SCREENING AND ASSESSMENT FOR FAMILY ENGAGEMENT, RETENTION, AND RECOVERY

(SAFERR)

NCSACW
national center on substance abuse and child welfare

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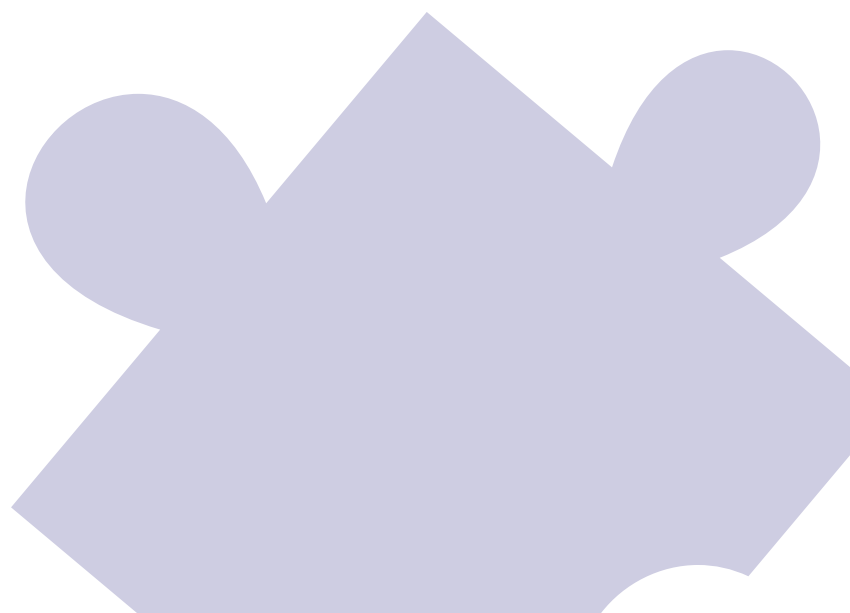
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INTRODUCTION

This guidebook presents the *SAFERR* (Screening and Assessment for Family Engagement, Retention, and Recovery) *model* for helping staff of public and private agencies respond to families affected by substance use disorders. The *SAFERR model* and this guidebook were developed by the National Center on Substance Abuse and Child Welfare (NCSACW), a training and technical assistance resource center established jointly by the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration and the Office on Child Abuse and Neglect of the Administration for Children and Families. Both agencies are part of the U.S. Department of Health and Human Services.

NCSACW developed SAFERR in response to frequent requests from managers of child welfare agencies for a "tool" that caseworkers could use to screen parents for potential substance use disorders in order to make decisions about children's safety. This guidebook is that tool, and more. Although research findings and practical experience have established that no single checklist yields the kind of information caseworkers need to make difficult decisions about whether children are safe, they have identified an array of screening instruments and practice principles that, if used appropriately, can provide timely information to guide those decisions. Moreover, if these instruments and practice principles are used collaboratively by child welfare and substance abuse treatment staff, they not only inform urgent decisions about child safety, but they also improve the way staff engage and retain families in services over time and they point to policy changes that make it easier for families and workers alike to succeed (Day, Robison, & Sheikh, 1998).

> SAFERR is based on the premise that when parents misuse substances and maltreat their children, the only way to make sound decisions is to draw from the talents and resources of at least three systems: child welfare, alcohol and drugs, and the courts.

Although there are a variety of tools for screening and assessing children and families and a range of substance abuse treatment and other services, it is only through collaboration and communication across the systems responsible for helping families that workers will get the information they need and that families will feel they have a chance at changing their lives.

Recent policy changes give new urgency to improving staff capacity to screen, assess, engage, and retain families. These include—

- The timelines in the Federal Adoption and Safe Families Act (ASFA) that "speed up the clock" when children have been removed from parental custody. These shorter timelines place pressure on child welfare workers to identify parental substance use disorders and then make decisions regarding their effects on child well-being, the likelihood that parents can recover, and the level of stability in the family. They also place pressure on dependency court judges to keep informed about parents' participation in treatment and the status of their recovery.

- The efforts of the Children's Bureau, through Child and Family Service Reviews (CFSRs), to assess each State's performance on child welfare outcomes and its level of conformity with Federal child welfare outcomes and to assist States in improving their outcomes. Findings of completed CFSRs indicate that many child welfare agencies are not adequately assessing substance use disorders or making timely referrals to treatment.

- The 2003 amendments to the Child Abuse Prevention and Treatment Act (CAPTA) that place new requirements on hospitals to refer to child protective services (CPS) staff newborns identified as affected by illegal substances.

Research and practical experience repeatedly indicate that parental substance use disorders and child maltreatment are highly correlated and that many if not most children under the jurisdiction of child welfare agencies and the courts come from families with substance use disorders. Although substance use, abuse, or dependence alone is not the sole determinant of risk to children, the *SAFERR model* holds that because so many families involved with child welfare have these problems, there is a need for child welfare policies that call for initial and ongoing screening and assessment of possible substance use disorders with an assumption that those disorders are likely to exist (i.e., that practice should be to "rule out" substance use disorders). Similarly, this correlation suggests a need for alcohol and drug policies that call for initial and ongoing assessment of child safety and risk of child maltreatment within families.

The *SAFERR model* further maintains that decisions from the court system about the future of children should not be made without sufficient information from the child welfare and alcohol and drug systems regarding the extent of substance use disorders, their impact on the children, and the potential for engaging parents into treatment and recovery.

What SAFERR and This Guidebook Offer States, Counties, and Localities

SAFERR puts forth an approach to help child welfare services, alcohol and drug services, and court staff promote child safety and family well-being within the practical realities and legislative mandates that drive their agencies. While SAFERR suggests standards of practice within each of the three systems, its focus is on the connections, communications, and collaborative capacities across them. These standards apply to the child welfare service, alcohol and drug service, and court systems. Because families involved with these systems are also likely to be known to other systems such as welfare, criminal justice, and mental health, the strategies suggested are relevant for coordinating services across a wide range of systems.

Each system has a process it uses to meet its responsibilities to families. These processes are somewhat parallel, unfolding in somewhat similar ways over about the same periods of time. For example, both the alcohol and drug and child welfare service systems screen people for potential problems, conduct assessments to determine the nature and extent of those problems, develop service plans, and monitor progress in meeting requirements of those plans. For families who become involved with the court system, courts review assessments regarding the nature and extent of problems in order to establish jurisdiction and adjudicate petitions, and they oversee and monitor the performance of agencies and families in meeting requirements of plans.

Traditionally, these processes take place independently of each other, but all three systems are using similar and parallel processes involving many of the same families, which strongly argues for strategies to reduce duplication, simplify work, save time, and make the processes more clear and practical for families to follow. The *SAFERR model* depicts these parallel processes in the form of the following questions that each system—child welfare, alcohol and drug, and courts—individually addresses during the time it works with families:

- Is there a substance use or child abuse or 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 or neglect issue?

- What is the response to the substance use or child abuse or neglect issue? Are there demonstrable changes? Is the family ready for transition and what happens after discharge?

- Did the interventions work?

The *SAFERR model*, as described in this guidebook, suggests strategies to help workers answer these questions in a more coordinated manner. Specifically, SAFERR will help staff—

- Create and guide collaborative teams charged with improving services to families through sharing information and coordinating services;

- Support the work of those teams through developing clear expectations regarding mission, authority, and accountability;

- Identify and address State-level policies that may block efficient practice;

- Select screening and assessment tools and strategies that can be incorporated into daily practice protocols;

- Support and oversee implementation of improved practices at the local level; and

- Monitor and evaluate successes and problems.

SAFERR Principles and Premises

The SAFERR model is based on three overarching *principles*:

1. The problems of child maltreatment and substance use disorders demand urgent attention and the highest possible standards of practice from everyone working in systems charged with promoting child safety and family well-being.
2. Success is possible and feasible. Staff in child welfare, substance abuse, and court systems have the desire and potential to change individual lives and create responsible public policies.
3. Family members are active partners and participants in addressing these urgent problems

These principles lead to the following fundamental premises that are addressed in detail throughout this guidebook:

1. **The team is the tool, and people, not tools, make decisions.** Paper and pencil tools to screen and assess for substance use disorders do just that. They do not provide information that allows child welfare workers, substance abuse counselors, attorneys, judges, or other staff to determine whether children are safe or whether there are substance use disorders or other problems in the family that put children at risk. Decisions regarding child safety and child placement are made by people, who draw on the expertise of multiple perspectives.

2. **The family is the focus of concern.** Although it is easy to understand how child welfare staff come to focus their attention primarily on the children and substance abuse counselors focus theirs primarily on the parents, isolating family members in this way tends to provoke tensions among

service staff and anger and alienation among family members. In order for staff and families to succeed, child welfare policies and workers have to acknowledge and address the implications of parental substance abuse on child safety, and substance use policies and counselors have to develop a family focus and incorporate the needs of children into treatment protocols.

3. **Problems don't come in discrete packages: they are jumbled together.** It is extremely difficult for workers to get an accurate picture of the ways that factors such as poverty, mental and physical illness, domestic violence, and lack of basic living skills interact with substance use disorders and child maltreatment. It is virtually impossible for managers to establish policies and procedures that address these constellations of problems in some coherent manner unless they work and communicate with colleagues from other systems with expertise in these fields.

4. **Assessment is not a one-person responsibility.** Assessments that are done separately by either child welfare or substance abuse staff, in parallel but not coordinated processes, run the risk of overlooking factors critical to recovery and family stability, thereby depriving families of needed services and reducing the likelihood that they will achieve their goals. In addition, as families become engaged in services, they resolve one problem and prepare to address the next, they may backslide, and they may face new situations requiring changes in their case or treatment plans. Throughout this process, child welfare and substance abuse treatment workers, attorneys, and family members must seek feedback from each other, reassess progress and needs, and change plans accordingly. Because assessment reports may be used in court as a standard for determining whether children remain with or return to their parents, it is essential that they include the perspectives of everyone involved and that they accurately represent the family situation at each point in time.

5. **Information is limited, and there is no research-based answer.** Even though identifying substance use disorders and identifying risk to child safety are inseparable, there is little research or practice that speaks to the connections between the two. Moreover, there is now no definitive research or evidence-based answer to determine how alcohol and drug use affects child maltreatment. In the practical environment in which child welfare, substance abuse, and court staff make decisions, it is enough to know that substance abuse or dependence is correlated with child maltreatment.

6. **There is no time to lose.** Recent child welfare policies emphasizing timely permanency decisions and the use of termination of parental rights hearings under ASFA have considerable impact on parents with substance use disorders who come under supervision of the child welfare and court systems. These parents face difficult challenges in managing many and at times conflicting requirements, and the stakes are high. Time is short for these families. Each day that assessments are deferred, service needs are overlooked, or services are not delivered is valuable time lost.

7. **The Indian Child Welfare Act (ICWA) creates specific guidelines for working with American Indian populations.** More than 560 federally recognized American Indian Tribes operate child welfare programs and may be resources for treatment for tribe members. Many tribes also operate their own dependency courts. Indian tribes and agencies are important partners in establishing both responsible frontline practices and agency-level policies.

8. **Developing and sustaining effective collaborations is hard work.** Outcomes for children and families depend on informed decisions by teams of people who work in disparate systems that are driven by unique funding, philosophical, and legislative mandates. While SAFERR lays out ways to help managerial and frontline staff make these decisions, it does so with an understanding that both the collaboration and the decisions to be made are difficult to come by and with a deeply felt respect and regard for the staff who work with troubled families.

The table on the next page, **The SAFERR Program Model**, is a graphical representation of the *SAFERR model*. The SAFERR principles lead to a series of collaborative structures, roles, responsibilities, and frontline practices indicated in the three "SAFERR Intervention" boxes. These boxes correspond to the next three sections of this guidebook. The SAFERR Intervention should yield outcomes listed in the bottom box of the diagram.

The SAFERR Program Model

SAFERR PRINCIPLES

- The problems of substance abuse and child maltreatment demand urgent attention and the highest possible standards of practice from everyone working in systems charged with promoting child safety and family well-being.
- Success is attainable and feasible. Staff in child welfare, substance abuse and court systems have the desire and potential to change individual lives and create responsible public policies.
- Family members are active partners and participants in addressing these urgent problems.

SAFERR INTERVENTION

Builds Collaborative Structures	Establishes Individual and Cross-System Roles and Responsibilities	Identifies Frontline Collaborative Practices
An Oversight Committee **A Steering Committee** **Subcommittees** **Mission and Principles** **Shared Understanding and Language about Processes** **Goals, Timetables & Products** **Training Curricula & Strategy** **Baseline Data** **Progress Reports** **Outcome Data**	**Child Welfare System Understands—** - the basics of substance use and how use affects child development; - how to screen for substance use - the local treatment system and how to help families remain in treatment; and - the implications of tensions between substance use recovery and ASFA rules. **Alcohol & Drug System Understands—** - how substance use puts children at risk and how child welfare must respond; - child maltreatment reporting requirements; and - how to screen for child safety. **Court System Understands—** - the basics of substance use and child development; - its role in requiring substance use and child development assessments; and - its authority to prompt or require collaboration. **Collaboratively, All Three Systems—** - establish joint policies and procedures for sharing information; - establish case plans; - develop shared indicators of progress; and - monitor progress and evaluate outcomes.	**Child welfare, alcohol and drug, and court systems have collaborative policies, protocols and tools to:** - screen for substance use and child maltreatment; - assess for substance use and child maltreatment; - communicate across systems; - develop & implement collaborative case plans; and - monitor progress and evaluate results.

EXPECTED OUTCOMES

- Substance use disorders among families reported for child maltreatment will be identified more accurately and at earlier points in time.
- Potential child maltreatment among families assessed for or entering substance abuse treatment will be identified more accurately and at earlier points in time.
- Child welfare, alcohol and drug and court systems will communicate effectively in screening and assessing families for substance use disorders or child maltreatment.
- Child welfare, alcohol and drug and court systems will communicate effectively and collaborate in monitoring family progress in services.
- Staff will make informed, timely, and shared decisions regarding reunification, aftercare or continuing services, and filing of petitions for termination of parental rights.
- Families will enter and remain in alcohol and drug and child welfare services at higher rates.
- Work processes will be streamlined, resulting in reduced duplication and removal of inconsistent rules that create excessive burden in meeting case plan requirements.
- Families will enter and remain in treatment and other services at higher rates.
- Risks of child maltreatment will be reduced.
- Family stability, reunification, and well being will be increased.

The Layout of the SAFERR Guidebook

This guidebook is organized into 3 sections and 10 appendixes:

Section I: Building Cross-System Collaboration. This section describes ways in which collaborative groups differ from other kinds of work groups, creates a framework for selecting and guiding a Steering Committee, and offers ideas about how to establish the group's mission and mandate.   It also describes two essential elements of successful collaboration: understanding each other's systems and communicating across systems.

Section II. Collaboration Within and Across Systems. This section first lays out elements that people in each system should know about their own system and about the other two systems—things they can do internally in preparation for working with other agencies.   It then presents elements that require communication with the other two systems. It concludes with suggestions regarding how the Steering Committee should guide both the "within system" and the "cross-system" discussions.

Section III. Collaboration in Action: Working Together on the Frontline. This section presents activities that compose the daily work of substance abuse counselors and child welfare workers and offers guidance on how they can collaborate in these tasks. Activities include screening for substance abuse disorders and for child maltreatment, conducting initial and ongoing assessments, and developing techniques for engaging families and monitoring their progress. It concludes with suggestions regarding how the Steering Committee should guide these frontline practice changes.

These sections are followed by a series of appendixes that provide more detailed information, tools, and fact sheets to help program managers implement the SAFERR model.

