe at home or are at serious enough risk to warrant further involvement with child welfare, workers resolve the immediate safety concern and then begin a more comprehensive process of screening and assessment for a range of services. At this point, screening and assessments for substance use disorders should take place.

Screening and assessment are not specific events conducted by professional staff at predetermined points in a family’s involvement with child welfare, alcohol and drug treatment, and court systems. Rather, they are continual processes that engage both families and staff in identifying family strengths, developing services, and monitoring progress and addressing challenges. These processes are more helpful to families and more efficient for staff if they are undertaken in a coordinated rather than parallel manner. The Introduction to this guidebook lays out questions that all three systems struggle to address, and proposes that these questions are better answered if systems coordinate their responses than if they respond in isolation.

These questions are repeated here:

- Is there a substance use or child abuse and neglect issue in the family, and if so, what is the immediacy of the issue?
- What are the nature and extent of the substance use or child abuse and neglect issue?
- What is the response to the substance use or child abuse and neglect issue? Are there demonstrable changes? Is the family ready for transition, and what happens after discharge?
- Did the interventions work?

Some local agencies may want to improve their ability to screen and assess families but are not prepared to address broader issues regarding collaborative approaches to screening and assessment. The information included in this section provides practical guidance regarding screening and assessment

that can be used even if there is need for a larger framework that focuses on collaboration and should be useful to agencies that simply want to improve their internal practices.

After a discussion of communication protocols, the remainder of this section provides guidance in developing answers to these questions.

### **3.1 Developing Communication Structures and Protocols**

Responding to the questions listed above requires formal and clear patterns of communication. Results from screenings and assessments must be communicated across systems to answer questions regarding what kind of treatment and other services best meet family needs, how families can best be engaged and retained in these services, how well families are progressing and what problems are they experiencing, how transitions are handled, and how systems can know whether they have succeeded?

The *Pathways of Communication Template* on the next page illustrates the communication flow that must occur between community agencies, the alcohol and drug service system, the child welfare service system, and dependency court system during the stages of answering the questions: “What is the response?,” “Are there demonstrable changes?,” “Is the family ready for transition?,” “What happens after discharge or case closure?,” and “Did the interventions work?”

Policymakers, administrators, legal experts, and practitioners must consider each of the communication points depicted on the template and provide the policies, procedures, and specific content needed for staff to share information about families with each other and with family members. Each of the communication bridges (shown in areas in between the columns of text on the figure) must be clearly defined within each community and jurisdiction. Local office staff or Subcommittees charged with designing protocols for local offices should use this template as a guide to define the communication bridges, track how communication occurs in their office or jurisdiction, and identify areas in which communication breaks down. (An example of a completed communication template is included in Appendix A.) On the basis of this analysis, local staff or the Steering Committee should establish formal communication guidelines for use by staff from all three systems. The content of information to be exchanged across the bridge must be specified, including the exact information and method for exchange required to make an effective bridge across the systems. The results of this exercise also provide a good basis for creating a cross-system training initiative that is grounded in solid information developed by staff from all systems.



## Screening and the Indian Child Welfare Act

At the time they conduct initial screens, child welfare staff should determine whether families are or might be eligible to be members of an American Indian Tribe. If a child is an American Indian, the child welfare agency must be sure it complies with the Indian Child Welfare Act and must send notice to the tribe. Appendix I includes more information about requirements under the Indian Child Welfare Act.

Child welfare workers may use brief screening tools that can be administered orally in virtually all interviews or imbedded in a standard questionnaire. These are more practical and efficient within the context of the many issues that child welfare workers explore in their early interactions with families. In addition, these screening instruments are available without cost.

Whether screening results indicate that substance use is a problem depends in part on the threshold, or the cutoff point above which substance use disorders are determined to exist and below which they are determined not to exist.

Decisions regarding cutoff points may vary across different agencies and jurisdictions. These decisions are important because they form the basis for determining which people are referred for treatment. If the cutoff point is low so as to cast a wider net, positive results will include both people who do have substance use disorders (true positives) and those who do not have disorders (false positives). The advantage of this approach is that it is less likely to overlook situations in which family substance use disorders pose risks to children. The disadvantage is that families without substance use disorders will appear to have those disorders. These families will be referred for more indepth evaluations that drain scarce personnel and financial resources from alcohol and drug treatment programs.

One commonly used short substance use screen is the UNCOPE.

### The UNCOPE:

- U: In the past year, have you ever drank or **used** drugs more than you meant to?/or Have you spent more time drinking or **using** than you intended to?
- N: Have you ever **neglected** some of your usual responsibilities because of using alcohol or drugs?
- C: Have you felt you wanted or needed to **cut down** on your drinking or drug use in the last year?
- O: Has anyone **objected** to your drinking or drug use?/or has a family, friend, or anyone else ever told you they **objected** to your alcohol or drug use?
- P: Have you ever found yourself **preoccupied** with wanting to use alcohol or drugs?/or Have you found yourself thinking a lot about drinking or using?
- E: Have you ever used alcohol or drugs to relieve **emotional discomfort**, such as sadness, anger, or boredom?

Additional information about the UNCOPE and other screening tools is provided in Appendix D, “Examples of Screening and Assessment Tools for Substance Use Disorders.” These tools have been evaluated and have sufficient sensitivity and specificity for most applications. The screens with four to six items seem to strike appropriate balances between sensitivity and specificity, whereas screens

with more than 10 items do not seem to be significantly more accurate and they are more complex to administer.

Screens are not assessments and cannot be used to diagnose the nature or extent of substance use disorders or to make decisions regarding alcohol and drug treatment services. Screening results do provide important baseline information regarding whether substance use disorders exist and at times, whether the disorder is such that immediate action is required to address problems such as severe withdrawal symptoms or likelihood of seizures, or to keep children safe. In making diagnoses or more permanent decisions regarding parents and children, staff should combine screening results with information gathered from other sources.

Screening tools are based on self-report responses to questions, and screening results are only as accurate as the honesty of the replies they yield. Although families under investigation for child maltreatment may feel frightened or desperate enough to respond honestly to questions about their substance use patterns, they may also feel that disclosing substance use disorders will jeopardize their chances of retaining their children. Many families may therefore withhold information about their substance use. Although families may not reply honestly to screenings conducted as part of initial investigations, it is likely that indications of substance use disorders will emerge as workers become more familiar with family histories. For this reason, as noted throughout this guidebook, it is essential for workers to approach screening as an ongoing and routine part of their work, and not as a one-time event confined to initial and early investigations.

### **Screening for Child Safety in the Child Welfare Service System**

In the child welfare system, the words “risk and safety assessment” are often used interchangeably. For the purposes of this guidebook, however, they are separated for clarity. Safety assessments, discussed here, work to answer the question “What is the immediacy of the issue?” and risk assessments, discussed later in this section, work to answer the question “What are the nature and extent of the issue?”

## **Risk and Safety Assessments**

**Safety Assessments** are used by child welfare staff at the “front end” to determine the degree of immediate danger of maltreatment to the child.

**Risk Assessments** are used by child welfare staff to assess the likelihood that a child is at risk of near-term abuse and/or neglect, help predict future maltreatment, or inform decisions about removing children from the home.

When child welfare investigators first visit families’ homes in response to an allegation of maltreatment, their highest priority is to determine whether children are safe, and if they are not, to locate acceptable arrangements for them. The Child Welfare League of America published a monograph, “*Ours to Keep: A Guide for Building a Community Assessment Strategy for Child Protection*,” which set forth the following components of safety assessments conducted at early stages:

- Life-threatening living arrangements (such as young children left alone or caretaker’s behavior is violent and out of control).