Appendix A: Facilitator's Guide. This appendix presents managers with templates and techniques for creating and sustaining a Steering Committee or other multidisciplinary group.
It includes samples of Action Plans, instruments to help Steering Committee members assess their values and their capacity to collaborate, and other forms to make it easier for the Steering Committee to accomplish its goals. This appendix is a companion to Section I of the guidebook.

Appendix B: Fact Sheets. This appendix provides a series of fact sheets on topics such as the number of people involved with child welfare, substance abuse, and the court systems, the number of children born prenatally exposed to substances, and research findings on the extent of substance abuse problems in child welfare. These fact sheets may be useful in educating legislators and policymakers or heightening awareness among frontline staff. They are intended to complement and not replace more indepth training activities that should take place.

Appendix C: Understanding the Needs of Children in Families Involved in the Child Welfare System Who Are Affected by Substance Use Disorders. This appendix provides information about prenatal and postnatal substance exposure and the consequences of exposure on children, issues related to substance use among youth, and a description of resources for children who have been identified as affected by parental substance use disorders.

Appendix D: Examples of Screening and Assessment Tools for Substance Use Disorders. This appendix presents a sample of commonly used screening tools for substance use disorders and discusses the pros and cons of each tool for use by child welfare staff. Child welfare and substance abuse staff should jointly select the tools that best meet their needs.

Appendix E: Substance Use, Abuse, Dependence Continuum, and Principles of Effective Treatment. This appendix presents Federal principles of effective treatment for substance use disorders and a description of the continuum of substance use, abuse, and dependence. This appendix is a companion to Sections II and III of the guidebook.

Appendix F: Examples of Safety and Risk Assessments for Use by Child Welfare Staff. This appendix provides an annotated list of commonly used risk and assessment tools, including practice-based tools and the Strategic Decisionmaking tool. The purpose of these examples is to provide general information to substance abuse counselors regarding the issues addressed in child welfare safety and risk assessments.

Appendix G: Sharing Confidential Information. This appendix describes Federal rules regarding acceptable means for sharing confidential information. It includes information that can be incorporated into consent forms for use by multiple agencies and links to Federal resources for sharing information in ways that comply with HIPAA and other confidentiality regulations.

Appendix H: Glossary of Terms. This appendix provides short definitions of terms commonly used by child welfare, substance abuse services, and court staff.

Appendix I: A Guide to Compliance With the Indian Child Welfare Act. This appendix provides a short description of key provisions of the Indian Child Welfare Act, including when it applies, State/tribe jurisdictions, burden of proof requirements in removing children, and removals of children in emergency situations.

Appendix J: Acknowledgment of Contributors and Reviewers.

SECTION I: BUILDING CROSS-SYSTEM COLLABORATION

The Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR) model and this guidebook are based on principles holding that (1) the problems of child maltreatment and substance use disorders demand urgent attention and the highest possible standards of practice from everyone working in systems charged with promoting child safety and family well-being; (2) success is possible and feasible; and (3) family members are active partners and participants in addressing these urgent problems.

> Although many parents with substance use disorders are involved with a variety of social service systems, SAFERR is focused on three key systems that have particular responsibility for and influence over how families fare: the child welfare service system, the alcohol and drug service system, and the court system.

No system or set of workers has the authority, capacity, or skills to respond to the array of challenges faced by these families, but collectively they do have those capacities and skills. When leaders have common vision, create joint policies, and require collaborative frontline practices, they create work environments and expectations that encourage staff to work with colleagues from other systems in making decisions that affect family stability and recovery.

Collaboration among child welfare, alcohol and drug, and court systems is necessary if families are to succeed, but effective collaboration at all levels of each system is very hard to accomplish. The barriers to building successful collaborations between the alcohol and drug and the child welfare systems are well known and have been described in several publications (Children and Family Futures, 1999). Adding the court system to the mix complicates the challenges.

This section of the guidebook provides managers with information about ways to create, guide, and sustain a State or countywide initiative aimed at improving services to families who are involved with child welfare and affected by substance use disorders. The "Facilitator's Guide"
(see Appendix A) provides exercises and tools to assist States and communities in their efforts to implement a cross-systems initiative. It proposes that administrators create a Steering Committee to direct the initiative, and it describes specific functions of the Steering Committee. Subsequent sections of the guidebook describe the activities that must take place within and across systems in order for staff to collaborate effectively on behalf of families.

1.1   Developing a Collaborative Team

> A SAFERR collaborative involves—
> An Oversight Committee
> A Steering Committee
> Subcommittees

The decision to collaborate on behalf of families involved with substance use disorders, child maltreatment, and the courts has to come from top officials who give priority to this work. If leaders are not committed, little will be sustained. Leaders are the only ones who can free up staff time and invest staff with authority to make decisions on behalf of the agency. Appendix B, "Fact Sheets," includes

several fact sheets that describe the challenges facing each system and the extent to which families need services from them. This information should help administrators understand how their own successes are intertwined with the successes of other agencies. It should also help managers and others educate administrators about the numbers and types of families that are involved with several systems. The following subsections present a structure for States and counties to use to govern a multidisciplinary initiative.

The Oversight Committee

The top child welfare, alcohol and drug services, and court officials (and, if appropriate, members from the governor's or county commissioner's office) serve as the Oversight Committee for the initiative. Officials on the Oversight Committee must direct senior managers in their systems to give this initiative priority, and they must ask for periodic progress reports. In addition, these officials have to be willing to change their own agencies' policies when those policies impede the ability of staff to serve families.

Because the Oversight Committee includes the most senior officials from each system, all of whom are likely to be facing many demands and pressures for their time, it is anticipated that this committee will meet as a group only three or four times each year. It is also expected that each member will receive regular updates from Steering Committee members between meetings.

The Steering Committee

After top administrators form the Oversight Committee, they can take a significant first step by establishing a senior-level multidisciplinary Steering Committee charged with creating, directing, and evaluating the activities required to translate shared commitment at the top to shared screening, assessment, engagement, and retention policies and practices in the field.

Running a multidisciplinary Steering Committee requires skills that differ from those required to direct single-agency hierarchical workgroups. It is helpful if the Steering Committee is cochaired by senior managers from the child welfare service, alcohol and drug service, and court systems who will share responsibility for ensuring that the Committee functions effectively. If this approach is infeasible or unwieldy, consideration should be given to rotating the chair of the Steering Committee among the three systems.

This Steering Committee will include members who do not have jurisdiction over each other, who report through separate hierarchies, and who most likely have different (nonparallel) positions within their respective agencies. Decisionmaking by decree or majority rule will not work in these situations. Some jurisdictions hire outside facilitators to convene and staff their Steering Committees. These facilitators are generally not considered to be chairs of the Committee and they are not authorized to make decisions that Committee members should make. If funds are available, using facilitators is a good strategy to avoid the perception that the initiative is being "run" by one agency. In addition, facilitators are trained in guiding multidisciplinary groups to make decisions.

The Steering Committee should focus on the big picture of State policies, protocols, monitoring and evaluation, and include the representatives of the following, at a minimum:

- Administrators and mid-level managers from State and some county child welfare agencies;

- Administrators from the State alcohol and drug service agency and directors of some substance abuse treatment provider agencies;

- Judicial officers and attorneys for parents, children, and the social service agency;

- Representatives from a recognized Native American Tribe that provides child welfare services in the State; and

- Representatives of the families served by these systems, including individuals who received or are receiving services from the child welfare or alcohol and drug systems.

There are three minimum requirements for establishing an effective Steering Committee:

- **Members must have authority to make decisions on behalf of their agencies.** The Steering Committee should be able to reach conclusions and take actions without losing time and momentum while members return to their agencies for approval.

- **Members must have sufficient time to participate in meetings.** The committee members must have time to attend meetings and to work on both collaboration building and the substantive issues involved in creating screening, assessment, retention, and engagement strategies. Attending meetings and completing related work between the meetings must be considered part of the members' work assignments.

- **An administrative staff person should be assigned to coordinate committee activities.** The staff person should arrange logistics for the meetings, issue agendas, send reminder notices, track Committee milestones and deadlines, take minutes, and reproduce and disseminate meeting materials as necessary. Although freeing up or funding a dedicated staff person represents an investment from one of the agencies, this level of administrative support is a critical component in supporting the work of the Steering Committee and, ultimately, in building a successful collaborative team. Ideally, this investment would be shared among participating agencies if resources permit joint funding of this position.

It is possible that Steering Committee members have had frustrating experiences with multidisciplinary groups who they felt did not yield meaningful results. Leaders, however, do respond well to groups when their time is respected, the discussions are engaging and being held at the appropriate policy level, multiple perspectives are sought, and decisions are made. Whether convening the Steering Committee is the responsibility of an outside facilitator or an employee of a particular agency, that person gains credibility by achieving consensus among Committee members, focusing on specific tasks leading to outcomes that Committee members feel are important, airing and resolving tensions professionally, and creating a sense of energy and excitement among the members. As noted earlier, multidisciplinary groups differ from traditional single-agency groups in important ways. Steering Committee members—

- Report to a multidisciplinary Oversight Committee and not solely to supervisors within their own agency;
- Are authorized to make decisions and commitments on behalf of their agency; and
- Cannot make decisions on their own, independent of the Steering Committee as a whole.

What the facilitators or chairs lack in formal authority over members can be achieved by creating high standards for meeting logistics and discussions. Therefore, attention must be paid to the way Steering Committee meetings are arranged and conducted or members are likely to either stop attending or send substitutes who lack authority to make decisions.

Techniques for facilitators are as follows:

- Facilitators and committee chairs may not be able to set priorities for members who work for other agencies and systems, which makes scheduling meetings difficult and frustrating. Therefore, it is important to **establish and send out a schedule of meetings for 12 months**. Members should know that meetings will not be cancelled or rescheduled, and that they will start and end on time. People tend to adjust their attendance to the expectations of the group, and setting meeting schedules for several months ahead makes it harder for other priorities to "bump" these meetings.

- Facilitators should **tell members in advance about issues that require decisions** at the next meeting, giving them time to consult with supervisors or review background information that will prepare them to make a decision or commitment on behalf of their agency. Therefore, they should receive annotated agendas in advance of each meeting. Annotations can indicate whether each agenda item involves a decision, whether background reading is suggested, who is leading the discussion, and what length of time is allocated for that item. Summaries of the prior meeting should be attached to the agenda.

- Facilitators should **help Steering Committee members approach their work believing that they are all responsible to the Oversight Committee** and not solely to supervisors within their own agency. Therefore, if decisions are to be made at a meeting, the agenda should indicate that decisions will not be deferred because a member is absent or an agency is not represented by a member who has authority to make decisions.

- Chairs and facilitators have to **strike a balance between encouraging open *dialogue* and allowing healthy debate of sensitive and controversial issues on one hand, and avoiding monopolizing monologues or pointless and repetitive arguments on the other**. This balance may be more difficult when people engaging in these debates have limited understanding of each other's systems and when they may have unequal positions within their systems. If the duration of the meeting is appropriate and each agenda item includes a reasonable amount of time for both presentation and discussion, frequently the group will monitor itself in striking a good balance.

- If an issue cannot be resolved during the meeting or does not warrant participation of the entire group, the facilitator can **create alternative mechanisms**, such as referring the issue to a Subcommittee or creating an ad hoc workgroup.

Appendix B, "Facilitator's Guide," includes sample tools and templates to help facilitators create effective Steering Committees.

The Subcommittees

Steering Committees of the type proposed in this guidebook will oversee a wide range of tasks and activities related to improving the way their State or jurisdiction screens, assesses, engages, and retains families in services. In order for the Steering Committee to retain its focus both on large policy issues facing the three systems and on the real-world practices that need to be changed and monitored, the Steering Committee structure should include appropriate Subcommittees composed of county or local frontline and supervisory staff from all three systems.

Subcommittees provide a structure within which the Steering Committee can provide and receive feedback about current and proposed policies and protocols. They should be charged with identifying,

researching, and raising concerns to the Steering Committee for discussion and decision. They create a forum in which county and local staff can raise concerns to policymakers and identify pressures that make it difficult to collaborate. They also serve as pilot sites and guide the work of pilot sites for testing new training curricula, screening or assessment tools, or multidisciplinary teams.

Ideally, each Subcommittee should be chaired by a member of the Steering Committee, who should provide Subcommittee progress reports at each Steering Committee meeting. This structure ensures that the ties between the Subcommittees and the Steering Committee are clear and subcommittee chairs serve as conduits between the ongoing work of their Subcommittees and the oversight and decisionmaking work of the Steering Committee.

Subcommittees might be charged with researching and recommending screening or assessment instruments that should be used by all systems, reviewing existing training curricula and recommending changes, identifying shortcomings in current local office practice for attention by the Steering Committee, or pilot testing models of collaboration (some of which are described in Section II of this guidebook).

The remainder of this guidebook focuses only on that part of the Steering Committee scope of work concerned with screening and assessments and only on the Subcommittees established to address issues related to screening and assessments. It is understood, however, that screening and assessment are just two parts of a larger and related agenda that is of concern to States and to the Steering Committees.

Section III of this guidebook describes frontline collaborative activities and protocols that might be guided by the Steering Committee or Subcommittees.

1.2   Establishing the Steering Committee's Charge and Approach

The Oversight Committee that establishes the Steering Committee should specify what it expects from the Steering Committee and by when. It is essential that the Steering Committee members understand and agree upon the purpose, objectives, and parameters of their work. When participants are not clear about the purpose of a Steering Committee, they tend to use meetings to address any of several general or unrelated issues that exist among their agencies. When this misuse of meeting time happens, the focus becomes diluted, decisions are not made, and everyone becomes frustrated.

> The primary activities of the Steering Committee are to—
> - Create a mission statement based on exploration of values and principles;
> - Enhance understanding of current systems and the barriers to communication across systems;
> - Establish a common set of baseline information data to be used to establish goals and monitor progress;
> - Establish goals, timetables, and milestone products and implement a plan of action to achieve the goals and milestone products;
> - Identify training curricula and strategies that promote increased knowledge and collaboration; and
> - Monitor progress and evaluate outcomes.

Create a Mission Statement Based on Exploration of Values and Principles

Although there are structural and philosophical differences among the alcohol and drug, child welfare, and court systems that tend to highlight their differences, in reality staff from these systems hold several important core values in common. It is important for Steering Committee members to identify and make explicit the shared values and principles, and to use those values as building blocks for a mission statement. The recognition and explicit statement of common principles create the foundation on which a collaborative can be built.

For example, people from all three systems generally hold the following principles:

- Services should be tailored to the specific needs of the individual or family;
- Services should be provided in a timely manner; and
- Services should be provided in a manner that is appropriate for the gender and culture of the individual or the family.

At the same time, both individuals and systems have areas of difference, and those areas should be brought to the surface and discussed. The goal in these situations should be to enhance understanding and respect for values rather than to force agreement in areas where people simply do not agree. Areas of disagreement that are not put "on the table" and aired out seriously undermine the ability of the team to do its work.

The Steering Committee, Subcommittees, and other groups should start their work by surfacing values shared by the child welfare, alcohol and drug, and court systems. The following "Examples of Shared Principles" presents principles used in collaborative initiatives in California, Ohio, and New York. Appendix B provides a protocol to use in developing shared principles and values and other examples of principles and collaborative mission statements.

Examples of Shared Principles

1. All children deserve to live in safety.
2. Effectively addressing alcohol and drug abuse and related problems among families involved in the child welfare and court systems would contribute to better results for children and their families.
3. Substance use disorders must be addressed in the context of other issues affecting children and parents, including parenting, domestic violence, health, mental health, criminal justice involvement, nutrition, housing, family services, education, and employment.
4. No one agency has the resources and expertise to respond adequately to the needs of parents who are addicted and who have abused or neglected their children, but collectively, it is likely that they do have these capacities.
5. Early and effective intervention for substance use disorders and related problems among families involved in child welfare systems contribute to better outcomes related to safety, child and family well-being, and permanency.
6. Most families involved with the alcohol and drug and child welfare systems can reduce risk in their lives and achieve self-sufficiency, particularly when they have access to a full continuum of prevention and treatment services tailored to their needs.
7. Interventions and decisionmaking for families involved in the alcohol and drug and child welfare systems should be based on a thorough, strength-based, and holistic approach to assessment, which includes addressing the impact of substance use disorders on child safety, child development, parental competency, and self-sufficiency.
8. Empowered families are capable of defining their needs, identifying their strengths, and actively participating in the development of case plans.
9. Removal of children from families with substance use disorders should occur only when there are no other options to ensure their safety.
10. Parents must be held accountable for maintaining expectations of compliance with case plans and court orders while, at the same time, be treated with dignity, understanding, and fairness.
11. Although sobriety is an appropriate goal for parents, caregivers, or siblings who have substance use disorders, recovery is a lifelong process and may include an occasional relapse. Other measures of success must also be acknowledged and valued.
12. Parents and children best respond to services that are family focused, responsive to their strengths and needs, culture, ethnic, and gender identities.
13. Staff that serve families involved with child welfare and alcohol and drugs should feel secure that they have the knowledge, skills, tools, empathy, and resources to do their jobs well.
14. Human service and legal professionals have a responsibility to strengthen families' natural and informal networks within their own communities and to reduce reliance on professional systems.
15. Service providers, families, and other helping networks should respect each other to collaborate effectively. They can show respect by taking time to understand each other.
16. Services can benefit families only to the extent that there is a structure in place within which the coordination of those services can take place.

Enhance Understanding of Current Systems and the Barriers to Communication

Too often, people from one system have little knowledge or understanding of the mandates, responsibilities, and priorities that guide the operations of systems with which they have to collaborate. In order to meet the needs of families in which both substance use disorders and child maltreatment occur, staff from the alcohol and drug, child welfare, and court systems have to learn about each others' roles, responsibilities, nomenclature, values, and practices. The Steering Committee can advance this knowledge and understanding by educating its own members about these systems and by creating joint policies and protocols for assuring that knowledge is systematically transmitted across all three systems.

The table on the following pages, **Terms and Processes in the Alcohol and Drug Service, Child Welfare Service, and Dependency Court Systems**, explains the terms and describes the activities undertaken by the alcohol and drug, child welfare, and court systems through the time each system is involved with a family. This time starts with the initial report of substance use or child maltreatment (*"Is there an issue?"*) through eventual disposition and continuing care if needed (*"What happens after discharge or case closure?"*). While the terms for these activities and the processes that guide them are likely to differ across and even within States, all jurisdictions are involved with all the activities described here.

The Steering Committee should ask a Subcommittee to "translate" the terms and process outlined in the chart into their local language so that all staff can develop a common language and base of understanding to guide them in responding to situations that inevitably arise when multiple people are serving the same family. The Subcommittee should develop a unified glossary of terms and process that would be used by all systems in discussing case activities, or it could use this table as a template to create a table specific to their jurisdiction that could be used as the framework for all systems. The Steering Committee can use the outcome of that assignment to inform its own members about all of the systems and to identify areas of confusion or disagreement that need to be resolved.

Once the Subcommittee and the Steering Committee have created a shared base of understanding and knowledge about each other's systems and have identified activities in which there is confusion or disagreement, they can begin to create or modify training curricula for use with front line supervisors and staff. If the Steering Committee endorses a unified glossary or template that describes the activities of each system at various points in time, it becomes easier to develop cross-system training curricula and training approaches. Resources for cross-system training are available free of charge through online courses developed by the NCSACW at *www.ncsacw.samhsa.gov*.

SAFERR Terms and Processes in the Alcohol and Drug Service, Child Welfare Service, and Dependency Court Systems

Identification through community or family awareness of signs, symptoms, and behaviors						
	Alcohol and Drug Service System		**Child Welfare Service System**		**Dependency Court System**	
Is there an issue?	*Screen*	Use of brief screening questions	*Child Abuse Report*	Brief questions posed to determine whether a report of abuse or neglect will be accepted for in-person response		The court may not be involved; if there is a prior history of court involvement by a family, it is important for both alcohol and drug services (ADS) and child welfare services (CWS) to inquire.
What is the immediacy of the issue?	*Immediate Need Triage*	Clinical determination of imminent risk	*In-Person Safety Assessment*	Use of a formal tool to determine imminent harm to a child, whether the child will be removed from or remain in the home	*Preliminary Protective Hearing*	The court may not necessarily be involved; Some jurisdictions require a CWS worker to seek judicial approval for emergency removal of a child—a removal hearing is also referred to as a shelter care hearing, a temporary custody hearing, and a protective custody hearing. (see Glossary).
What is the nature of the issue?	*Diagnosis*	Use of standardized questions in an interview to differentiate between substance use, abuse or dependence	*In-Person Response/ Risk Assessment*	Use of an interview protocol and risk assessment tools to determine level of risk to a child and whether services will be voluntary or court involved	*Court Findings*	If a Preliminary Protective Hearing is held, the court will issue key written findings as mandated by ASFA and State statute
	Alcohol and Drug Service System		**Child Welfare Service System**		**Dependency Court System**	
What is the extent of the issue?	*Multi-Dimensional Assessment*	Use of a standardized set of questions by a staff member trained in substance abuse issues, including functioning, needs, and strengths leading to a determination of the level of care required and needed services	*Family Assessment*	Family assessment of strengths and needs to determine the areas of family functioning requiring interventions for children to be safe in a permanent living situation that contributes to their well-being	*Petition Filed; Preliminary Protective Hearing (court process could begin here as well).*	A petition may be filed—it may or may not include allegations related to substance use or dependence; the court, attorneys, child welfare workers, CASAs, and other treatment providers also become involved; the court must establish jurisdiction; and adjudication and dispositional hearings then take place—these can be held on the same day
What is the response?	*Treatment Plan*	Individualized treatment plan with measurable objectives and outcomes	*Case Plan*	Individualized treatment plan with measurable objectives and outcomes	*Adjudication and Dispositional Hearing; Court-Ordered Case Plan*	Court orders include federally mandated findings regarding court review; the case plan and the treatment plan may be incorporated into the court order to varying degrees of specificity; various court orders may be used to ensure parental compliance with services and to facilitate parent's visitation at placement facilities; and court oversight monitors provision of services by CWS and ADS.

	Alcohol and Drug Service System		Child Welfare Service System		Dependency Court System	
Are there demonstrable changes?	*Treatment Monitoring*	Conducting oversight and tracking of participants' progress in treatment and recovery	*Case Plan Monitoring*	Regularly reviewing of the family case plan and reports to the court (when applicable) on parents' progress and children's well-being when applicable	*Court Review Hearings*	ASFA requires that periodic review occurs within six months of foster care entry—reviews include receipt of written and oral reports from all stakeholders on the progress of parents and well-being of children; consideration of permanency needs of children at each hearing by the court, other stakeholders (e.g., CASA, attorneys, and community members)
Is the family ready for transition?	*Transition Planning*	Assessment of on-going recovery plan, support systems and other needed services	*Permanency Determination*	Assessment of the most appropriate form of permanency for the child	*Permanency Hearing*	A Permanency Hearing is required within 12 months of entering foster care to determine whether a child should be returned home, file for TPR, freed for adoption, custody transferred to another individual or couple, or long-term foster care
	Alcohol and Drug Service System		Child Welfare Service System		Dependency Court System	
What happens after discharge or case closure?	*Recovery Management*	Ongoing self-assessment, and periodic professional, assessment, as needed	*Family Well being*	Ongoing self-assessment of enhanced capacity to care for children	*Case Closed*	In traditional courts, although the court case may be closed, parents and children may work with treatment providers in an aftercare program or with CWS for services; in a Drug Court program, the court may review parent's progress in aftercare 6 months after case is closed (e.g., Washington, DC, Reno, and Charlotte, NC Model Courts' Dependency Drug Courts)
Did the interventions work?	*Outcome Monitoring*	Data-driven outcome monitoring of changes in life functioning and substance use-related consequences	*Outcome Monitoring*	Data-driven outcome monitoring of recurrence of maltreatment and reentry into child welfare system	*Outcome Monitoring*	Recidivism—reabuse of child, refiling of petition, or sibling entry

Establish a Common Set of Baseline Information Data

If the Steering Committee has been able to develop its principles and reach consensus on terms and processes, members should create a set of baseline data agreed upon by all members. Baseline data include the following information:

- For the child welfare service system:
  - Number of child maltreatment reports and substantiated reports;
  - Number of children in foster care;
  - Number of families receiving preventive services;
  - Length of time families are involved by child welfare; and
  - Kinds of services most frequently used.

- For the alcohol and drug service system:
  - Number of people admitted to alcohol and drug treatment;
  - Number of people admitted who have minor children;
  - Number of children born prenatally exposed to substances;
  - Number of parents in treatment who have had children removed by child welfare; and
  - Kinds of treatment most frequently used.

- For the court system:
  - Number of dependency cases filed;
  - Number of children who are court involved because of placement in foster care;
  - Number of children who are court involved but not removed from home; and
  - Number of dependency cases involving families with substance use disorders.

Efforts should also be made to determine the number of families who are involved with more than one or all three of these systems. This information is often partly or completely lacking, so it can help Steering Committee members determine some first steps in their future work or information system gaps and needs.

Establish Goals, Timetables, and Milestone Products, and Implement a Plan of Action

After the Steering Committee has gathered baseline data, it should establish goals and then timetables and interim milestone products to achieve those goals. Goals, timetables, and milestone products should be incorporated into a plan of action that serves as a blueprint for Steering Committee priorities and as a framework for monitoring progress and evaluating outcomes. Each goal is likely to include multiple milestone products that can be monitored and whose results can be evaluated by the Steering Committee. The following text box provides an example of one goal and several practical milestone products that might be developed and overseen by the Steering Committee.

> **Goal: Develop statewide guidelines for alcohol and drug providers to ask questions about children.**
>
> **Milestone Products:**
>
> Report of research of guidelines used by other jurisdictions
> Draft of guidelines prepared by Subcommittee for Steering Committee
> Steering Committee approval/issuance of final guidelines
> Training curricula for guidelines

Identify Training Curricula and Strategies for Increased Knowledge and Collaboration

As Steering Committee and Subcommittee members explore their values and learn more about each other's systems, it is almost certain that staff development and training needs will emerge as a priority. Staff from each system are likely to need training about the operations, philosophies, techniques, mandates, and limitations of the other systems. They will also need training and support in learning how to work with colleagues from those systems, including how to share confidential information, develop coordinated or uniform case and treatment plans, share decisionmaking, and work as members of multidisciplinary teams.

The Steering Committee can guide the development of appropriate approaches to training and professional development by—

- Assigning a Subcommittee to compile an inventory of current training curricula used by all three systems; examine the content of curricula to determine areas where there is duplication or inconsistency and identify those curricula that appear most effective; and recommend training strategies to the Steering Committee;

- Identifying training resources within and outside of the State. For example, resources for cross system training are available free of charge through online courses developed by the NCSACW at *www.ncsacw.samhsa.gov*;

- Establishing policies that promote the creation of cross-system training curricula and that allocate resources for staff from all systems to collaborate in creating, delivering, and evaluating training; and

- Overseeing and analyzing feedback from pilot tests of new training approaches implemented in selected counties and localities under guidance from the Subcommittee.

Section II provides more specific information regarding training topics. In addition, an annotated guide to training resources can be ordered through a link to *www.ncsacw.samhsa.gov*. The guide is called "The Child Welfare-Substance Abuse Connection: A Compendium of Training Curricula and Resources." It includes (1) curricula for training child welfare personnel about substance use disorders and about the system that serves people with substance use disorders; (2) curricula for training alcohol and drug personnel about child maltreatment, about the child welfare and court systems, and on the implications of substance use disorders for child maltreatment; (3) curricula designed to cross-train child welfare, alcohol and drug, and court staff (and other relevant professionals) about how to work collaboratively and how to address the barriers to collaboration. It is important to note, however, that existing training curricula must be adapted to meet the needs of communities and the operations of systems within those communities.

Monitor Progress and Evaluate Outcomes

One of the most critical activities for the Steering Committee (and one likely to be of high interest to the Oversight Committee) is to measure the families' progress in recovering from substance use disorders and in attaining appropriate parenting capacities. Indicators and benchmarks should be based on specifications included in case plans and may include changes in patterns of substance use (e.g., periods of sobriety, nature and frequency of lapses or relapses, negative drug test results, participation in treatment activities); engagement in parenting, mental health, employment, or other services included in the child welfare case plan; consistency in child visitation; changes in risk factors to children, and others.

Steering Committee members should create and publicize standards they will use to determine whether collaborative strategies result in improved screening, assessment, engagement, and retention of families in treatment and other services and should monitor those standards against the baseline they created. These standards should include establishing mechanisms to determine how many screenings and assessments have been conducted, how many families have entered services, and when families have dropped out of services. State and local jurisdictions should be monitored against those standards, and corrective action taken when performance is below the established standards.

Section III of this guidebook, "Collaborative Practice at the Frontline," provides more information about alcohol and drug and child welfare case plans.

SECTION II: COLLABORATIVE ROLES AND RESPONSIBILITIES

Section I of this guidebook establishes the importance of collaboration and presents a structure within which collaboration among child welfare, alcohol and drug, and court systems can take place. It is beyond the scope of this guidebook to address other systems such as mental health and welfare that serve the same families, but SAFERR's premises and processes should also be useful in collaborating with those systems.

The current section identifies and discusses individual and shared responsibilities of people working in the child welfare, alcohol and drug, and court systems. It begins with a summary of essential roles within each system and concludes with a description of cross-system roles.

2.1   Responsibilities of the Child Welfare Service System

Child welfare officials have a responsibility to ensure that their employees and employees of contract agencies have adequate and accurate knowledge about the alcohol and drug service and the court systems. Specific responsibilities along these lines include:

- **Ensuring that personnel with decisionmaking roles involving families understand the fundamentals of substance use disorders, the implications of those disorders on child safety and well-being, and the potential for effective treatment.**

Although there is general consensus among child welfare staff that substance use can contribute to child maltreatment, many do not understand substance use, treatment and recovery, and how use and recovery are related to child safety and well-being. These relationships are often complex. Although a substance use disorder can have a causative relationship to child maltreatment, it also is possible that the underlying causes of child maltreatment are not related to substance use disorders. In the latter situations, treating parental substance use disorders may not resolve child maltreatment problems. In other situations, especially when maltreatment involves child neglect rather than abuse, successfully treating parental substance use disorders is more likely to resolve the parent's neglectful behavior.

It should be required that child welfare training curricula include attention to fundamentals of substance use disorders, treatment engagement, treatment services, recovery, and the impact of disorders, treatment, and recovery on child safety and well-being. Appendix A provides fact sheets that address the impact of parental substance use disorders on children's development and well-being.

At a minimum, child welfare staff should understand—

- How and why people develop substance use disorders;
- Types of substance use disorders;
- How addiction affects a person's ability to function (particularly as a parent);
- How people are screened and assessed for substance use disorders;
- Types of treatment available to families;
- The role of relapse in the recovery process; and
- How treatment improves family stability, employment, and other outcomes.