- The child is perceived in extremely negative terms by one or more parents (such as repeated negative statements to the worker about the child, or the child is afraid of people living in or coming to the home).
- The family lacks resources to meet basic needs (such as no food or child hygiene supplies in the house).
- One or more parents intended to hurt the child and showed no remorse (Day et al., 1998).

The monograph also notes “Safety interventions are not expected to provide rehabilitation or change behavior or conditions. The interventions are employed to control the situation until permanent change can take place. When child safety has been assured, then a more comprehensive assessment can take place” (Day et al.).

The National Child Welfare Resource Center in Family-Centered Practice recommends that families be involved in safety assessments by helping to identify protective factors that workers should weigh when making determinations regarding child safety. The following protective factors should be explored:

**Protective factors for children:**

- The family has safe and sober relatives and friends.
- The family has a plan to call a safe and sober person if abstinence is threatened.
- The family has identified a place where the child can stay if the parent intends to use substances.
- The parent has identified a place to go if he or she uses substances.

**Screening Pregnant Women for Substance Use Disorders**

Studies have shown that pregnant women are frequently motivated to stop using substances for the duration of their pregnancies. By working together during this critical period in the lives of young women, child welfare, alcohol and drug, and health care staff can identify problems early in pregnancies, support women in entering treatment, and make a significant difference in helping them deliver full-term healthy babies. The issues specific to screening for substance use during pregnancy are most often germane to prenatal care staff and physicians. Child welfare agencies, however, may be involved if there are older children in the family, and substance abuse treatment agencies may be involved with the family if the mother has entered treatment.

Some studies suggest that trained interviewers who have rapport with and can credibly refer pregnant women for treatment can also reliably detect prenatal substance use (Arendt, Singer, Minnes, & Salvator, 1999). The Centers for Disease Control and Prevention (CDC) has identified characteristics associated with a higher risk of alcohol use during pregnancy. Factors include having a history of physical or sexual abuse, being a smoker, being unmarried, having a history of previous or current illicit drug use, having psychological stress, having mental health disorders, being of low socioeconomic status, being of African-American and American Indian/Alaska Native ethnicity, and other factors including a family history of substance abuse (National Organization on Fetal Alcohol Syndrome, 2004). Screening techniques that include questions about quantity, frequency, and heavy episodic drinking, as well as behavioral consequences of drinking, have proven to be most beneficial; simple questionnaires have been developed to screen for problematic alcohol use among adults in multiple populations and settings (Cherpitel, 2002). It is suggested that primary care physicians and obstetricians incorporate basic

questions about substance use into the larger context of prenatal health evaluations and refer women for complete alcohol and drug assessments if yes is the answer to any of the questions (Chasnoff, Neuman, Thornton, & Callaghan, 2001; Morse, Gehshan, & Hutchins, 1997). As of January 2007, the Federal Centers for Medicare and Medicaid Services (CMS) have added two new billing codes to their system that allow for billing and reimbursement for substance abuse screening and brief intervention by medical staff.

The National Organization on Fetal Alcohol Syndrome provides a summary of several screening tools identified by the National Center for Education in Maternal and Child Health (NCEMCH) including the T-ACE and the TWEAK. (See the NCEMH-published guidelines for screening a substance abuse during pregnancy at <http://www.ncemch.org/pubs/PDFs/SubAbuse.pdf>.) The T-ACE was the first validated screen for risk drinking (defined as alcohol consumption of 1 ounce or more per day) developed for obstetric-gynecologic practices (Sokol, Martier, & Ager, 1989). The T-ACE questions are as follows:

- T, how many drinks does it take for you to feel high (Tolerance)?
- A, do you feel Annoyed by people complaining about your drinking?
- C, have you ever felt the need to Cut down on your drinking?
- E, have you ever had a drink first thing in the morning (Eye opener)?

The T-ACE is positive with a score of 2 or more. One point is given for each yes answer to the Annoy, Cut-down, and Eye-opener questions and if the tolerance question is 2 or more drinks, it is scored with 2 points. Although the T-ACE has been found to be good at identifying women at high risk, it has also been found to have a chance of misclassifying non-risk women. An alternative to the T-ACE to reduce that chance of misclassification is the TWEAK.

The TWEAK combines items from three other tools and includes the following questions:

- How many drinks does it take for you to feel high? (Tolerance)
- Does your partner (or do your parents) ever Worry or complain about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (Eye opener)
- Have you ever Awakened the morning after some drinking the night before and found that you could not remember part of the evening before?
- Have you ever felt that you ought to K/Cut down on your drinking?

A woman receives 2 points on the tolerance question if she reports that she can hold more than five drinks without falling asleep or passing out. A positive response to the worry question scores 2 points, and a positive response to each of the last three questions scores 1 point each. A total score of 2 or more indicates that the woman is a risk drinker and requires further assessment (Russel, 1994).

The “4Ps” screening instrument was developed to begin a discussion with a pregnant woman about her use during pregnancy. (For more information on the 4Ps, contact H. Ewing, Medical Director, Born Free Project, Contra Costa County, 111 Allen Street, Martinez, CA 94553.) It asks simple questions about alcohol and drug use in the past and among significant others.

The questions are as follows:

- Have you ever used drugs or alcohol during this **Pregnancy**?
- Have you had a problem with alcohol or other drugs in the **Past**?
- Does your **Partner** have a problem with tobacco, alcohol, or other drugs?
- Do you consider one of your **Parents** to be an alcoholic or addict?

More recently, the 4Ps questions have been adapted for various purposes and projects. For example, the Alcohol Screening Assessment in Pregnancy (ASAP) Project in Massachusetts found that adding a question regarding smoking rather than “Current Use” alone identified significantly more pregnant women who were at-risk for substance use and abuse. Other studies have found that past alcohol and tobacco use are excellent predictive factors for substance use during pregnancy and suggest adding questions to the 4Ps screening tool specific to tobacco and alcohol use in the month before pregnancy. The summary of these and other tools, including information on the tools’ features, strengths, and concerns, can be accessed at [www.nofas.org/healthcare/screen.aspx](http://www.nofas.org/healthcare/screen.aspx).

### **Screening for Risk to Children of parents With Substance Use Disorders**

The *SAFERR model* holds that workers in child welfare agencies are responsible for screening families for substance use disorders and counselors from the alcohol and drug treatment system are responsible for exploring whether the adult’s substance use places children at risk. At the time parents come to alcohol and drug treatment programs for services, they may not be involved with the child welfare system. In many cases, such involvement is not warranted; nonetheless, treatment staff should conduct child safety assessments to determine whether parents’ substance use disorders place their children at risk. Appendix F includes information about risk and safety assessment tools used by child welfare staff that can also be of use to alcohol and drug treatment staff. If children are at risk, referrals should be made to child welfare or other appropriate agencies.

Not all substance use endangers child safety, and some children who live with adults with substance use disorders can safely remain at home. For example, assume that in a family comprising two parents and their children, the father has a drink before dinner and drinks wine with the meal. He helps with chores and interacts with his children until they go to bed. Then, he drinks a pint or more of distilled spirits and becomes intoxicated. His wife does not drink or use drugs and is always at home when her husband is intoxicated. The husband’s level of drinking is excessive by accepted standards and constitutes “risky drinking” by some criteria. In the absence of consequences to children, however, this father does not meet formal criteria for alcohol abuse or dependence, even though others who drink less may become out of control or display behaviors that do meet abuse or dependence criteria.