Child welfare staff also require training to give them the skills to screen families for potential substance use disorders, including skills needed to interact with families in ways that encourage them to disclose and address their substance use disorders. Training may be enhanced if child welfare staff visit a substance abuse treatment program and hear stories of families who have recovered from addiction, including parents involved with the child welfare system.

Finally, child welfare workers need opportunities that allow them to explore their attitudes and values about addiction. Few people in our society are immune from the effects of substance use disorders, and staff experiences with these disorders affect how they address those disorders with families. Therefore, staff need training that helps them recognize how their personal beliefs and attitudes may affect how they relate to families.

Resources and training curricula are available to assist the Steering Committee in creating training standards and expectations and to assist local jurisdictions in delivering training to staff. For example, *Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers* can be used to train child welfare workers in (1) recognizing the relationship between substance use disorders and child welfare; (2) understanding addiction and how to support families during the treatment and recovery process; (3) enhancing collaboration with substance abuse treatment partners; and, (4) improving outcomes for children of parents with substance use disorders. This guide is available online at *www.ncsacw.samhsa.gov*.

- **Ensuring that children from families with substance use disorders receive developmentally appropriate services that address the effects of substance use disorders on their lives.**

Children whose parents have substance use disorders and who come in contact with the child welfare system often lack the environment, support, and structure required to move through childhood in appropriate developmental stages. Child welfare staff should ensure that these children are assessed to determine whether they are functioning at the stage of development appropriate for their chronological age. Knowing the developmental skills that are expected for each chronological age will help staff determine whether or not children are exhibiting deficits or delays and should be referred for further assessment or intervention. Attending to developmental stages is important because behavior that is appropriate at one stage may be considered maladaptive at another developmental stage. Good resources that succinctly present characteristics of children across developmental stages are available online and can be found at *www.childdevelopmentinfo.com/development/normaldevelopment.shtml*.

After children are assessed, child welfare staff should assure that they receive developmentally appropriate services that allow them to grow and mature, and they should share information about children with alcohol and drug treatment staff working with parents. Appendix C provides information about prenatal and postnatal substance exposure and the consequences of exposure to both, issues related to substance use among youth, and a description of resources for children who have been identified as affected by parental substance use disorders.

- **Ensuring that there are protocols for screening family members for possible substance use disorders, and that results of screens are entered into case files and shared with alcohol and drug and court staff, if relevant.**

Many, if not most, children under the jurisdiction of child welfare agencies and the courts come from families with substance use disorders. The *SAFERR model* therefore holds that child welfare staff should screen for substance use disorders as a routine procedure. Screening for substance use disorders

determines the likelihood that a problem exists (or, the presence of a problem) and is most often conducted in places outside of the alcohol and drug service system: places such as criminal justice agencies, mental health agencies, maternal and child health care providers, hospitals, or child welfare agencies.

There are many screening tools for substance use disorders. Because child welfare workers often have large and complex caseloads, screening tools should be brief, easy to learn, and able to be administered as part of an interview or imbedded in a standard questionnaire. At the same time, screening tools should be sufficient to achieve a reasonable balance between sensitivity (ability to detect problems when they do exist) and specificity (ability to rule out problems when they do not exist). Decisions regarding which tool to use must be made in conjunction with and supported by the alcohol and drug treatment system and others who conduct screenings for substance use disorders. A Subcommittee of the Steering Committee, comprising representatives from relevant systems, can be charged with recommending screening tools. Because the results of screenings conducted by child welfare staff become the baseline used by alcohol and drug services staff, information derived from screenings should meet the needs of staff and should be consistent with information provided by other systems.

Section III of this guidebook presents detailed information about substance abuse screening and assessment tools and strategies, and Appendix D, "Alcohol and Other Drug (AOD) Preliminary Assessment," provides information about several screening tools that include only six to eight questions and are sufficient to meet the needs of child welfare staff. Regardless of which tool is selected, however, as noted in the Introduction, the premise of SAFERR is that collaboration and communication—not the too—will ultimately make the difference in whether staff can meet the needs of children and families.

Screenings may be able to detect whether substance use disorders are a factor in the overall family situation, but they do not provide information on which to make decisions about the nature and extent of substance use disorders. These decisions require complete information derived from indepth assessments conducted by trained and qualified personnel.

Activities regarding screenings for substance use disorders and referrals for assessments should be documented in child welfare case records and made available for monitoring purposes, reviews for court hearings if appropriate, and use by alcohol and drug services staff if requested. These records are particularly important given the frequent turnover of staff in many local child welfare agencies.

Although it is generally not feasible for alcohol and drug treatment staff to screen all families involved with child welfare, some jurisdictions have co-located substance abuse counselors at child welfare offices to help in specific situations, provide consultation, and conduct comprehensive substance abuse assessments. Colocation is described more thoroughly at the end of this section, and exploring colocation may be a task charged to either the Steering Committee or one of its Subcommittees.

- **Ensuring that families have the opportunity to be successful in treatment by—**

  - Understanding treatment plan requirements, schedules, and activities;
  - Communicating with alcohol and drug treatment staff to coordinate schedules so that families do not have conflicting demands that force them to choose between meeting their child welfare case plan and their substance abuse treatment plan goals and expectations;
  - Ensuring that the array of child welfare services provided to families support the goals of treatment; and

- Sharing information with alcohol and drug treatment staff regarding how children are doing, how parent and child visits are working out, and how parents are progressing in developing parenting capacities.

- **Ensuring that all personnel working with children and families or making decisions regarding families understand how their local alcohol and drug service system works and the nature of local assessment and treatment services.**

It is not reasonable or appropriate to expect child welfare staff to have the skills to conduct the indepth substance use diagnoses and assessments that follow screenings. These diagnoses and assessments must be conducted by substance abuse clinicians with relevant training and expertise. The key purpose of the diagnostic and assessment process is to determine whether treatment is needed, and if it is, to identify the level of treatment and types of services necessary to maximize the potential for recovery.

Child welfare staff should know the following about their local alcohol and drug service systems:

- What are the procedures for making referrals for assessments regarding the nature and extent of substance use? Who has to "sign off" on referrals? Who pays for assessments? Where are substance use disorder assessments conducted and how accessible are these locations to families?
- What assessment instruments are used? How long do assessments take? Are they always the same, and if not, why are different ones used?
- Is there a waiting list for an assessment, and if so, how long is it?
- What do the "results" look like? What releases of information are necessary to receive results? How long does it take to receive them? How are the results used to decide what type of treatment, particularly residential treatment, is needed?
- What treatment resources are available in the community? Are there waiting lists, and if so, how long are they and for what type of treatment? Are there interim programs for parents while they wait for an opening in a treatment facility?
- What are the implications of substance use disorder assessments and type of treatment selected for child welfare planning?

To ensure that child welfare staff have this level of knowledge, the Steering Committee should establish guidelines to ensure that the information is understood by managers throughout the child welfare system and that basic information about local alcohol and drug service systems is incorporated into training for child welfare staff. If training is provided by staff from the local alcohol and drug service system, its structure and format can be incorporated into collaborative agreements established by child welfare, alcohol and drug, and court systems.

- **Ensuring that staff understand the substance use disorder treatment process and its relationship to ASFA requirements and timeframes.**

Treating substance use disorders involves ongoing management of a lifelong disease such as diabetes or high blood pressure, as opposed to short-term interventions for acute crises such as broken arms. Recovery from substance use disorders is not a straight line from use to sobriety, but it involves periods in which people may return to use and then stop again. Appendix E, "Substance Use, Abuse,

Dependence Continuum, and Principles of Effective Treatment," provides information about substance use disorders and summarizes substance abuse treatment principles developed by the Federal Government.

Understanding the substance use disorder treatment process is essential in case planning and decisionmaking regarding permanency for children in foster care, particularly decisions pertaining to reunification, termination of parental rights, and continuing and aftercare services when children have been reunified with their families. Staff from the alcohol and drug service system frequently voice concerns that the timeframes for reunification and termination of parental rights are not consistent with the substance use disorder treatment and recovery process.

> **ASFA** requires States to file a petition for termination of parental rights for children who have been in foster care for 15 of the most recent 22 months, unless any of the following conditions are met:
>
> - At the option of the State, the child is under the care of a relative;
> - A State agency has documented in the case plan a compelling reason for determining that filing such a petition would not be in the best interests of the child; or
> - The State has not provided to the family, consistent with the time in the State case plan, such services as the State deems necessary for the safe return of the child to the child's home.

Because child welfare staff must make decisions that conform to ASFA rules, it is urgent that they screen, assess, and engage families in treatment at the earliest possible moment. The process of recovery from substance use disorders can easily take more time than ASFA rules permit, so it is imperative that families be given the best opportunity and the longest possible time to make satisfactory progress.

- **Ensuring that staff understand the State or District Family Court System, including the roles of judges or magistrates, mediators, CASAs, and attorneys.**

Athough many court decisions are driven by the requirements of ASFA, there are other legal protocols and procedures that child welfare staff must understand and follow. It is not uncommon for child welfare cases to involve three attorneys (one representing the parent, one representing the children, and one representing the child welfare agency) and a Court Appointed Special Advocate (CASA). Child welfare officials should work with court staff to obtain training regarding the roles of various legal representatives in child welfare cases, how court staff make decisions, and what information attorneys require to best represent their clients.

2.2   Responsibilities of the Alcohol and Drug Service System

People working in the alcohol and drug service system share responsibilities with colleagues from the court and child welfare systems in ensuring that collaborative structures and relationships result in better services to families. In recent years, treatment providers and the public alcohol and drug service system have come to understand that family members are important in the recovery process for individuals in treatment. As a result, they have assumed greater responsibility for determining the parenting status, capacities, and needs of people in treatment.

Responsibilities of staff in the alcohol and drug service system differ somewhat depending on whether parents have an open child welfare case and whether the child is in the custody of the court or the parent. Specific responsibilities include—

- **Understanding the ways that substance use disorders put children at risk and the ways that the child welfare system must respond to those risks, including ASFA requirements.**

Traditional assessments for substance use disorders have focused on the effects of substance use on the person entering treatment, including effects on employment, housing, and mental and physical health. Workers in the alcohol and drug treatment system were less likely to explore the effects of substance use on other people in the person's life, including children. Moreover, treatment counselors are not generally trained in the area of child development and may overlook important signals suggesting that children of parents in treatment are not developing appropriately, may need help, or may need to be removed from their homes at least temporarily. Alcohol and drug treatment staff may feel that reporting suspicions of child abuse or neglect will undermine their therapeutic relationship with parents and may be hesitant to or uncertain about taking action.

Reporting requirements for child maltreatment are discussed below. It is, however, essential that alcohol and drug treatment staff receive training about basic principles of child safety, theories of child development, stages of child development, and ways that parental substance use disorders affect children at all developmental stages, including prenatal substance exposure. In addition, they should receive training regarding the range of possible responses from the child welfare system, including responses such as preventive services that may allow parents to retain custody of their children while they participate in treatment.

Staff working in the alcohol and drug service system need specialized training that addresses at least the following:

- State definitions of child maltreatment;
- The role of the treatment provider in reporting suspected abuse or neglect;
- Benefits from addressing family dynamics and potential child maltreatment when working with a parent who has a substance use disorder;
- Consequences for children whose parents have substance use disorders;
- Other family issues that arise when parents are involved with child welfare;
- Ways treatment staff help parents prepare for child welfare and court reviews; and
- How ASFA requirements influence decisions regarding treatment.

Just as child welfare staff need to explore their beliefs about addiction, alcohol and drug services staff need opportunities that will allow them to address their experiences with and exposures to the child welfare and court systems, and to identify the attitudes that have come from these experiences. Training for alcohol and drug services staff must also help them recognize how their personal beliefs and attitudes regarding child maltreatment may affect their ability to work with families.

The NCSACW developed an online training curriculum for substance abuse professionals, entitled "Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals" available at *www.ncsacw.samhsa.gov*.

- **Ensuring that alcohol and drug services staff understand and comply with State laws regarding the reporting of child abuse and neglect.**

In order to avoid confusion about reporting child abuse and neglect, alcohol and drug services staff must be trained about State rules regarding mandatory reporting of abuse or neglect. As noted above, treatment workers may hesitate to report suspicions of child abuse or neglect. Decisions regarding responsibility to report maltreatment, however, are dictated by law, making reporting less a personal decision than a professional responsibility. Staff also need to understand that privacy rules pertaining to reporting limit their responsibility and authority to making only an initial report. These rules do not allow people making reports to respond to followup requests for information or subpoenas unless the parent has signed a consent form or a court has issued an order that complies with relevant rules.

In order to make appropriate reports or provide child welfare staff with information that will help them secure services for families and monitor family progress, alcohol and drug services staff must understand how their local child welfare system works. Child welfare operations and regulations vary greatly across States and localities. Variation is found in statutory definitions of child maltreatment, how reports of maltreatment are handled when first received, the kinds of evidence necessary to substantiate reports of maltreatment, and the use of police and/or child welfare personnel to investigate reports and conduct initial safety assessments. Ideally, staff from the local child welfare agency should provide this training to workers in the alcohol and drug service system, and at a minimum, child welfare staff should provide input into the training curriculum.

The following additional examples of variations among child welfare systems underscore the importance of training workers in the alcohol and drug service system about child welfare operations in their particular community.

Variations among child welfare systems:

- In some localities, reports of domestic violence are considered "eligible" child maltreatment reports, while in other localities, domestic violence is not included in the statutory definition of child maltreatment and such reports are "screened out" (i.e., they are not referred to the child welfare for further action).

- In some localities, child welfare responses include an "alternative response track." This option permits child welfare agencies to respond to families on whom reports have been made with an assessment and an offer of voluntary services rather than with an investigation to determine whether child maltreatment actually occurred.

- In some localities, any one of these methods of contacting families may occur: first contacts after a maltreatment report has been accepted are generally made by the police; these contacts are generally made by child welfare staff; the police respond to some types of maltreatment reports (such as sexual abuse and severe physical abuse), and child welfare staff respond to others; the police make initial contact if it is "afterhours," while child welfare workers make contact during regular working hours; and police and child welfare staff make the first contact as a team.

- **When there is not an open child welfare case, determining whether children are present in the home, whether the parent has caretaking responsibilities for children in the home, and whether the nature of the substance use disorder (whether or not the person is a caretaker) creates a risk of child maltreatment.**

Just as child welfare staff should seek advice from colleagues in the alcohol and drug treatment system in selecting substance abuse screening tools, so should alcohol and drug service system staff seek

advice from colleagues working in child welfare in selecting tools to screen for child safety. Because the Subcommittee charged with recommending substance use disorder screening tools includes representatives from multiple systems, that Subcommittee would be well positioned to recommend a child safety screening tool as well.

When screenings conducted by workers in the alcohol and drug service system suggest that children are at risk or have been maltreated, those workers should consult with child welfare staff regarding next steps. Therefore, alcohol and drug service staff must understand how to make reports of child maltreatment, and they must be aware of preventive services in the community if the information obtained from the screening process is a concern but does not warrant a child maltreatment report.

Determining child safety and child risk is not a precise science, and although many strategies have been developed to evaluate safety and risk, none can guarantee that maltreatment will or will not recur. Training for alcohol and drug services staff should focus on the general assessment tools used by the local child welfare services agency, the limitations of those assessment tools, and how those tools incorporate substance use disorders into the safety and risk assessment process. Appendix F, "Examples of Safety and Risk Assessments for Use by Child Welfare Staff," provides information regarding safety and risk assessment tools used by child welfare staff.