Although there are many short tools to screen for substance use disorders, there are fewer tools to help alcohol and drug treatment staff screen for potential child maltreatment. In some jurisdictions, the alcohol and drug service system has implemented a screen that includes a set of questions similar to the following.

### **Questions for treatment counselors to ask to determine whether children are at risk:**

- Where are your children at the times you use alcohol or drugs?
- Have you ever worried that you would not be able to take care of your children while you were using alcohol or drugs?
- Has anyone ever told you that they were worried about how you could take care of your children because of your drug or alcohol use?
- Have you ever had trouble getting your children food, clothes, or a place to live, or had a hard time getting your kids to school, because you were using?
- Has anyone ever reported you to the child welfare system in the past?
- Are any other agencies involved with your family because of concerns about your children?

The Colorado Department of Human Services Alcohol and Drug Abuse Division revised its alcohol and drug licensing standards to require that programs serving women screen parents for child safety issues.

### **State of Colorado child safety questions for use by substance abuse treatment providers:**

- How are your children supervised during the day and at night? Who is the main caregiver for you children when you are at home and when you are not at home?
- How do you discipline your children? How do others in your household and/or family discipline them?
- When do your children eat their meals and what are examples of food they often eat?
- Do your children have a medical provider? If so, who is that person and when were they last seen? If your children do not have a medical provider, how do you handle medical situations or emergencies?
- (For parents known to have open child welfare cases): What is the connection between your substance use and your child welfare case?

Treatment counselors should also explore protective factors in place within the family to determine whether children are safe. Using the responses to these screening questions and involving family members to the extent possible, alcohol and drug treatment and child welfare staff should determine whether children can remain safely at home, whether they should be placed in care, and what services parents and children require in order to create safe and stable family environments.

### **The Role of Dependency Courts and Attorneys in Screening**

Families frequently undergo screening for substance use disorders and child maltreatment before they become involved in dependency court because only those families with these problems end up before the court. When families come before the court, court staff should determine that appropriate screenings were conducted. They can make this determination by asking whether an alcohol and drug screen was conducted and requiring that they be conducted if they were not. In addition, court staff can require that screenings were conducted to determine children's needs.

As noted previously, this guidebook does not recommend a particular tool to use to screen for substance use disorders or child safety because no tool will provide the answer as to what should be done. Screening is only as successful as the strength of the relationships among staff and the protocols and practices they have developed in using information gleaned from screening tools. If relationships are strong and protocols are in place, any tested screening tools will suffice. Subcommittees of the Steering Committee should be charged with developing protocols consistent with the themes noted in this section, and the Steering Committee as a whole should be responsible for ensuring that jurisdictions employ the recommended protocols. The *Pathways to Communication Template* presented later in this section provides guidance to staff in creating communication protocols.

### **3.3 Assessment: What is the nature of the substance use or child abuse and neglect issue? What is the extent of the substance use or child abuse and neglect issue?**

The answers to these two questions are gathered through *assessments*. Assessment generally begins once the screening process has been completed, a child welfare department response has been determined, and the family is assigned to a child welfare services worker. Assessment in the child welfare system broadly refers to both the prediction of future harm to a child and the indepth process of determining the family's strengths and needs in several areas that affect child and family well-being.

Assessments usually involve collection of detailed information that allows staff to determine whether a person does in fact have a given condition or meets diagnostic criteria for a given disorder. Assessment should also involve determining appropriate levels of care and creating treatment and case plans. Assessments may include identifying levels of functioning and determining potential risks or level of risk to children. The assessment process is longer and more detailed than screening, requires added expertise and experience, and yields information about children and families that can have more profound effects on their experiences in the alcohol and drug service system, the child welfare service system, and the dependency court than screening can. (The term "child welfare system" is used in this guidebook to include public agencies operated by States, counties, and federally recognized Indian tribes as well as nonprofit or for-profit organizations operating under the auspices of those governments.)

Assessment in both alcohol and drug and child welfare systems must be viewed as cumulative processes of information gathering that involve weighing information garnered from several sources including results from screening tools, reports from other service providers and, most important, information provided by family members themselves. During each step of the assessment process workers must build upon prior information. The more that treatment and child welfare staff communicate with each other systematically, the more complete and beneficial the assessment process will be. As workers gain expertise in sharing information with each other, assessments should take less time even as they become more effective. Information garnered from assessments should be shared with dependency courts for situations in which families are under court jurisdiction so that needed services can be included in court-ordered case plans. In addition, dependency courts can aid in obtaining needed information by the court ordering assessments if necessary.

The subsections below provide a short discussion of essential elements of substance use and child welfare assessment concepts, strategies, and techniques. For alcohol and drug assessments, this discussion includes a brief overview of the continuum of alcohol and drug use, the role of motivation

to change in alcohol and drug treatment, and treatment placement criteria. Like the section on presence and immediacy, with a few exceptions, the discussion of specific tools is reserved for the appendixes.

These concepts, strategies, and techniques can inform frontline collaborative practice related to screening, assessing, engaging, and retaining families in services. It is important, however, that the Steering Committee charge relevant subcommittees with exploring these ideas and recommending ways to use them. The ideas will work best if used as part of the framework for collaboration presented throughout this guidebook. They will work less well if used in isolation from other collaborative structures and philosophies.

### **Assessments on Substance Use Disorders**

When people screen positive for potential substance use disorders, the alcohol and drug service system moves to *diagnosis* and *multidimensional assessment*. (The term “substance abuse disorder (SUD)” is used in this guidebook as the more precise terminology indicating diagnostic criteria of the *Diagnostic and Statistical Manual (DSM)* of substance abuse or dependency. The term “alcohol and drugs” is used when referring to the broad general sense of substance use.) *Diagnosis* is the use of standardized questions in an interview to differentiate between substance use, abuse, or dependence. A *multidimensional assessment* is a standardized set of questions asked by trained alcohol and drug services staff that provides information regarding a person’s functioning, needs, and strengths and that leads to a determination of level of care and needed services.

As noted earlier, workers with minimal expertise in substance use disorders can conduct screenings for substance use, but diagnosis and assessment require that a trained clinician conduct a detailed assessment interview with findings interpreted by a qualified professional.

As noted earlier, substance use screenings are generally conducted by staff outside of the alcohol and drug service system. If screening results indicate that an assessment is warranted, a referral for assessment should be made to a trained clinician in the alcohol and drug service system. Although some staff in child welfare and other service systems may have the expertise to conduct some assessments, it is a safer assumption that most do not. The point at which families are referred from one system (in this case, the child welfare system) to another system (the alcohol and drug service system) for assessment is a critical one in setting the stage for whether families engage and remain in services. If the transition across systems is seamless and timely, families are more likely to feel that service plans will be realistic, feasible, and targeted to their needs. If the transition is marked by passive paper referrals that are not coordinated and that lack followup by either system, families are likely to feel disconnected from their service providers and are more likely to fall through the cracks as they attempt to create the linkages they expect from their service providers.

While child welfare workers are not likely to conduct detailed substance use disorder assessments, they need to have some knowledge of instruments and procedures used in diagnosing substance use disorders and in developing treatment plans. Substance use diagnoses, treatment recommendations, and responses to treatment are all critical factors in how child welfare workers monitor improvements in family functioning and stability. Such information should assist caseworkers in making recommendations concerning next steps in ensuring the welfare of children in the household.