- **When there is an open child welfare case, participating in creating case plans, sharing information about parents and children with child welfare staff, and guiding their patients in taking steps to comply with plans. Alcohol and drug treatment staff should also understand the continuum of child welfare activities, processes, and timetables and that a parent can have an open child welfare case and still have custody of children (these are often referred to as "in home" services).**

Most staff in local child welfare agencies complete standard required case plan forms. Alcohol and drug treatment staff should understand these forms and participate in developing child welfare case plans recorded on them. They should conduct multidimensional assessments and share assessment results with child welfare staff as quickly as possible, generally within 7 days.

Although child welfare staff interact regularly with court staff, alcohol and drug treatment personnel do so less frequently and need to understand the role of courts when children of their clients are in foster care. It is important for them to understand the Federal, and sometimes State, statutory requirements that govern child welfare case plans and decisions about families. In particular, they need to understand the Federal ASFA requirement that permanency hearings be held after children have been in foster care for 12 months, with the expectation that decisions and next steps regarding permanent placement of children will result from permanency hearings.

The child welfare and court timeframes put added pressure on parents to progress quickly through treatment. One way that the alcohol and drug service treatment system can respond to this urgency and increase collaborative relationships with child welfare and courts is to give treatment priority to people with open child welfare cases involving children in foster care, where possible and within Federal rules regarding access to treatment.

Treatment providers can support family members by—

- Encouraging them to sign consent forms allowing for disclosure of treatment progress to child welfare workers and court professionals;

- Understanding their child welfare case plan requirements, meetings, appointments, and expectations for visits or involvement with children;

- Communicating with child welfare caseworkers to coordinate schedules so that family members do not have conflicting demands that force them to choose between meeting their child welfare case plan goals and expectations and those of their substance abuse treatment plan; and

- Ensuring that child welfare workers understand the difference between treatment lapses and treatment relapses, and communicating clearly how both lapses and relapses are being addressed in treatment.

Alcohol and drug treatment staff should have the following knowledge about the operations of their local child welfare systems:

- What are the indicators of child maltreatment, and how are reports made?

- How does child welfare staff respond to reports of maltreatment, and how are initial and subsequent investigations and assessments made? What assessment forms are used, and how long does it take to conduct an investigation or assessment?

- What happens when a child abuse report to a hot line turns into allegations of child abuse or neglect? What happens when the allegations are not substantiated, and what happens when they are substantiated? How long does it take to determine whether reports are substantiated?

- How does child welfare make determinations about removing a child from a parent's custody and how do they determine when to return a child? What services are available to children and families, and how are those services delivered?

- What are the implications of child welfare findings for treating substance use disorders?

2.3 Responsibilities of the Court System

Court officials have a responsibility to ensure that employees, attorneys, and volunteers receive adequate and accurate training about the alcohol and drug service and child welfare systems. These responsibilities include—

- **Understanding the fundamentals of substance use disorders, the implications of those disorders on child safety and well-being, and the potential for effective treatment.**

As noted earlier, the relationship between substance use disorders and child maltreatment is often complex. Court and legal staff and volunteers should be required to receive training in topics such as the nature of substance use disorders, treatment engagement and services, recovery, and the impact of substance use disorders and treatment on children including aspects related to prenatal substance exposure. Continuing legal education credits can often be provided for this kind of training.

Ideally, staff from the alcohol and drug service system or a local treatment provider should develop curricula and provide training to court and legal staff. NCSACW developed an online curriculum aimed at court and legal staff that is available at *www.ncsacw.samhsa.gov*. Alcohol and drug treatment staff can adapt the curricula for their jurisdiction.

- **Understanding the fundamentals of child development and how substance use disorders affect children's capacity to grow.**

Child welfare staff are often well versed in the developmental stages of children and attempt to address those stages in the decisions they make regarding placement of and services to children whose parents have substance use disorders. Court and legal staff are much less likely to have this knowledge and therefore may make decisions regarding services and custody without understanding how those decisions affect the ability of children to progress developmentally.

Staff from the child welfare service system can adapt curricula used to train their own staff for use in training court staff, and they can provide training in this area.

- **Requiring that all families coming before the court be screened, and if appropriate, assessed for substance use disorders; that developmental assessments of children have been completed; and that prenatal substance exposure, if it exists, be addressed.**

Despite the correlation between substance use disorders and child maltreatment and the importance of screening for substance use disorders upon first contact with a family reported for maltreatment, such screenings may not occur. Judges and magistrates can greatly increase the likelihood that screenings will be completed if they routinely ask whether they have been done and for information about their outcome.

Ideally, court or legal staff should participate in the Subcommittee of the Steering Committee charged with recommending a particular screening tool for substance use disorders.

If screening results suggest that family members have substance use disorders, judges and attorneys should ask for information regarding followup assessments, referrals to services, and protocols for supporting and monitoring family members through treatment.

- **Using court authority to prompt collaboration required to ensure compliance with ASFA.**

Because ASFA imposes strict timelines for terminating parental rights, it puts added pressure on child welfare and alcohol and drug treatment agencies to collaborate.

Judges and magistrates should use the authority of the court to hold families, child welfare staff, and alcohol and drug treatment staff accountable for complying with ASFA requirements or developing compelling reasons why ASFA rules should not apply in a particular case. Judges also can issue findings that the State has not made reasonable efforts (or active efforts for families covered by the Indian Child Welfare Act) to provide services to families. These findings generally require immediate remedial actions by agencies to make those efforts.

2.4   Collaborative Responsibilities of the Child Welfare, Court, and Alcohol and Drug Service Systems

Although each system has certain individual responsibilities to the other systems, as described above, there are also critical collaborative activities whose responsibilities must be shared across the three systems. The Steering Committee should specify those areas of shared responsibility, create communication structures that promote and enforce them, and develop mechanisms to guide and evaluate local jurisdictions in adapting and implementing shared responsibility across the three systems. Section I suggests that the Steering Committee develop a plan of action to oversee progress toward collaborative goals and objectives, and these collaborative activities should be incorporated into the plan

of action. Appendix B of this guidebook provides a template for creating the plan of action. Some of the basic shared collaborative responsibilities of the child welfare, court, and alcohol and drug systems are described below:

- **Child welfare, court, and alcohol and drug service systems share responsibility for facilitating engagement of families by establishing joint policies and procedures for sharing information regarding screening, assessment, treatment, and case planning.**

Child welfare, court, and alcohol and drug treatment staff share responsibility for helping families engage in child welfare and treatment services. An important factor in influencing whether families are engaged is the extent to which staff from all systems have accurate and timely information about families they serve, information that is gathered and shared at critical points across the span of a family's involvement with any system. Having formal structures in place to make it easier for staff to communicate information increases the likelihood that they will in fact communicate appropriately, which in turn increases the likelihood that they will be able to engage and retain families in services.

One important element of effective communication involves protecting people's rights to privacy, rights that are specified and guaranteed by Federal and State laws. Appendix H, "Sharing Confidential Information," includes a detailed discussion of confidentiality concerns and informed consent procedures. Staff from all three systems should develop uniform protocols that provide guidance to workers in sharing information. The Steering Committee should charge a Subcommittee with researching existing protocols, locating promising practices from other jurisdictions, and developing recommendations for improvements to protocols.

- **The child welfare, court, and alcohol and drug systems share responsibility for ensuring that case plans and court orders (when relevant) for children and families are developed collaboratively and create a context within which staff from each system can actively help families engage and succeed in services.**

Although each system has its own requirements for case plans, plans generated by each system should incorporate information about families obtained from the other systems and all plans should be constructed so as to support the capacity of families to engage in required services. When case plans do not include the array of activities required by all systems, the plans duplicate one another, contradict one another, or pose barriers for the family due to excessive or conflicting demands on family members' time. For example, it is extremely difficult for families to participate in daily outpatient substance use disorder treatment programs as required by the alcohol and drug treatment plan, hold a full-time job or participate in daily employment training programs as required by the child welfare case plan or court order, attend two parenting education or anger management classes per week as required in the child welfare case plan, and visit with their children twice per week, also as required by the child welfare case plan.

Alcohol and drug treatment and child welfare case plans should be developed through joint efforts of staff from both systems and the court, and must accommodate the timetables under which all systems operate. Information regarding the following responsibilities should be shared.

In developing case plans, alcohol and drug treatment and child welfare staff should share the following:

• Treatment plans and requirements, including drug testing requirements;

• Child welfare case plan activities and objectives;

• Family service interventions;

• Plans for ensuring child safety;

• Parent and child visitation plans; and

• Permanency goals and plans.

Ideally, sharing these responsibilities should result in a unified plan that emphasizes engaging and retaining families in services, ensuring child safety and family stability, promoting recovery, and continuing services even after families complete case plan requirements (sometimes called aftercare).

- **The child welfare, court, and alcohol and drug service systems share responsibility for developing indicators of progress that meet the needs, requirements, and missions of each system and that focus on the entire family.**

"Progress" has different meanings to people working in different systems, although in all three systems, progress frequently is not characterized by an unbroken straight line to success. In fact, staff in child welfare, court, and alcohol and drug systems routinely report that families make progress, stumble, resume progress, stumble again, and so on. The "Stages of Change" theory described in Section III arose out of research involving people with substance use disorders, but it applies as well to other situations in which people attempt to change longstanding behaviors. Movement from one state of change to another is an important marker of progress.

The tensions surrounding what constitutes progress have often been expressed in discussions about substance use relapse. When people who have abstained from using substances have an episode of using again, child welfare and court staff may view the substance use as equivalent to "backsliding" into substance abuse. However, staff in the alcohol and drug service system distinguish between "lapse" (a period of substance use) and "relapse" (the return to problem behaviors associated with substance use). It is important for child welfare and court staff to understand that distinction and avoid concluding that relapse is the same as treatment failure.

Relapse may occur because the treatment plan has not adequately addressed issues relevant to the substance use disorder. At the same time, alcohol and drug treatment staff should understand that relapse does have implications for child safety.

While relapse is most frequently associated with substance use disorders, it is important for staff from all systems to have a shared understanding that families may also experience periods of return to child maltreatment or criminal involvement. In general, progress can be considered as the degree to which people have increasing periods of sobriety, decreasing incidences of relapse and improved ability to take care of responsibilities, including parenting. Staff should develop shared responses to relapses and setbacks when they occur.

As noted in Section I, one important task for the Steering Committee is to develop broad indicators or benchmarks for measuring families' progress in both recovering from substance use disorders and attaining appropriate parenting capacities. Indicators and benchmarks should be based on requirements

included in the treatment and case plans. These indicators and benchmarks help alcohol and drug treatment staff determine the appropriateness or effectiveness of the treatment services provided to families. These tools also guide child welfare and court decisions regarding permanency arrangements for children (particularly with respect to seeking termination of parental rights or providing aftercare services to families when children are reunified) and services to ensure child safety and well-being. The Steering Committee uses indicators and benchmarks to assess how well their systems are sharing information, engaging and retaining families, and making appropriate and timely decisions.

Joint indicators and benchmarks require that staff have protocols for obtaining information from families and for sharing information with colleagues. The following strategies can be useful in securing and sharing important information:

- o Developing joint disclosure forms that meet the needs of all relevant systems;
- o Convening meetings of staff from all systems to address pertinent issues;
- o Conducting meetings involving all involved staff and family members, to discuss progress, problems, and next steps; and
- o Working with the parent's legal advocate to ensure that the court is responsive to the parent's treatment needs and progress.

- **The child welfare, court, and alcohol and drug service systems share responsibility for monitoring and evaluating the results of collaborative screening, assessment, engagement, and retention efforts. Evaluations should include determinations regarding whether individual system and collaborative responsibilities are being met, determinations about whether expected outcomes are being achieved, and procedures for making revisions based on evaluation information.**

If families are not engaged and retained in services, collaborative efforts have failed. The primary objective of the collaborative endeavor presented in this guidebook, and the most important goal for the Steering Committee, is to ensure that families receive timely, appropriate, and well-coordinated services.

As described in Section I, at the onset of working together, members of the Steering Committee should gather and understand the data from their own systems and then create a baseline of information that the Steering Committee and local Subcommittees can use to establish priorities. Appendix B provides information regarding the *Collaborative Capacity Instrument* and other tools to help the Steering Committee members assess the strengths and weaknesses of their systems. This assessment should be conducted at one of the early Steering Committee meetings and periodically thereafter. Results from these tools frequently prompt discussions among Steering Committee members about the ways systems are perceived, reasons why they conflict, and areas in which strong collaborations already exist. Information from assessments should be shared with Steering Committee and Subcommittee members and with others who have a stake in improving collaborative capacities among agencies.

When the baseline has been established, all three systems share responsibility for establishing outcomes they feel equally responsible to achieve. Outcomes should not be merely a compilation of outcome measures specific to each system, and each system should feel responsible for the outcomes of the three systems as a whole. Each system's performance should be measured at least in part against those overarching outcomes.

2.5   Models for Cross-System Collaboration

Successful collaborations usually involve the creation of a "teaming" approach. These teams can be formal or informal and can function within a variety of structures. Team approaches that have been used in some localities are described below.

Colocation of Staff

One team model involves colocating staff from different systems in the same office. For example, some localities "outstation" staff from the alcohol and drug service system in a child welfare office or court environment. Although colocating staff does not in itself ensure effective collaboration, reports from localities that have implemented this model suggest that workers are generally satisfied with the arrangement and believe that everyone, including the families, benefits from it. Colocation is usually the model that many tribes have developed to deliver services to families.

Colocation has considerable potential for enhancing cross-system collaboration. It provides opportunities for people to learn about other professions and to develop more complete understandings about family strengths and problems. In many localities that have implemented the colocation model, staff from the alcohol and drug service system not only conduct assessments of families, but also participate in staff meetings and conduct trainings for staff and sometimes families.

The following factors are to be considered in deciding whether and how to colocate staff from different agencies:

- Program
    - Are the goals for colocation clear, and do all staff share these goals?
    - How will information be shared and privacy protected?
    - Have staff that will be colocated received basic cross-training to work together effectively?
    - What functions will the colocated staff perform? (For example, will alcohol and drug services colocated staff conduct screenings and/or assessments, provide ad hoc advice, conduct home visits, or participate in child welfare staff meetings, or perform any combination of these functions?)

- Logistics
    - Where will staff sit, what access will they have to computers, photocopiers, and similar equipment?
    - How will supervision be handled?
    - How will differences in work rules such as dress codes, signing-in, coming and going into the field, pay, and reward structures be resolved?

- Lessons learned
    - Staff who are colocated in another agency must be part of the agency where they sit and maintain their own identity.
    - Alcohol and drug training provided by alcohol and drug treatment staff that are outstationed with child welfare staff is often better received than training provided by child welfare staff.

Creating Specialized Staff Positions

Another team approach is to create specialized workers who work only with particular types of families and who are responsible for interacting with other staff from systems that work with those families. For example, some child welfare agencies have created specialized units or specialized worker positions to focus on cases in which problems such as sexual abuse, domestic violence, or parental substance use disorders are prominent.

When families struggle with both substance use disorders and child maltreatment, this approach permits designated child welfare workers to develop expertise in the area of substance use disorders and familiarity with the local alcohol and drug treatment providers. This expertise and familiarity between child welfare and alcohol and drug treatment staff increases the likelihood that staff will communicate consistently, and it promotes a sense of teamwork and camaraderie. Specialized child welfare workers may spend part of their week at treatment sites to meet with families or resolve problems. Because they learn how treatment programs operate, these specialized workers can collaborate with treatment staff to ensure that families are not confused or frustrated in their efforts to meet potential conflicting requirements of the alcohol and drug service, court, and child welfare systems.

Multidisciplinary Teams

Another collaborative team model involves developing multidisciplinary teams to participate in child welfare case staffing meetings or case conferences. Multidisciplinary teams can be combined with the colocated or specialized staff strategies described above, or they can be used independently. Multidisciplinary teams that include representatives from the alcohol and drug service and court systems create a context that makes collaboration more feasible because team meetings afford structured time for workers to get and provide information about families, seek suggestions on resolving problems, and share resources.

Establishing and implementing multidisciplinary teams often brings to the fore the underlying tensions and inconsistencies that have existed among the systems. Therefore, it is essential that people from all systems expected to participate in multidisciplinary teams share in establishing the framework and protocols for how the teams will operate. In particular, attention should be paid to establishing clear roles for each team member, defining ways that information will be shared among team members, reaching consensus regarding the role of family members on teams, and clarifying how decisions will be made and enforced. The Steering Committee could charge a Subcommittee with exploring these and other options and recommending one or more for use in the State.

Creating multidisciplinary teams requires significant upfront investments in identifying staff who are comfortable working in groups, creating and delivering training regarding effective group processes and teamwork, and determining who has authority to make which kinds of decisions. Some jurisdictions have limited the number of families or assigned only those with the most intense service needs to the multidisciplinary team, because they can be time and resource intensive.

However difficult, teams can be very productive, and their work can result in several benefits:

- Multidisciplinary teams ensure that a broad range of knowledge and expertise is available to address problems, thereby increasing the likelihood that services will be comprehensive and that families will engage and remain in them.

- Because team members learn about one another's services and procedures, each is less likely to provide incorrect information to families and more likely to communicate and coordinate services.

- The multidisciplinary approach allows child welfare workers to develop a broader understanding of the needs of the children and parents and enhances their ability to match services to family needs.

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.

Pathways of Communication Template
Identification Through Community or Family Awareness of Signs, Symptoms and Behaviors
Family and Extended Family Services

Other Community Agencies

- Screening
- Community Based Family Support Services

Alcohol and Drug Services

- Screen
- Immediate Need Triage
- Diagnosis
- Multidimensional Assessment
- Treatment Plan and Services
- Treatment Monitoring and Transition Planning
- Recovery Management
- Outcome Monitoring

Child Welfare Services

- Child Abuse Report
- In-person Safety Assessment
- In-person Response/Risk Assessment
- Family Assessment
- Case Plan Development and Services
- Case Plan Monitoring, Permanency Determination
- Family Well Being
- Outcome Monitoring

Dependency Court

- Detention/Shelter Hearing
- Jurisdiction Disposition Hearings
- •Review Hearings
  •Family Treatment Court Hearings
  •Case Closures
- Outcome Monitoring

3.2   Screening: Is there a substance use or child abuse and neglect issue in the family? What is the immediacy of the substance use or child abuse and neglect?

Screening for Substance Use Disorders in Child Welfare System Families

When reports of child maltreatment are based on or accompanied by allegations of substance use by parents or when children are born prenatally exposed to substances, child welfare staff do not need to further screen for substance use problems.

When substance abuse is not evident from the report of maltreatment or the birth of a child who has been exposed prenatally, the answer to the question "Is there a substance use issue?" is arrived at through a variety of sources such as observations in the home or information gathered from neighbors or other family members. For cases in which the child welfare worker is unsure whether substance use is a problem, the use of a standardized set of questions—*a screen*—is recommended. Alcohol and drug screens, as those used in this guidebook, refer to brief tools or procedures designed to determine *risk or probability* that an individual has a given condition, or disorder. Screens should be designed for use by a broad range of people, including those with little clinical expertise. An ideal screen should be short, easy to administer orally or in writing, inexpensive, and capable of detecting a problem or condition when it exists.

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 (**T**olerance)?
- A, do you feel **A**nnoyed by people complaining about your drinking?
- C, have you ever felt the need to **C**ut down on your drinking?
- E, have you ever had a drink first thing in the morning (**E**ye 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? (**T**olerance)
- Does your partner (or do your parents) ever **W**orry 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? (**E**ye opener)
- Have you ever **A**wakened 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*.

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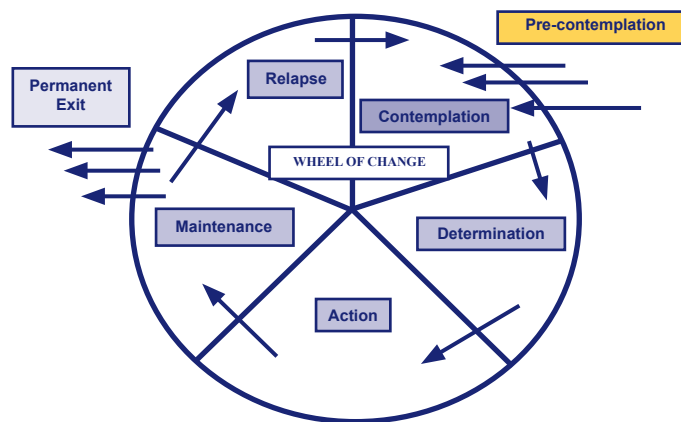
Over a period of time, people progress from one stage to the next, even though they may occasionally lapse back to a prior stage. The Stages of Change model holds that these lapses are not necessarily failures but are often part of the normal process by which people change.

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.

Purpose of Activity	Example of Tool	What Activity & Tool Indicate
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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APPENDIXES

Appendix A

Facilitator's Guide

Facilitator's Guide

As noted in the Introduction of this guidebook and of no surprise to anyone working in child welfare, alcohol and drug treatment, and dependency court systems, collaboration is not easy. Even when people sincerely want to collaborate, it is hard to share authority and accountability with people who come from different backgrounds, have different values, and work for different systems from our own. The previous sections of this guidebook recommend activities and approaches that may be quite different from those currently in use. Reading about and even endorsing these strategies will not make them happen. Creating change takes dedication, commitment, support, and perseverance.

This section provides suggestions, tools, and templates to help staff create, govern, and work within a collaborative structure. It is a close companion to Section I of this guidebook, in which a collaborative structure and activities are suggested. This section is specifically aimed at people responsible for chairing or facilitating Steering Committee or Subcommittee meetings. While every collaborative endeavor is unique, collaborative groups tend to go through similar processes and struggles. The material included here draws from insights gained from providing technical assistance to more than 40 States and countless local communities.

The SAFERR tools and materials were developed specifically for use by staff working in the child welfare, alcohol and drug, and court systems, but they are not specific to any particular State. Each jurisdiction should use the information included here in the way that best addresses its own priorities and concerns. Successful collaborative endeavors depend on the leadership, relationships, communication, and specific policy priorities of the group, not on the use of any particular tool. Some communities may adhere closely to the processes suggested in this section, and others may simply use some of the templates to help them in their own processes. In either case, this section is an attempt to provide staff with the benefit of prior efforts made by colleagues across the country.

Screening and assessment are just two components of a larger framework of collaboration. While these materials focus on those two components, communities should approach them in the context of a larger framework of collaboration that goes beyond screening and assessment to include engaging and retaining families in services and evaluating family and systems outcomes (Young & Gardner, 2002). A revised framework, included in the Appendix of Young and Gardner's document, can be found in "Framework and Policy Tools for Improving Linkages between Alcohol and Drug Services, Child Welfare Services and Dependency Courts" at *http://ncsacw.samhsa.gov*.

Step One: Getting Started

Establishing the Project

The Oversight Committee, composed of the top officials in each system, can give the initiative significant weight among their employees and in the larger community if, at the outset, they release a short notice and statement of support. This notice would be signed by all of them on letterhead stationery that includes all agency logos. The notice might include the names of Steering Committee members and a few facts about goals and timetables. The next page is a generic letter, adapted from one developed by staff in Colorado.

Sample Project Announcement Letter

LOGO	LOGO	LOGO
(Court)	(Alcohol and Drug)	(Child Welfare)

Substance abuse and child maltreatment are two of our country's most pressing social problems, and they are elaborately interconnected. Nationally, in cases in which a child has been placed in custody, estimates of parental substance abuse range from 33 percent to 66 percent. Anecdotal evidence suggests that over 90 percent of dependency court cases involve children affected by substance abuse. *(State or county specific data can be added here)*

Despite these connections and the implications involved in removing children from their parents, child protective services workers, substance abuse counselors, and judges and lawyers often lack guidelines, protocols, and knowledge when making decisions about child placement, services to families, and termination of parental rights.

We understand that no employee and no agency can resolve problems of child maltreatment and substance use disorders1 on its own and that unless we work together to better serve families, none of us will succeed. (The term "substance use disorder (SUD)" is used in this paper 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 issue of substance use.) Therefore, we have jointly created a *State-* or *county- (specify)* wide initiative that will result in protocols for screening, assessing, engaging, and retaining families who have substance use disorders and who are involved with our child welfare and dependency court systems.

Overall guidance for this initiative is provided by the Steering Committee listed below. We have asked the Steering Committee to create relevant topic-specific Subcommittees and hope that many of you will participate on these subcommittees. We will serve as the Oversight Committee, and for purposes of this project, the Steering Committee will report to all of us regarding progress, problems, and results.

It is essential that the Steering Committee and Subcommittee processes be inclusive, open, and based on principles shared by all systems. It is equally essential that the results be both grounded in research and practical to implement.

This project represents an important and exciting opportunity for families and staff. We look forward to working together and thank you for your support and interest as we go forward.

_____	_____	_____
Court Administrator	**Alcohol and Drug Director**	**Child Welfare Director**

Steering Committee Members

Name	Affiliation and Contact Information

The Oversight Committee should issue written letters of appointment to each Steering Committee member. These letters give the project prominence within each system, provide support for Steering Committee members to spend the time required to participate in the project, and make it clear that the member has authority to make decisions on behalf of the agency.

Sample Project Announcement Letter

LOGO   LOGO   LOGO
(Court)   (Alcohol and Drug)   (Child Welfare)

Dear

We are pleased to announce that (name of jurisdiction) is launching an initiative to help us better serve families with substance use disorders who are involved with child welfare and dependency courts. With this letter, we are appointing you to serve on the Steering Committee for this important project. The three of us collectively compose the Oversight Committee, and the Steering Committee reports to all of us.

We will meet with the Steering Committee at its first meeting and then quarterly thereafter. At our kickoff meeting, we plan to explore more deeply what each agency would like to achieve from this project, identify areas of common and diverging priorities, and develop one or more overarching goals that cross our three systems. We will also discuss more fully the authority, scope, and mandate of the Steering Committee.

By the end of the kickoff meeting, we plan to have identified areas of greatest interest and priority for action. We also will talk more fully about the Subcommittees that we know will be necessary to achieve the goals, and we will set a schedule of Steering Committee and Oversight Committee meetings for the next 12 months.

You will receive more information about the kickoff meeting in the coming days.

We are very excited about this project and look forward to working with you.
Thank you for agreeing to serve on the Steering Committee.

_____   _____   _____
Court Administrator   **Alcohol and Drug Director**   **Child Welfare Director**

Section I, "Building Cross-System Collaboration," lists the type and level of staff who should serve on the Steering Committee and specifies that they should be at a level to make decisions and commitments on behalf of their agencies. Each jurisdiction should add other perspectives to the Steering Committee as determined by local needs and structures.

Steering Committee Structure and Governance

Initiatives of the scope and importance described in this guidebook that address challenging issues warrant the use of a paid outside facilitator, at least in the beginning. While some members of the

Steering Committee will not know each other before coming together for this project, others will have had prior experiences, both positive and negative, with each other. It is asking a lot of senior managers to participate in decisionmaking groups in which one of their colleagues is "in charge," even if only as a facilitator. It is also expecting a lot of a senior manager to ask him or her to facilitate a senior-level decisionmaking body while serving as a "voting" member of that body.

The Steering Committee facilitator need not be a full-time job. A skilled consultant who is familiar with the subject matter and State operations can be hired on an hourly or fixed-price basis. Ideally, the three systems should contribute to pay facilitator fees, thus modeling the collaboration they expect of staff. It is also quite possible that a local foundation would fund such a position if requested by the top officials from all three systems.

As noted in Section I, if hiring an outside facilitator is simply not possible, the Oversight and Steering Committees must find other ways to ensure members that they will be treated equally. Communicating to all Steering Committee members that the Steering Committee reports equally to the three Oversight Committee members can help reduce the perception that one agency is running the initiative. Or, the Steering Committee might be co-facilitated by representatives of all three systems. As a last alternative, people from each system could rotate as facilitators. This section uses the term "facilitator" to include internal staff or external consultants.

Using Internal Facilitators

If an internal facilitator is used, it is important for the facilitator and the Steering Committee to be aware of the person's multiple and potentially conflicting roles. The facilitator should tell the group at the outset that he or she is serving as a facilitator and not as a staff member or agency representative, and then must diligently maintain that distinction. The facilitator's job is to manage discussions without getting pulled in. If the facilitator absolutely needs to make a point as a staff or agency representative, he or she should make a statement to that effect, make the point, and then state that he or she is returning to the facilitator role. When the boundaries of these different roles are delineated and respected, others will be more inclined to trust and respect the boundaries as well. (Adapted from Arnie Arnoff, Director of Training and Organizational Development, The University of Chicago, May 2002.)

The Steering Committee will require the services of an administrative person to take minutes during meetings, follow up on decisions and commitments made during meetings, and distribute agendas or other reading material. It is impractical to ask the facilitator or Steering Committee member to perform these tasks.

The Steering Committee should consider using student interns. Graduate public policy or social work students often need field placements in order to complete their course requirements. These students frequently know how to conduct literature reviews and other research, and they are often skilled at preparing presentations or other public information brochures and fact sheets.

One important responsibility of the Steering Committee will be to create and oversee the activities of several Subcommittees that will work on one or a few specific issues related to screening and assessment. Subcommittee members should represent the frontline of practice in each system and come from local offices that are interested in pilot testing and implementing cross-system training strategies, screening or assessment protocols, or multidisciplinary teams that emerge from the project. Ideally, a

Steering Committee member should chair each Subcommittee, to ensure that information flows easily and accurately between the two groups.

Details of Steering Committee members' roles and responsibilities should be thoroughly explored and recorded during its first, kickoff meeting, described below. Initially, it is recommended that the Steering Committee meet monthly, especially if it will meet with the Oversight Committee quarterly. After plans of action have been developed and Subcommittees established, the Steering Committee could possibly meet less often.

Step Two: The Kickoff Meeting

If possible, the Steering Committee should start its work with a 2-day kickoff meeting, with the three members of the Oversight Committee attending for at least part of that time. This meeting should be held in a neutral location, to avoid the appearance that any system is leading the initiative and to reduce the likelihood that members will go back and forth to their offices. If a 2-day meeting is not feasible, the activities planned for that time can be accomplished over a series of meetings.

Outcomes of the Kickoff Meeting

By the end of the kickoff meeting, the following should be in place:

Substantively:
    There should be a "wish list" describing the kinds of policies, protocols, training curricula, multidisciplinary teams, and other innovations that members would like to explore through this initiative. This list does not have to reflect consensus of the group, but there should be general agreement on highest priority areas.

Procedurally:
    Members should understand their roles and responsibilities, meeting dates should be established for the next 12 months, and members should understand and support ground rules for meetings, discussions, and decisions.

The next two pages offer an annotated generic agenda for the kickoff meeting. This agenda covers all the important items that should be discussed at the first meeting. The page following the agenda provides more information and some exercises to help facilitators guide the discussion on some of the topics included on the agenda.

Location and Time

Day One

8:45 – 9:45   **Introductions**

Participants will introduce themselves to the group, including descriptions of their backgrounds, what they and the organizations they represent hope to gain from this initiative, and what changes they would like to see for the families they serve.