### ***Use, abuse, and dependence continuum***

Alcohol and drug use occurs along a continuum, and clearly not everyone who uses substances abuses or is dependent on them. Levels of use are generally identified as use, abuse, and dependence. Although any level of substance use by a parent can present risks for children, this discussion focuses on dependence.

The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)*, defines **substance abuse** as a pattern of substance use that results in at least one of four consequences: (1) failure to fulfill role obligations; (2) use placing one in danger (e.g., driving under the influence); (3) legal consequences; or (4) interpersonal and social problems. A diagnosis of **substance dependence** means that the pattern of use results in at least three of seven consequences: (1) tolerance; (2) withdrawal; (3) unplanned use; (4) persistent desire or failure to reduce use; (5) spending a great deal of time using; (6) sacrificing activities to use; or (7) physical and psychological problems related to use.

Biological, genetic, and clinical research findings suggest that substance dependence is chronic and differs from abuse. Loss of control of the frequency and/or amount of substance use and continued use despite adverse consequences are key differentiating factors between abuse and dependence.

Urinalysis testing, the most frequently used marker of alcohol and drug problems in the child welfare and dependency court systems, does not provide sufficient information regarding someone's place on the spectrum of use, abuse, or dependence.

Appendix E, "Substance Use, Abuse, Dependence Continuum, and Principles of Effective Treatment," includes a detailed list of characteristics of substance use, abuse, and dependence and the risk to children for each. It also includes a summary of research-based principles of treatment for substance use disorders.

### ***Concepts in diagnostic criteria***

Many treatment programs rely on clinical judgments by staff based on interviews rather than on formal assessments or protocols in arriving at diagnoses of substance use disorders. Many other programs, however, use commercially available instruments or locally developed tools to standardize their diagnostic and assessment processes. Diagnostic instruments are written documents that guide clinicians in conducting structured interviews that cover all of the *DSM-IV* dependence and abuse criteria. These documents provide a written record of diagnoses reached through the assessment. Interviews using diagnostic instruments usually take between 30 to 45 minutes to complete. It is important for staff to be familiar with the diagnostic practices used in their State or community and to build on those practices in developing protocols.

### ***Stages of Change and the role of motivation***

A key factor in assessing people entering alcohol and drug treatment services is ascertaining their motivation to change. "Stages of Change" is a well-regarded and widely used approach in understanding this motivation. Developed by Prochaska and DiClemente (1982) this model puts forth a process in

which people progress through several steps or stages as they try to change patterns or behaviors that have caused problems in their lives. The stages are described in the box and figure below.

## Stages of Change

**Precontemplation:** The idea of change is not on the person's "radar screen," and he or she has no plans to change in the coming months. The person may not be aware of the need to change.

**Contemplation:** The person is aware that change is needed, but is "on the fence," considering or planning to make changes in the coming months.

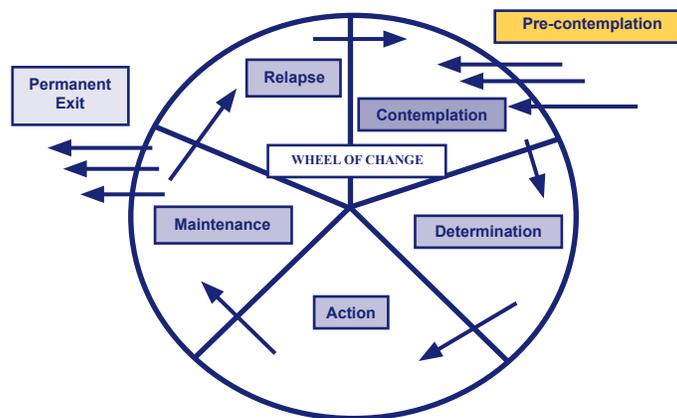
**Determination:** The person has clearly decided to change and has taken some steps toward change.

**Action:** The person has made overt and real changes in behavior.

**Maintenance:** The person has sustained the change over a period of several months and continues to work on sustaining changes.

**Relapse:** The person has started to engage in the previous behavior, although the extent may vary.

## Six Stages of Change



Over a period of time, people progress from one stage to the next, even though they may occasionally lapse back to a prior stage. The Stages of Change model holds that these lapses are not necessarily failures but are often part of the normal process by which people change.

As the role of motivation has become more widely understood, instruments have been developed that focus specifically on assessing a person's motivation to change rather than on the severity of the substance use disorder. One instrument, the *Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)* guides the person through a self-assessment of readiness to change substance use behavior (Miller & Tonigan, 1996). This tool includes a series of questions for clinicians to ask, a form for scoring responses, a form presenting a profile of the person, and guidelines for interpreting scores based on the extent of the person's recognition, ambivalence, and ability and interest to take steps. Another

tool, the “Stages of Change Form” developed by PROTOTYPES, a women’s comprehensive treatment agency, to assist clients in recognizing their readiness for changing behaviors in several domains, is included in Appendix D. This tool uses visual cues to help women determine their readiness to change in several areas, including substance use.

Miller and Rollnick (1991) further developed these stages of change into therapeutic techniques based on a therapeutic style called “motivational interviewing.” Motivational interviewing is used to help people recognize and respond to problems whose resolution involves significant behavioral changes. Its intent is to assist people in moving to the next stage of change and in creating permanent changes in their lives. With motivational interviewing, responsibility for change is placed on the individual, and the therapist uses persuasive language rather than coercive actions or threats. The therapist uses supportive, direct, and nonconfrontational approaches that help people identify the choices available to them.

Stages of Change and Motivational Interviewing are important and useful therapeutic techniques for engaging families in services as well as for assessing their service needs. If workers can understand where families are in their readiness to change (the stage), they can use motivational interviewing to help families identify their own readiness to change and decide what changes they are prepared to make. Workers can then use the same techniques to support families in making and sustaining the changes they identified.

The final step in assessing for substance use disorders involves making a decision regarding appropriate treatment. The *American Society of Addiction Medicine’s Patient Placement Criteria—2nd Edition Revised (ASAM PPC-2R)* provides the most widely used structure and criteria for treatment placement and planning.

**ASAM PPC-2R criteria to determine treatment needs and the environment required for treatment:**

- Intoxication/withdrawal;
- Medical conditions;
- Mental health conditions;
- Stage of change/motivation;
- Recovery/relapse risks; and
- The recovery environment.

Assessing these dimensions leads the clinician to make a recommendation regarding the amount of structure that may be needed to support the individual’s recovery.

The *ASAM PPC-2R* guides staff in determining the level of care that best meets a person’s immediate need. Levels of care are described as “outpatient, intensive outpatient/partial hospitalization, residential/inpatient, medically managed intensive inpatient, and opioid maintenance therapy.” Ideally, people should be matched to level of care that is appropriate for their pattern of substance use, but in reality, this is not always the case. Impediments to ideal matches include reimbursement considerations, availability of appropriate care in proximity to the client, or mandated care or length of stay (for example, mandated by a judge) that is inconsistent with the placement decision indicated by ASAM criteria. These problems may be exacerbated by the scarcity of gender-specific or culturally appropriate treatment programs in some communities. Finally, people who need a particular level of treatment may,

for a variety of reasons, decline or refuse that level. For example, women may refuse to enter residential treatment if such treatment means their children will be placed in foster care, or parents may disagree with child welfare or treatment staff and believe their substance use disorder does not require the level of treatment recommended.