9:45 – 11:00   **Overview of the Project**

The Oversight Committee, comprising the Court Administrator, and Directors of the Alcohol and Drug and Child Welfare Service2 systems, will describe why they established this initiative, what they expect from it, and what kind of guidance and direction they will provide to the Steering Committee. (The term "child welfare service system" includes 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.) The Oversight Committee will present its view of roles and responsibilities of the Steering Committee and will hear suggestions and ideas from Steering Committee members.

11:00 – 11:15   **Break**

11:15 – 12:30   **Presentations From Agencies, Tribes, and Consumers**

Representatives from the three State systems, a county, a tribe, and consumers will present overviews of their agencies and systems. The presentations will describe agency missions, structures, and principal activities. In addition, the representatives will highlight particular "hot" issues facing their agencies, and will describe relationships their agencies have with each other, the State legislature, and universities.

12:30 – 1:30   **Lunch**

1:30 – 2:15   **Presentations From Agencies, Tribes, and Consumers (cont'd)**

2:15 – 3:15   **Brainstorming**
(including break)

Members will express their ideas and hopes for desired activities, products, and outcomes of the initiative. All ideas will be accepted and recorded. The result of this exercise will form the basis for project goals and tasks.

3:15 – 4:15   **Steering Committee Ground Rules and Future Meetings**

This session will establish meeting dates for the Steering Committee for the coming year. Meeting times will be established, and ground rules regarding attendance, communication, and decisionmaking processes will be discussed and agreed to. A process for creating and distributing minutes and background materials will be determined.

4:15 – 4:30   **Closing Comments**

Day Two

8:30 – 9:00   **Recap of Day One**

All participants will reflect on the prior day to clarify issues that may seem vague, to ask questions, or to raise additional issues that have occurred to them.

9:00 – 10:30   **Framing the Project**

Members will review the wish list that resulted from the brainstorming and explore key priorities, challenges, and additional tools or resources that might be required to achieve goals. The group will reach consensus on the issues of most importance, the ideal outcomes for those issues, and barriers to achieving the outcomes.

10:30 – 10:45   **Break**

10:45 – 12:00   **Exploration of Subcommittee Topics and Structures**

On the basis of results from the Brainstorming and Framing the Project discussions, the group will identify issues that are most likely to be addressed through the work of Subcommittees. It will determine Subcommittee structures, roles, and responsibilities, including Steering Committee responsibilities in guiding Subcommittees. Preliminary lists of possible Subcommittee members will be established.

12:00 – 1:00   **Lunch**

1:00 – 2:00   **Planning for Next Meeting/Meeting With Oversight Committee**

Members will develop agenda items for the next meeting, assign the lead person for each item, and determine background material required. (Agenda items/exercises are likely to include completing the Collaborative Values Inventory or completing the Understanding Our Systems Worksheet, both of which are described below and included in this *Facilitator's Guide*).

2:00 – 2:30   **Closing and Next Steps**

The Steering Committee will identify unresolved issues and develop strategies for addressing them.

Techniques for Guiding the Kickoff Meeting

Steering and Subcommittee procedures and ground rules are described in Section I. The following paragraphs address the substantive items that will be discussed during the
kickoff meeting.

Introductions

Not all Steering Committee members will know one another, especially those Committees that have broad representation including consumers, family members, tribal members, and social service agencies. The facilitator should develop creative and enjoyable ways to have people introduce themselves or each other to the group.

Overview of the Project

The kickoff meeting is the first time the Steering Committee will be coming together, and it will be joined by the directors from all three systems. Some members are likely to be unsure of why they were asked to participate, uncertain of demands that might be placed on their time or resources, and unfamiliar with others on the Committee. The facilitator should work with members of the Oversight Committee before the meeting to help them present their vision and ideas, to concretely describe their goals and expectations, and to specify clearly their charge to the Steering Committee. In addition, the facilitator should ensure that the Oversight Committee is open to hearing ideas and suggestions from the Steering Committee.

Presentations From Agencies, Tribes, and Consumers

Not all Steering Committee members will be knowledgeable about each other's systems. Representatives from the three State systems, counties, tribes, and consumers should be asked in advance to present brief overviews of their agencies, systems, or experiences with agencies and systems. The facilitator should work with presenters before the meeting to be sure they prepare comments in advance and have visual or written information to accompany their comments. Presenters should consider this presentation to be an important and substantive one about their agency mission, structure, and activities.

Brainstorming

Brainstorming is helpful when a group is interested in generating a lot of ideas and when people need encouragement to speak out.   The group can use ideas generated in a brainstorming session to choose the specific issues they want to develop into projects and plans of action. Brainstorming discussions are likely to raise questions about which families will be the focus of this initiative. The child welfare and alcohol and drug service systems are involved with a larger group of families than are the courts and will be interested in developing strategies that include both court-involved and non-court-involved families. Court staff will be more interested in focusing on families under court jurisdiction. The box below provides some guidelines regarding brainstorming sessions.

Rules of Brainstorming

1. Postpone and withhold judgment of ideas.
2. Encourage wild and exaggerated ideas.
3. Quantity, not feasibility, counts in brainstorming.
4. Build on the ideas put forward by others.
5. Every person and every idea has equal worth.

(Adapted from Infinite Innovations Ltd., c 1999–2001)

Methods of Brainstorming

Structured Go-Arounds
To be used when interested in hearing from everyone. Each person is given an opportunity to speak, usually within a time limit. Responses are saved until everyone has had a chance to contribute.

Gallery Method
Large sheets of paper, blackboards, or flip charts are used on which general themes or ideas are written. Participants then walk around the "gallery," read the ideas, and add their comments or thoughts. This method is good for people who prefer writing to speaking and for people who are visual learners.

Individual Writing
Group members are given a topic, task, idea, or free reins to write for a defined period of time, typically 15 minutes. This method is good for generating ideas, soliciting opinions, slowing down a heated discussion, or for unlocking a stalled discussion in which no one is participating.

(Adapted from Arnie Arnoff, Director of Training and Organizational Development, The University of Chicago, May 2002)

Framing the Project

The brainstorming session provides the opportunity for everyone to put thoughts on the list without having to explain or defend them. The outcome of the brainstorming session should yield a diverse and rich list of interests, issues, and concerns. The Framing the Project session allows members to think more deeply about these ideas, understand other points of view, and challenge assumptions and be challenged. From this discussion, the group should be able to group topics into general categories and to select a few categories that are the most important to address, even if there is not agreement on every item. This discussion also will help the Steering Committee envision topics for future meetings and for assignment to Subcommittees.

The next steps included in this section provide information about tasks and activities that the Steering Committee should undertake at subsequent meetings.

Step Three: Developing Shared Values, Principles, and a Mission Statement

Experience has repeatedly shown that the most critical first activity in creating an effective collaborative Steering Committee or other workgroup is holding open and honest discussions about values and

principles. These discussions are not focused on securing or forcing agreement on every value, but they should ultimately yield statements of mission, values, and principles that the group endorses and supports.

When people from the alcohol and drug system, child welfare system, dependency courts, tribes, consumers, and other agencies come together, they bring with them both overlapping and divergent values and philosophies. Systems, agencies, and workers have values that reflect their organizations and their professional training. For example, child welfare agencies are charged with ensuring child safety, alcohol and drug treatment agencies have deep concern for the adult's recovery from substance use, and the court is focused on establishing permanent living arrangements for children. These values are intense, deep seated, and long lasting.

Value differences cannot be ignored, and they will not always be reconciled. Unless differences are acknowledged and accepted, however, they will emerge repeatedly and frustrate efforts to make important changes. At the same time, when people acknowledge their differences and then move on to explore and reinforce their shared values, those values become the base on which significant progress can be made.

Developing Trust

At their most fundamental, collaborations are based on trust. Trust is both a prerequisite for and a product of collaborative activities. Trust is most often discussed in terms of relationships between families and workers, but in fact trust includes other important dimensions. For example, staff at all levels in each system must believe that staff in the other systems will respond appropriately to the needs of children and families and will both share their expertise with and seek help from people from other fields. In addition, staff within each system must trust that officials in their own system will give them the skills to do their jobs well and will support them in their work. This *Facilitator's Guide* includes a more detailed discussion regarding how leaders can address all of these dimensions of trust.

The first task of the Steering Committee will often be to create the level of trust required for systems to work together effectively. It is likely that the same trust issues that emerge during Steering Committee discussions also exist in local jurisdictions and at the frontline. To the extent that members of the Steering Committee create and sustain their own trust, they can communicate and model that trust within their own agencies and to their staff. As people develop trust in one area or around one issue, it will be easier for trust to develop in other areas as well. Trust will be an outcome of the work staff does to identify shared values, increase their understanding and knowledge about each other, participate in training together, and develop communication structures.

The table below, **Dimensions of Trust**, summarizes the many dimensions of trust that have to be addressed.

Dimensions of Trust	
Trust Dimension	**Examples**
Workers have to earn the trust of their clients.	Workers have to: • Refrain from passing judgment. • Be comfortable in their knowledge of program rules and services. • Be forthcoming and clear in presenting options and consequences. • Explain why they need to know certain information and what will happen with information provided. • Not turn over to such an extent that recipients feel no one knows them. • Respect recipients. • Believe that recipients have strengths and potential. • Hold confidential information in confidence and explain to families when and how information may be shared.
Agencies have to earn the trust of their clients.	Agencies have to: • Create forms, brochures, and letters that are user friendly. • Ensure that services exist to help recipients. • Develop written and visual material to help recipients learn about services. • Create the most private and pleasant waiting and interviewing areas possible. • Seek feedback from families regarding services and procedures. • Create policies that support recipients in disclosing problems.
Workers have to trust their skills and capacities.	Workers need opportunities to: • Learn about addiction, child maltreatment, and legal processes. • Identify and explore their personal beliefs and values about addiction and child maltreatment. • Visit substance abuse treatment programs. • Work collaboratively with staff from treatment programs in making shared decisions about services and progress. • Achieve and be recognized for their achievements.
Agencies have to earn the trust of their staff.	Workers need to feel confident that: • If recipients seek help, the agency has resources to provide that help. • They will have ample opportunity for training that includes both conceptual and practical elements, and that they can practice and problem-solve what they have learned. • Their judgment, perspective, and autonomy are respected and valued by supervisors and managers. • The agency has employee assistance plans or other mechanisms for staff who have substance abuse problems themselves or within their families. • They have opportunities for growth.

Task 1: Complete the Collaborative Values Inventory and the Collaborative Capacity Instrument

Children and Family Futures staff have been providing technical assistance to collaborative efforts in States and local jurisdictions for the past decade. This work led them to develop the *Collaborative Values Inventory (CVI)*, a self-administered questionnaire that provides jurisdictions with an anonymous way of assessing the extent to which group members share ideas about the values that underlie their collaborative efforts. (The CVI is included at the end of this section and is available at *www.ncsacw.samhsa.gov*.) The CVI is simple and short, but it identifies areas of commonality and difference that are easily overlooked either because people feel uncomfortable discussing values or because they move directly to program and operational issues.

When disagreements arise, it is easy for people to feel that others are merely protecting turf, playing politics, or unaware or unsympathetic to a need. If a group explores values and beliefs, however, and learns that members feel differently about some basic assumptions that affect community needs and responses, it has a better grasp of why disagreements arise. The group also can respond more professionally and appropriately during such disagreements. For example, value discussions frequently lead to the realization that systems have different beliefs on something so basic as "who is the client." The alcohol and drug system has traditionally viewed parents as clients, and the child welfare system has considered the child to be the client. If this difference is aired and discussed, generally staff from both systems conclude that everyone serves the *family*, even though each may focus on specific aspects of family functioning.

The *Collaborative Capacity Instrument* (CCI) is also a self-administered questionnaire that provides people with information on how well members of their group perceive that systems collaborate and on areas in which members believe that collaboration is either strong or weak. The CCI is also included at the end of this section and can be obtained through *www.ncsacw.samhsa.gov*.

Task 2: Create a Mission Statement and a Statement of Values and Principles

By the end of the Steering Committee kickoff meeting, Committee members will have reached general agreement on issues that are the most important or interesting. After completing and discussing the *CVI* and *CCI*, the group will have a good feel for those values members share and are important to everyone.

The next task for the Steering Committee is to translate that agreement and knowledge into a simple, preferably one-page document that includes a mission statement for the initiative and a list of principles and values that will guide the group in its work. The principles should be specific enough to guide decisionmaking.

The box below provides an example of a mission statement and shared values and principles. The values and principles relate to the practice questions posed in Section III of this guidebook, "Collaborative Practice at the Frontline." Section I of this guidebook includes a list of principles that have been developed in some jurisdictions, and the end of this section includes values and principles developed by the Sacramento County Dependency Drug Court and Cuyahoga County, Ohio. It also includes a statement of values and principles developed jointly by the American Academy of Child and Adolescent Psychiatry (AACAP) and the Child Welfare League of America (CWLA).

Mission Statement

To improve screening and assessment for families involved in the child welfare service system and dependency courts who are affected by substance use disorders.

Shared Values and Principles

Determining the existence and immediacy of a child welfare or substance use issue

- In making decisions regarding child safety and family well-being, practitioners from all systems should consider the possibility of substance use disorders and adopt a "screen out" stance with regard to substance use.
- Regardless of which system (alcohol and drug, child welfare, or dependency court) the family enters and what the presenting problem is, practitioners should systematically inquire about potential involvement with the other systems.

Determining the nature and extent of a child welfare or substance use issue

- Team members' effective communication is more critical than the specific tool in determining the relationship between substance use and child safety or risk.
- Sharing information appropriately is desirable, helpful, and feasible.
- To make appropriate referrals for assessment, people from all systems should understand the range of funding streams that are available and should know how to access them.

Developing treatment and family case plans, monitoring change, transitions, and outcomes.

- Case plans can and should be modified as circumstances change.
- Actions should have consequences that are fair, timely, and appropriate to the action.
- Consequences should apply to families and to staff; consequences should not be used solely as punishments.
- Family progress should be recognized, noted, and shared with family members.

Step Four: Review Current Operations

Steering Committee members will by now have at least a passing knowledge of each other's systems, but it is unlikely that they will have enough knowledge on which to make decisions about policy and practice changes. Therefore, it is important for the members to develop a deeper level of understanding about each system and where systems connect.

Task 1: Define Terms and Processes

Section I features the **SAFERR Terms and Processes in the Child Welfare Service, Alcohol and Drug Service, and Dependency Court Systems** table that provides short definitions and descriptions of processes within all three systems at several points in time during the period they are working with families. The Steering Committee should charge a Subcommittee with using this chart to define, review, and describe each process as it exists in the State or jurisdiction. Experience has shown that this task

includes many "eye opening" moments during which people realize that they have been unaware of or misunderstood other agencies' processes.

At the end of this task, members should understand how other systems operate and how different systems define similar processes in different ways. Most important, the Steering Committee should address differences in language or inconsistencies in processes to develop common terms and descriptions. In addition to setting the stage for changes in policies and practice, creating a uniform set of terms and processes provides a good basis for creating or revising training curricula that can be used with staff in all systems.

Task 2: Complete Worksheet 1: Understanding Our Systems

The outcome of the analysis undertaken in Task 1 can be used to complete Worksheet 1: Understanding Our Systems. A sample completed Worksheet 1 follows on the next page. This worksheet provides the Steering Committee with a short summary of the current situation and concerns about current practice that need to be addressed. Information from this worksheet will be useful in creating the plan of action for the project.