The *ASAM PPC-2R* dimensions overlap with sections of the *Addiction Severity Index (ASI)*, but with a separate focus. The ASI is a program evaluation instrument widely used in evaluating addiction treatment programs and is probably one of the most often cited tools in clinical research related to the treatment of alcohol and dependence. For proper use, the *ASI* requires indepth training and is not used as a method for diagnosing substance use disorders or for making decisions regarding treatment placement. It is used to gather information and guide treatment planning about seven areas of a person’s life: medical, employment, drug or alcohol use, legal status, family history, family and social relationships, and psychiatric status.

The discussion of assessments for substance use disorders is summarized in the box below.

<b>Purpose of Activity</b>	<b>Example of Tool</b>	<b>What Activity &amp; Tool Indicate</b>
Diagnosis	DSM-IV	Use, abuse, or dependence
Motivation	SOCRATES	Stages of change and readiness
Level of Care	ASAM PPC-2R	Treatment program structure
Severity Assessment	ASI	Areas of life affected

### **Assessments on Child Maltreatment**

As noted earlier in this section, child welfare workers conduct safety and risk assessments to determine whether children are in imminent danger and to make arrangements to ensure their safety, if necessary. Child welfare assessments other than initial safety assessments begin after screenings for child maltreatment have been completed and determined to warrant further action, and after the case is assigned to a child welfare investigator or caseworker. In practice, assessments for safety and risk factors may be occurring simultaneously. Therefore, assessments in the child welfare system broadly refer to the prediction of future harm to a child and to the process of determining the family’s level of function in several domains that affect child and family well-being.

These assessments fall generally into two categories: risk assessments and family assessments.

The process of assessment is an important first step in engaging families in treatment. Discussions emerging from assessments can help families understand why they need treatment, what treatment options are available to them, and why a particular treatment provider is recommended. It is especially important, at these early stages in working with families, that child welfare and substance abuse treatment staff work closely together in ensuring that the transition from one system or service to another is well coordinated and clear and comfortable to families.

#### ***Risk assessments***

*In-Person Risk Assessments* involve interviews to determine the level of risk to the children and whether services will be voluntary or court involved.

Determining risk to children involves assessing the status and condition of the children and the nature and extent of the parents' substance use disorder. Child welfare and alcohol and drug treatment staff alike should understand the impact of substance use disorders on all family members. They have to distinguish between substance *use, abuse, or dependence* for adults or adolescents. For other family members, the assessment must gauge the effects on children and suggest the best service response.

Determining the effect of family substance use disorders on child safety and risk is only one part of the comprehensive risk and safety assessments that child welfare caseworkers complete. Although SAFERR focuses on substance use aspects of child maltreatment and speaks to the urgency with which substance use disorders need to be addressed, it also recognizes the importance of other factors that affect child safety.

The *Casey Decision-Making Guidelines*, developed by the American Humane Association, provide guidance to staff by suggesting specific, tangible standards that child welfare and alcohol and drug treatment staff can use in assessing the nature and extent of substance use disorders in parents and how those disorders affect child risk. The Guidelines conclude, "The issue for child welfare is how the substance abuse results in problems in appropriately caring for the child (Field & Winterfield, 2003)."

The *Casey Decision-Making Guidelines* specify that in making child risk assessments, workers need to assess both the child and the addiction. Therefore, the Guidelines include seven indicators of substance use disorders among caregivers and six sets of risk factors to be included in assessing risk associated with alcohol and/or drugs, noting "Professional substance abuse screening is preferred if available" (Field & Winterfield, 2003).

## Casey Decision-Making Guidelines:

### Seven Indicators of Substance Use Disorders Among Caregivers:

- Was the child born with a positive drug toxicology screen?
- Was the child left without adequate supervision?
- Does the child arrive tardy or miss school frequently without apparent good reason?
- Does the child miss well-child medical appointments and frequently appear unkempt when he or she shows up at appointments?
- Are the child's basic needs for food, shelter, and hygiene not met?
- Is there a pattern of neglect where the child does not receive adequate food, medical care, or supervision?
- Was the child abused while an adult caregiver was under the influence of alcohol or drugs?

### Six Risk Factors for Substance Use Disorders Among Caregivers:

- Caregiver history
- Caregiver characteristics
- Environmental pressures
- Awareness of impact of substance abuse on child
- Parenting skills and responsiveness to child
- Family Support systems

One of the few recent efforts to link specific substance use disorder-related factors to child maltreatment was conducted in Chicago. Fuller and Wells (2003) analyzed an Illinois database of child maltreatment files to determine what risk factors recorded in the database (and the accompanying case files) are linked with recurrence of maltreatment—a second report within 60 days of the initial maltreatment report. Among the factors that they found related to short-term maltreatment recurrence were—

- The safety assessment item about caretaker alcohol and other drug use checked ‘yes’;
- A high risk assessment rating for caretaker criminal behavior; and
- No police involvement during the investigation.

The researchers suggest that this observation for single, African-American women may be due to the fact that pregnant African-American women and those of lower socioeconomic status are more likely to be reported to child protective services than are Caucasian women.

The *Risk Inventory for Substance Abuse-Affected Families* is a tool that has been the subject of some research publications. This risk inventory explores the effects of substance use disorders on risks for child maltreatment and family functioning (Children’s Friend and Service, 1994; Lester, Andreozzi, & Appiah, 2004). It consists of eight scales (sets of questions) rated on a four- to five-point continuum, and has descriptions of the kinds of situations a child welfare worker might find for each point on the continuum for each scale. In addition to scales addressing substance use disorders and recovery, commitment to recovery, patterns of use, and supports for recovery, scales also cover effects of substance use on child caring, general lifestyle, self-efficacy, and self-care. The quality of the neighborhood is also rated.

*Structured Decision Making (SDM)* is a child welfare system case management model that features several risk and needs assessment instruments. The risk assessments focus on the probability of future maltreatment, and they use separate scales for neglect and abuse because different ethnic groups appear to manifest different patterns of maltreatment (Baird, Ereth, & Wagner, 1999). Data from a number of States indicate that the application of these risk scales can identify subgroups of families that vary in the probability of future maltreatment from under 4 percent to more than 47 percent over an 18-month period.

Appendix F provides more information about these and other risk assessment instruments.

### ***Family assessments***

A *Family Assessment* examines family strengths and needs in order to determine which areas of family functioning require interventions in order for children to have permanent and safe living environments. Family assessments require participation of parents, children, caregivers, alcohol and drug counselors, and others working in collaboration with the child welfare worker. Through family assessments, the child welfare services worker, family members, and others work to identify the family’s needs, strengths, and resources. Family assessment is a critical component in helping families enhance their parenting abilities and in ensuring child safety and well-being (from testimony submitted to the Senate Finance Subcommittee on Social Security and Family Policy for the Hearing on Issues in Temporary Assistance for Needy Families [TANF] Reauthorization: *Helping Hard-To Employ Families*, April 25, 2002).

One model of family assessment is the *Family or Group Conference Model (FGC)*. This assessment consists of two parts and is based on a trust-building approach. In the first part, information is gathered

by professionals through use of various assessment instruments and through direct observation of family functions. In the second part, a family meeting is called, which may include extended family members and relatives. The information collected is presented to participants in the form of strengths and limitation. Using this information to bolster the fabric of the family, members are able to make informed decisions about how the family members will be assisted, protected, and strengthened. In recent years, FGC models have received a good deal of attention in the victim-offender mediation and restorative justice movements in North America (Umbreit, 2000). Although this model may be growing as a common service, there is variability in how it is applied.

Another model for standardizing family assessments and developing case plans is the Family Assessment Form (FAF). The FAF, designed to assist in-home workers in determining what intervention is needed (McCroskey, Nishimoto, & Subramanian, 1991), measures risk variables by the Family Risk Scales and “emphasizes parental characteristics and family conditions that are believed to be predictors or precursors of child maltreatment or other harm to children” (Magura, Moses, & Jones, 1987). It also incorporates six Child Well-Being Scales, which are believed to be most useful for risk assessment.

### **The Role of Dependency Courts and Attorneys in Assessment**

When families and agencies appear before the court, judges or magistrates should ensure that appropriate assessments were conducted and that the court has information regarding assessment results and diagnoses. Attorneys for parents play a key role in advocating for timely assessments and in encouraging their clients to participate in the assessment process. Court staff, including attorneys, should be available to meet with staff and family members to discuss assessment results and their implications for services.

### **Considerations for Use by Child Welfare, Alcohol and Drug Treatment, and Court Systems**

Although it is logical to assume that substance use disorders increase the risk of child maltreatment, these disorders do not automatically equal risk and the risks they imply are not the same for all families. Substance use disorders need to be viewed in the context of other potential risk factors as well as specific behaviors, histories, and other evidence of how the substance use disorder affects the ability of parents to care for their children or poses specific risks for maltreatment. The presence of family members with substance use disorders increases the probability of risk to children, but the nature or level of risk that exists in a given case is more difficult to determine. More important, decisions about the nature or level of risk should be shared between child welfare and alcohol and drug treatment staff, and also by court staff if appropriate.

Risk to children is likely to be greater if the adult with the substance use disorder is also the primary caregiver for the children. Behaviors associated with substance use, however, vary significantly among different people, so staff have to examine each family situation individually. Questions to explore include these: Is the individual intoxicated or otherwise incapacitated while being the sole caretaker of children? Is the individual violent or hostile as a result of the use or addiction? Is there a history of the individual doing things that place children in potential danger or of having harmed a child?

### **3.4 Treatment and Family Case Plans: What is the response to the substance use or child abuse and neglect issue? Are there demonstrable changes? Is the family ready for transition? What happens after discharge?**

#### **Developing Treatment and Family Case Plans**

While collaboration between the alcohol and drug, child welfare and dependency court systems is crucial in answering questions regarding whether there is a substance use or child maltreatment issue and the nature and extent of the issue, these relationships may be even more critical in addressing questions ensuring that case plans are comprehensive and coordinated, that they lead to desired outcomes, and that progress can be monitored. To the extent that collaborative structures and protocols have been established as part of addressing the prior questions covered in this section, those structures and protocols set the stage for continued collaborative efforts in developing and monitoring responses.

To be useful, treatment and case plans must include information required to satisfy the goals and mandates of each system, but they cannot be simply a compilation of separate pieces of information as determined individually by each system. Ideally, individual system goals, mandates, and services should be woven into a single and comprehensive statement of services that is clear to families and service providers alike. If unified case plans are infeasible, it is especially important that plans be developed in a coordinated manner that gives clear and consistent guidance and directions to families. The Steering Committee can be useful in directing that jurisdictions work toward developing unified case plans, in supporting their efforts toward that goal, and in overseeing the results.

Family members should be actively engaged in creating their plans. Families often have resources in the form of relatives, friends, churches, or other support networks that can participate in creating plans and in ensuring that families are able to comply with their plans. Families should be welcomed as full participants in multidisciplinary team meetings during which decisions about case plans will be made.

Factors of importance to treatment plans include treatment goals appropriate to the individual's history of substance use, drug testing requirements, and requirements for attending group and individual treatment sessions and, when appropriate, self-help support groups. Factors of importance to child welfare case plans include the permanency goal for the child, services to be provided to the family as part of helping parents retain or regain custody, and details regarding parent and child contact and visitation schedules. Dependency court orders typically incorporate the information provided by the child welfare services agency, turning the child welfare case plan into a court order that complies with ASFA requirements.

#### ***Alcohol and drug treatment plans***

Alcohol and drug treatment plans should include information about a family's experiences and current status with child welfare. The fact that a parent's substance use disorder has resulted in family involvement with child welfare and possibly dependency court systems creates both incentives for parents to succeed in treatment and pressures regarding consequences if they do not. Treatment plans that reflect child welfare and ASFA timetables are important in helping parents demonstrate progress when they appear in court for their case reviews. If alcohol and drug, child welfare, and court staff are working together effectively in developing and monitoring treatment and case plans and court orders, they will be able to make informed decisions regarding child safety, permanency, and family well-being.

Alcohol and drug treatment plans should be based on results of prior screenings, assessments, and diagnoses. They should draw from child welfare safety and risk assessments and results of assessments conducted by staff from other agencies, if relevant. Treatment plans should contain the following information:

- Problems to be addressed (substance use, family relationships, medical care, and educational and employment needs);
- Goals of the treatment process (e.g., abstinence from the use of alcohol or drugs and improved parenting skills);
- Objectives and strategies to reach the treatment goals (e.g., develop social network with individuals who do not use substances and successfully complete parenting classes);
- Resources to be applied—treatment programs, funding, and other services;
- People responsible for actions such as making referrals, attending treatment sessions, and preparing followup reports;
- Timeframe within which certain activities should occur; and,
- Expected benefits for the individual participating in the treatment experience.

### ***Child welfare case plans***

Similarly, child welfare service system case plans should be based on results of prior screenings and risk and family assessments. They should draw from treatment assessment results, treatment plans, and results of assessments conducted by staff from other agencies if relevant. Child welfare caseworkers should work with family members and alcohol and drug treatment and other service providers to develop a case plan that sets forth agreed-upon activities and strategies to reduce or eliminate the behaviors and conditions contributing to the risk of maltreatment.

As suggested in the discussion on screening, families should be asked whether they are or are eligible to be members of American Indian Tribes. If a child is determined to be an American Indian, the child welfare service agency must ensure that it is in compliance with ICWA. Notice of child welfare service action should be sent immediately to the tribe, and tribal staff should be included in the development of the case plan.

The ASFA requirements are already built into the child welfare case plans developed with parents and represent conditions that parents must meet in order to have their children returned. There must be a case plan that places the child in the least restrictive (most familylike) environment available, in close proximity to the parents' home, and consistent with the best interests of the child. ASFA requires that the child welfare service system provide a program of services that represent "reasonable efforts" to prevent the out-of-home placement of a child or to promote the return of a child to the home as soon as possible. In situations governed by the Indian Child Welfare Act, however, there must be "active efforts" rather than "reasonable efforts" to prevent out-of-home placement if the child has not yet been removed from the home or to return the child to the home as soon as possible if the child has been placed in protective custody.

Child welfare service plans typically include the following:

- Required activities and objectives;
- Services for adults and children;

- Drug testing requirements;
- Visitation plans. Based on the parent's progress, visitation may range from no contact to monitored or unmonitored telephone calls, short supervised or unsupervised contacts, unsupervised long visits, or overnight visits;
- Safety plans that include identification of safety risks, strategies to decrease or eliminate risks, informal and formal safety responses, and steps that family members, providers, and others will take to ensure that children are safe;
- Permanency plans that state the permanency goal and specify steps to achieve the goal within ASFA timelines;
- Requirements such as successful completion of parenting classes, abstaining from substance use, and providing a safe home environment for reunification in cases when children have been removed; and
- Concurrent planning activities and objectives as applicable (Goldman, Salus, Wolcott, & Kennedy, 2003)

In developing and monitoring treatment and case plans, alcohol and drug treatment, child welfare, and court staff should share information regarding—

- Treatment and case plan activities and objectives;
- Family service interventions;
- Treatment requirements—including type of treatment recommended and number of required sessions;
- Required drug testing;
- Safety plans;
- Visitation plans;
- Requirements for reunification; and
- Permanency plan.

### **Demonstrable Changes and Their Monitoring**

The questions of whether there are demonstrable changes and whether changes are sufficient to warrant family reunification or closing the case can be answered only if all staff work closely with families to monitor their progress and adjust plans as needed, and if there is effective communication between the alcohol and drug, child welfare, and court systems.

### **Treatment does not equal recovery**

Treatment is an important element of recovery, but recovery involves more than obtaining sobriety. Moreover, abstinence from substances on its own is insufficient to support recovery or ensure child safety. Recovery involves a series of changes in thinking and behavior and the ability to maintain those changes over time. Traditional residential, intensive outpatient, and outpatient alcohol and drug treatment programs are time limited, but recovery from alcohol and drug abuse is a lifelong process. This tension between the reality of treatment models and the process of recovery poses a challenge for staff in determining whether treatment has been successful. An individual who has been successful in recovery may have participated in several treatment episodes before achieving that success.

In monitoring progress to determine whether there are demonstrable changes, alcohol and drug treatment staff distinguish between resolving acute problems and establishing recovery plans for a chronic condition. Acute crises or situational problems such as injury, divorce, or grief over losing a family member tend to resolve with time. However, for chronic conditions such as diabetes, bipolar disorder, or substance dependence, outcome expectations are better framed in the context of suitable plans to sustain stable functioning. Diabetics develop plans to check their blood sugar levels regularly, establish diet regimens, and go for periodic medical checkups. People suffering from bipolar disorders have to adhere strictly to medication protocols and receive periodic medical checkups. Counseling that includes attention to proper management of the illness, including ways to detect indications of mood swings and to develop strategies for dealing with them is also very important. Substance use recovery plans include strategies for dealing with cravings or temptations to use, creating and maintaining healthy support networks, and developing a list of people to contact at times of concern.

Markers that can be used to determine whether someone has made demonstrable change in substance use include decreased frequency of drug use, followed by short periods of abstinence and relapse, followed by prolonged periods of abstinence with fewer episodic relapses (Goldman et al., 2003). Achieving a period of abstinence from substance use requires making a cognitive and behavioral commitment to change one's lifestyle and stop using drugs. In the absence of these changes, cessation of drug use for a brief period (e.g., because of a lack of availability of the drug or a brief period of incarceration) does not constitute progress toward abstinence. Many treatment providers and the 12 Step fellowships (e.g., Alcoholics Anonymous [AA]) recognize a period of 1 month without drug use as the first significant measure of progress toward achieving abstinence. However, studies of treatment outcomes report that active participation in treatment for more than 90 days is associated with better long-term outcomes.

### **Relapse is not the same as treatment failure**

Relapse may be an indication that the treatment plan is not adequately addressing important issues, and it may present a therapeutic opportunity for people to learn that controlled use of substances is not possible for those who are addicted (U.S. Department of Health and Human Services (DHHS), 1999). Reaching agreement on the consequences of relapse poses challenges for staff that work in different systems. People who work in the alcohol and drug service system generally view relapse as a component of the recovery process and an opportunity to intervene, but relapse to substance use makes it extremely difficult for child welfare staff, dependency court judges, and attorneys to determine whether the person is making appropriate progress in treatment (DHHS, 1999). Even if progress is recognized, accurately determining whether progress is sufficient to ensure the child's safety may remain hard.

Relapse can happen at any time in the recovery process, but families involved with child welfare may be more at risk at certain points during their involvement. These critical points include before court hearings, after visitations with their children, shortly before regaining custody of their children, and shortly before exiting from the child welfare system. As noted in Section II, lapses differ from relapses. Alcohol and drug services staff can help parents understand this difference, accept the fact that their lapse or relapse does not mean they have failed, and can help them reengage in treatment as soon as possible. Child welfare workers, in concert with alcohol and drug treatment counselors, can assist parents in using lapse or relapse episodes to learn what factors trigger their cravings to use substances. Child welfare workers can also help parents anticipate the possibility of lapses or relapses by creating safety plans for their children. For example, if a mother begins to seek out situations involving substance users (a warning sign for relapse), is she able to make arrangements for her children so that they will be safe and secure if she does in fact relapse? Parents who learn their triggers can become

empowered to plan for the safety of their children and seek healthy ways to neutralize or mitigate triggers. One component in facilitating recovery is to develop a relapse prevention plan and strategies.

Monitoring progress to determine whether changes are taking place should be systematic, based on negotiated protocols for interagency communications as presented in the *Pathways to Communication Template* presented earlier in this section. Joint monitoring of progress can be as basic as obtaining a discharge summary or report from a treatment program, or as formal as monitoring through formal assessments designed to document family situations at repeated points in time.

### Monitoring: Case Examples

The **Monterey County** Department of Social Services, Division of Family and Children Service (FCS), and Health Department, Division of Behavioral Health (BH), have established policies and procedures that include “Hot Sheets” for use by treatment counselors to notify FCS and BH staff if a person is out of compliance with treatment requirements. In the event of a positive drug test, a no-show, intoxication, or other incident of noncompliance, the treatment provider calls the FCS social worker and BH staff person, and follows the call with a faxed “Hot Sheet” that outlines the problem and offers a recommended solution. The FCS social worker, BH staff, or treatment provider may then generate a case consultation to determine the appropriate course of action, which could include relapse intervention, a home visit, a health and welfare check, removal of the children, or other agreed-upon response.

**Sacramento County** requires, through a court order, that alcohol and drug treatment staff share information about treatment progress with child welfare workers twice per month. The information to be shared has been approved by attorney groups, county agencies, and provider organizations and includes overall assessment of compliance with recovery plan court orders; alcohol and drug tests requested, completed, or pending; treatment attendance and participation; contacts with a recovery manager; and attendance at 12 Step meetings or another appropriate support group if the individual does not adhere to the principles of the 12 Step program.

### The role of drug testing

Drug testing as part of an ongoing assessment of a treatment participant’s progress is often a component of treatment and can be used as a deterrent to relapse (DHHS, 1999). However, drug tests have limitations and should be approached with caution. Drug testing may not be an accurate method of determining current or recent drug use. Some drugs are quickly metabolized in the body; therefore, abstinence cannot be reliably measured solely by blood or urine drug tests, or with a breathalyzer, unless the individual is confined in a tightly controlled setting and is tested daily at random intervals (D’Aunno & Chisum, 1998). Even if available, the utility of such measurements may be limited, because they tell very little about the person’s ability to maintain abstinence outside of a highly structured setting and under the daily pressures facing most families involved with the child welfare and dependency court systems.

Although treatment researchers have established the reliability and validity of self-reports of drug use to impartial researchers (where there is no negative consequence for truthfulness), self-report of abstinence to one’s child welfare caseworker is apt to be far less reliable. Therefore, the probability that someone is not using substances is best evaluated by a combination of random drug tests, self-reports, and observations by treatment providers and child welfare workers of behavioral indicators such as positive changes in hygiene and grooming, improved functioning in daily life (in the absence of underlying

untreated psychological or psychiatric disorder), and improved consistency in complying with drug treatment and child welfare case plan requirements.

When used in the context of treatment, results of alcohol or drug tests can help treatment providers adjust treatment plans, change the type of treatment offered, or work with families to help them acknowledge and start to address substance use problems. These are therapeutic uses of drug tests, and qualified treatment counselors should make decisions regarding their use.

Monitoring change is an ongoing component of child welfare work, beginning as soon as the plan is implemented and continuing throughout the time the family is involved with child welfare. Evaluating whether risk behaviors and conditions have changed drives decisions regarding service needs and adjustments, recommendations to courts, and ultimately, whether children remain with their parents. Formal reviews regarding the status of each child in foster care are required no longer than and preferably sooner than once every 6 months. In some States, these reviews are conducted by child welfare staff and are presented to the court only if circumstances warrant. In most States, the reviews are conducted by the court.

Status reviews for children in foster care generally cover—

- The safety of the child;
- The continuing necessity for placement;
- The extent to which the parents have complied with the case plan;
- Progress toward alleviating the circumstances that required placement; and,
- Projected likely date by which the child may be returned.

The report *A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice*, issued by the National Clearinghouse on Child Abuse and Neglect Information (now known as the Child Welfare Information Gateway), notes that using case plan reviews to evaluate family progress helps answer the following questions:

- Is the child safe? Have the protective factors, strengths, or the safety factors changed, warranting a change or elimination of the safety plan or the development of a safety plan?
- What changes, if any, have occurred with respect to the conditions and behaviors contributing to the risk of maltreatment?
- What outcomes have been accomplished, and how does the caseworker know that they have been accomplished?
- What progress has been made toward achieving case goals?
- Have the services been effective in helping clients achieve outcomes and goals and, if not, what adjustments need to be made to improve outcomes?
- What is the current level of risk in the family?
- Have the risk factors been reduced sufficiently so that parents or caregivers can protect their children and meet their developmental needs so that the case can be closed?

- Has it been determined that reunification is not likely in the ASFA-required timeframes and that there is no significant progress toward outcomes? If so, is an alternative permanent plan goal needed (D’Aunno & Chisum, 1998)?

### **The Role of the Dependency Courts and Attorneys in Determining Demonstrable Change**

While not all families involved with child welfare are also involved with court, when courts are involved, judges and attorneys actively participate in monitoring how families are progressing in their case plans and whether agencies are complying with ASFA requirements. For judges to issue rulings and modifications to court orders, it is crucial that the court be given comprehensive information specifying the basis on which child welfare recommendations are made. This information is particularly important in situations when parents are participating in alcohol and drug treatment. The 6-month review hearings present opportunities for the attorney for the parents to provide information regarding progress and for attorneys, CASA volunteers, or guardians ad litem (attorney advocates) for the child to provide important perspectives as well.

### **Readiness of the Family for Transition, Discharge, and Case Closure**

When a parent has demonstrated progress in meeting treatment objectives, alcohol and drug counselors must make a determination about whether the parent is ready to make a transition out of formal treatment. This determination involves developing the person’s ongoing recovery plan.

Continuing care, or aftercare, services are essential to sustaining treatment success, child safety, and family well-being because they give the family an opportunity to anchor new behaviors and practice drug-free living and relapse prevention techniques. Without such services and community supports, relapse rates can be high, even if people have achieved long periods of sobriety while in treatment. Continuing care includes clinical treatment and community support that address needs identified in the relapse prevention plan, and that create a supportive net around the individual and family to encourage recovery. For families in the child welfare system, continuing services should provide help to parents in recovery who may be under new stress related to having their children returned home. Other supports that are frequently needed include housing, job training, or educational services.

Trusting relationships formed among treatment participants, their peers, and their counselors continue to provide support even after people have completed formal treatment (DHHS, 1999). Leaving treatment can be stressful, even when treatment has been successful. Alcohol and drug services staff are typically aware this is a critical time, prone to recurrence of problems or resistance to ending treatment (DHHS, 1999). Staff should help people as they end treatment by reviewing their relapse prevention strategies and by conducting risk assessments if concerns about child safety emerge (DHHS, 1999). In addition, alcohol and drug services staff should help people leaving treatment identify the issues that are worrying them and help them locate and use resources to deal with the stress (DHHS, 1999). Ongoing participation in self-help groups such as AA, mentioned previously, and Narcotics Anonymous (NA), is important in most people’s recovery.

Families should know how to get in touch with workers even after they have been formally discharged. Even though formal treatment may have ended, alcohol and drug service and child welfare workers continue to have responsibilities to help families in their recovery processes and in the prevention of future returns to substance use or child maltreatment. These responsibilities include reengaging the family if relapses occur and working with the family on developing strategies to prevent future relapses. Thus, in transition planning, it is important for all staff to ask, “What happens after discharge or case

closure?” Staff and family members should work together to establish a system of support for families and a process by which families can both assess their own progress over time and receive assessments from professional counselors as needed.

As noted earlier, when a child has been in foster care for 15 of the most recent 22 months, the State must file a petition to terminate parental rights unless a relative is caring for the child, there is a compelling reason that termination is not in the best interests of the child, or the State has not provided the needed services within the required deadlines.

When appropriate treatment services are not available to a parent within the timeframes of ASFA, the third reason may provide a justification for extending family reunification efforts. In these cases, it is essential that staff from all three systems communicate to determine whether an extension is appropriate.

### **3.5 Did the Interventions Work?**

This is the last of the questions guiding staff from child welfare, alcohol and drug, and court systems. In determining whether interventions work, the Steering Committee must evaluate both whether families have improved and whether the collaborative is effective.

The question regarding whether interventions work is answered in the alcohol and drug service system by examining changes in life functioning and consequences of substance-use after treatment. The question is answered in the child welfare system by examining recurrences of maltreatment and reentries into the system. Each of these individual measures is important, but it is equally important for the collaborative, through the Steering Committee, to develop shared outcome measures that are routinely monitored to determine whether their collaborative work has had a positive effect on families. Without agreement on accountability and outcomes, the agencies will likely measure progress using different measures of effectiveness.

These common outcomes can hold the collaborative group together and can provide justification to policymakers to continue supporting these efforts. Common outcomes might focus on efficiencies in the systems, such as timeliness of entry into treatment, timeliness of reunification, or timeliness of case closures.

To evaluate benefits to families, the Steering Committee is responsible for establishing common outcome measures, creating mechanisms for gathering data to track common outcomes, and reviewing reports of common measures to assess where the collaborative endeavors are successful and where they need more attention. Data from reports of common outcome measures should be used by all systems to modify policies and protocols that make it difficult for staff to work together.

To evaluate whether the collaborative has been effective, members of the Steering Committee must continually take an honest look at how well the collaborative is working and must monitor its progress in meeting the goals specified in the plan of action. Appendix A provides tools such as the *Collaborative Capacity Instrument* and the *Collaborative Values Inventory* that the Steering Committee can use to assess its internal processes and identify issues on which there is consensus and issues on which consensus is lacking. While it is important to monitor process, it is also important to monitor completion of work. Regular review of progress toward completing activities outlined in the plan of action is essential to keeping the group on task, adjusting deliverables and providing feedback to Subcommittees and local jurisdictions. Appendix A presents a template for a progress report that can be used by the Steering Committee or the Subcommittee.

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