WORKSHEET 1—UNDERSTANDING OUR SYSTEMS *SAMPLE*		
Where Are We Now?		**Issues with Current Policy/Practice**
How is a substance use disorder identified in the CWS system?		
When	Whenever CWS professional identifies it as an issue	CWS professionals often do not have adequate training in identifying and screening for alcohol and drug issues
Where	Wherever the CWS professional is with the family (e.g. CWS office or home visit)	No standard for screening families
By Whom	CWS professional	Over-referral by some CWS professionals and under-referral by other professionals; based on individual knowledge of SUDs
How is this communicated to the other systems?	CWS professional makes referral to ADS treatment provider with signed release of information form and history Inclusion in court report for court-involved families	Release of information form and history are not always being sent to the provider When CWS professional refers to the ADS treatment provider there may be a lack of follow up; individuals not making it to treatment and no one is going after them to try and engage them

PRESENCE AND IMMEDIACY

How is risk of child abuse or neglect identified in the ADS system?		
When	If an incident arises where a provider needs to report child abuse and neglect	Throughout a State, there is no structured way of identifying child abuse and neglect issues; agencies have their own training programs and ways of identifying (or not) children's issues
Where	ADS program	
By Whom	ADS professional	
How is this communicated to the other systems?	Through the CWS hotline	No structured training on mandated reporting laws; no information given when the law changes
How is a SUD identified in the dependency court?		Case specific; no systemic policy/procedure around CWS informing court of alcohol and drug issue
When	At the time of petition filing	
Where	Court	Issue of judges' misunderstanding or having a lack of knowledge around alcohol and drug issues; when and what type of testing is appropriate; same problem with attorneys and other judicial staff
By Whom	Attorney for CWS presents evidence that includes information from the CWS professional	
How is this communicated to the other systems?	Through the court report	

Task 3: Complete Worksheet 2: Where Do We Want To Go From Here?

Worksheet 2 continues the process started with Worksheet 1. Once people understand and agree on how systems currently operate, how information is or is not communicated, and what concerns exist with current policies and practices, they can begin to identify specific changes they want to make. Worksheet 2 is designed to help the Subcommittees, Steering Committee, and others think generally about the changes to be made in the areas of Determining the Presence and Immediacy of a Child Welfare or Alcohol and Drug Issue, Determining the Nature and Extent of the Issue, and Developing and Monitoring Treatment and Case Plans.

As the Steering Committee gets ready to consider and propose changes, it is helpful for members to review the statements of their mission, principles, and values that they developed, to be sure they continue to be the framework that guides decisions and activities.

Using Worksheet 2, Subcommittee or Steering Committee members should—
- Revisit the list of concerns with current problems included in Worksheet 1;
- Identify the desired goals and outcomes for each issue or concern;
- Consider implications of the desired changes; and
- Start to develop action steps.

At this stage, the analysis should address general implications and action steps and not become distracted by the many details that will arise when implementation starts. The plan of action, described below, will address all facets of implementation.

A sample of a completed Worksheet 2 follows this page.

		Identified Issues with Current Policies and Practice	Desired Changes	Implications of Changes							Action Steps
		What issues did we raise in the working session using Worksheet 1 regarding current policies and practice?	**As a collaborative, where do we want to be? What do we want our SAFERR policies/practices to be?**	**Family Involvement**	**Community Partners**	**Training/ Staff Development**	**Information Systems**	**Budget/Funding**	**Agency Policies**	**Legislation**	**How does the collaborative get to where it wants to be? What tasks do collaborative members need to complete to get us there?**
Presence And Immediacy	**Alcohol and Drug Services System**	Statewide there is no structured way of identifying children's issues; agencies have their own training programs and ways of identifying (or not) children's issues

No structured training on mandated reporting laws; no information given when the law changes | Statewide guidelines for ADS providers to ask questions about participants' children; training for ADS providers on guidelines

Online resource guide on services for children from families with SUDs

Protocols for information sharing with CWS and the court | | X | X | X | X | X | | • Develop guidelines and training curriculum
• Develop online resource guide
• Develop protocols for information sharing among ADS, CWS and the court |

WORKSHEET 2—WHERE DO WE WANT TO GO FROM HERE? *SAMPLE*

	WORKSHEET 2—WHERE DO WE WANT TO GO FROM HERE? *SAMPLE*										
	Identified Issues with Current Policies and Practice	**Desired Changes**	**Implications of Changes**							**Action Steps**
	What issues did we raise in the working session using Worksheet 1 regarding current policies and practice?	As a collaborative, where do we want to be? What do we want our SAFERR policies/practices to be?	**Family Involvement**	**Community Partners**	**Training/ Staff Development**	**Information Systems**	**Budget/Funding**	**Agency Policies**	**Legislation**	**How does the collaborative get to where it wants to be? What tasks do collaborative members need to complete to get us there?**
A-21 — **Child Welfare Services System**	CWS workers do not have adequate training in identifying and screening for alcohol and drug issues No standard for screening families Over referral by some CWS workers and under referral by other workers; based on individual knowledge of SUDs Release of information form and history are not always being sent to the provider When CWS worker refers to the ADS treatment provider, there is no follow up; individuals are not making it to treatment and no one is going after them to	Trained CWS staff in identifying and screening for alcohol and drug issues; pilot colocation of ADS worker in CWS office Screen Out policy; all families to be screened for alcohol and drug issues using a standard screening tool Standard screening tool used by all publicly funded treatment providers in the State Protocols for information sharing with ADS and the court Policy and procedure guidelines about follow up on referrals		X	X	X	X	X		• Develop guidelines and training curriculum • Conduct meeting with CWS and ADS administrators to determine where colocation pilot should take place; set up colocation pilot • Develop a Screen Out policy • Conduct research and select the screening tool to be used statewide • Develop referral followup guidelines • Develop protocols for information sharing among ADS, CWS and the court

		Identified Issues with Current Policies and Practice	Desired Changes	Implications of Changes							Action Steps
		WORKSHEET 2—WHERE DO WE WANT TO GO FROM HERE? *SAMPLE*									
		What issues did we raise in the working session using Worksheet 1 regarding current policies and practice?	As a collaborative, where do we want to be? What do we want our SAFERR policies/practices to be?	Family Involvement	Community Partners	Training/ Staff Development	Information Systems	Budget/Funding	Agency Policies	Legislation	How does the collaborative get to where it wants to be? What tasks do collaborative members need to complete to get us there?
Dependency Court		Case specific; no systemic policy/procedure around CWS informing court of alcohol and drug issue Issue of judges misunderstanding or having a lack of knowledge around alcohol and drug issues; when and what type of testing is appropriate; same problem with attorneys and other judicial staff	Trained judges, attorneys and other judicial staff on alcohol and drug issues and issues of children from families with SUDs Standards for inquiry by judges into whether or not families have been screened for SUDs and issues specific to children from families with SUDs; require screens when they have not been conducted		X	X	X	X	X		• Develop training for judges, attorneys, and other judicial staff • Develop standards of inquiry and court ordering of screens for families

Step Five: Develop and Implement a Plan of Action

By now, the Steering Committee has worked through a brainstorm list of all possible ideas and strategies, developed a set of values and principles to guide its work, identified current systems and operations and the problems with the current situation, and developed a list of desired changes. These changes should now be incorporated into a plan of action that focuses on implementation details, specific action steps, tasks, and timelines.

Task 1: Develop a "Visual" of Team Progress to Date

The visual representation of work done in preparation for the plan of action can be used as the first page in the plan and will remind everyone involved of the project's mission, principles, and priorities. It is also a simple, clear record of work accomplished. A sample visual representation follows this page.

Task 2: Develop the Products and Action Steps for the Plan of Action

The plan of action is an extremely important written product of the initiative. It becomes the roadmap or blueprint for the Oversight and Steering Committees and Subcommittees. It serves as the standard against which work of all three groups will be monitored and evaluated. The plan of action should clearly specify the following:

- Major activities to be undertaken;
- Products to be developed;
- Tasks required to complete activities and produce products;
- System and individuals responsible for completing each task; and
- Timelines for completion.

A hypothetical plan of action, **ADS, CWS, and Dependency Court SAFERR Collaborative Plan of Action: Determining Presence and Immediacy**, based on the information included in sample Worksheets 1 and 2, follows the visual representation. Please note that this example is not necessarily a complete or accurate plan for the activities noted. Each Steering Committee or Subcommittee should define its own action steps, tasks, and timelines. The sample is simply an illustration of the concept of a detailed plan of action.

SAFERR Model for Determining Presence and Immediacy

Mission: To improve screening, assessment, engagement and monitoring for families involved in the CWS system and dependency courts who are affected by substance use disorders

Guiding Principles:

In making decisions regarding child and family well being, practitioners from all systems should consider the possibility that substance abuse is a problem and adopt a "screen out stance" with regard to substance abuse

Regardless of which system (ADS, CWS or dependency court) the family enters and what the presenting problem is, practitioners should systematically inquire about potential involvement with the other systems

Desired Changes

ADS System

Statewide guidelines for treatment providers to ask questions about participants' children; training for treatment providers on guidelines

On-line resource guide on services for children from families with SUDs

Policy and procedure guidelines around information sharing with CWS and the court

CWS System

Trained CWS staff in identifying and screening for alcohol and drug issues; pilot co-location of ADS worker in CWS office

"Screen Out" policy; all families to be screened for alcohol and drug issues using a standard screening tool

Standard screen tool used by all publicly funded treatment providers in the State

Policy and procedure guidelines around information sharing with ADS and the court

Policy and procedure guidelines about follow up on referrals

Dependency Court

Trained judges, attorneys and other judicial staff on alcohol and drug issues and issues of children from families with SUDs

Standards for inquiry by judges into whether or not families have been screened for SUDs and issues specific to children from families with SUDs; require screens when they have not been conducted

Collaborative Action Steps

- Develop guidelines and training curriculum for ADS providers
- Develop on-line resource guide for services to children from families with SUDs
- Develop policy and procedure around information sharing among ADS, CWS, and the dependency court
- Develop guidelines and training curriculum for CWS providers
- Develop a pilot to co-locate ADS staff in a CWS office
- Develop a "Screen Out" policy
- Conduct research and select a screening tool to use Statewide
- Develop referral follow up protocols
- Develop training for judges, attorneys, and other judicial staff
- Develop standards of inquiry and court ordering for screens for families

ADS, CWS and Dependency Court SAFERR Collaborative Plan of Action Determining Presence and Immediacy *SAMPLE*			
Goals	**Action Steps/Tasks**	**System/Individuals Responsible**	**Timeline for Completion**
Goal 1—Develop statewide guidelines for ADS providers to ask questions about children	1.1 Convene workgroup on statewide guidelines and training for ADS providers	Representatives of ADS, CWS, dependency court, and any other agencies as deemed appropriate	10/10/06
	Research guidelines from other jurisdictions		12/16/05
	Draft guidelines		1/16/07
	1.2 Steering Committee to review guidelines	Steering Committee	1/30/07
	1.3 Workgroup to edit guidelines based on Steering Committee feedback	Workgroup	2/13/07
	1.4 Elicit input from CWS and ADS providers	Workgroup	3/10/07
	1.5 Workgroup to edit guidelines based on provider input	Workgroup	3/24/07
	1.6 Steering Committee to approve guidelines	Steering Committee	3/31/07
	1.7 Implement guidelines	Administrators and staff of ADS providers	On-going
Goal 2—Implement Training for ADS providers on statewide guidelines	2.1 Convene workgroup on guidelines and training for ADS providers	Representatives of ADS, CWS, dependency court and any other agencies as deemed appropriate	10/10/06
	Research training curriculum		12/16/06
	Select or draft curriculum		1/16/06
	Draft training plan		1/16/07
	2.2 Steering Committee to review training curriculum and plan	Steering Committee	1/30/07
	2.3 Workgroup to edit curriculum and plan based on Steering Committee feedback	Workgroup	2/13/07
	2.4 Elicit input from CWS and ADS providers	Workgroup	3/10/07
	2.5 Workgroup to edit training curriculum and plan based on provider input	Workgroup	3/24/07
	2.6 Steering Committee to approve training curriculum and plan	Steering Committee	3/31/06
	2.7 Train ADS providers	Identified Trainers	On-going

Goal 3—Develop online resource guide on services for children from families with SUDs	3.1 Convene workgroup to develop online resource guide	Representatives of ADS, CWS, dependency court, and any other agencies as deemed appropriate	10/10/06
	Conduct research on local, State and national resources		12/16/06
	Identify Web location for resource guide		12/16/06
	Identify Webmaster		12/16/06
	Draft resource guide		1/16/07
	3.2 Steering Committee to review resource guide	Steering Committee	1/30/07
	3.3 Workgroup to make edits/additions based on Steering Committee feedback	Workgroup	2/13/07
	3.4 Create online format	Webmaster	2/28/07
	3.5 Post online resource guide	Webmaster	2/28/07
Goal 4—Establish protocols for information sharing among ADS, CWS, and the dependency court	4.1 Convene workgroup to develop guidelines for information sharing	Representatives of ADS, CWS, dependency court, and any other agencies deemed appropriate	10/10/06
	Review current practice of information sharing		12/16/06
	Review current information management systems		12/16/06
	Draft protocols for information sharing		2/21/07
	4.2 Steering Committee to review and approve protocol	Steering Committee	2/28/07
	4.3 Implement protocol	Administrators and staff of ADS, CWS, and dependency court	On-going
Goal 5—Implement training for CWS Workers in identifying and screening for SUDs	5.1 Convene workgroup on training for CWS workers and development of colocation pilot	Representatives of ADS, CWS, dependency court, and any other agencies as deemed appropriate	10/10/06
	Research training curriculum		12/16/06
	Select or draft curriculum		1/16/07
	Draft training plan		1/16/07
	5.2 Steering Committee to review training curriculum and plan	Steering Committee	1/30/07
	5.3 Workgroup to edit curriculum and plan based on Steering Committee feedback	Workgroup	2/13/07
	5.4 Elicit input from CWS and ADS providers	Workgroup	3/10/07
	5.5 Workgroup to edit training curriculum and plan based on provider input	Workgroup	3/24/07
	5.6 Steering Committee to approve training curriculum and plan	Steering Committee	3/31/07
	5.7 Train CWS workers	Identified Trainers	On-going

Goal 6—Pilot colocation of ADS Workers in a CWS Office	6.1 Convene workgroup on Training for CWS workers and development of colocation pilot	Representatives of ADS, CWS, dependency court, and any other agencies deemed appropriate	10/10/06
	Research colocation models in other jurisdictions		1/20/07
	Explore interest among CWS offices		4/28/07
	Develop policies and procedures for pilot		4/28/07
	6.2 Steering Committee to review plan for pilot	Steering Committee	5/19/07
	6.3 Steering Committee to select CWS office for pilot	Steering Committee	5/19/07
	6.4 Final touches to plan for pilot	Workgroup	5/26/07
	6.5 Implement pilot	CWS and ADS administrators and staff	6/1/07
	6.6 Review success of pilot to date	Steering Committee	12/15/07
	6.7 Review success of pilot and determine whether going to scale with colocation	Steering Committee	5/31/08
Goal 7—Create a Screen Out Policy Statement	7.1 Convene workgroup to develop Screen Out Policy and develop/select standard screening tool	Representatives of ADS, CWS, dependency court, and any other agencies deemed appropriate	10/10/06
	Research policies in other jurisdictions		1/30/07
	Draft Screen Out policy statement		2/21/07
	7.2 Steering Committee to review Screen Out policy	Steering Committee	2/28/07
	7.3 Workgroup to edit policy based on Steering Committee feedback	Workgroup	3/24/07
	7.4 Steering Committee to approve policy	Steering Committee	3/31/07
	7.5 Implement policy	CWS administrators and staff	On-going

Goal 8—Implement Use of a Standard SUD screening tool by CWS Workers	8.1 Convene workgroup to develop Screen Out Policy and develop/select standard screening tool	Representatives of ADS, CWS, dependency court, and any other agencies deemed appropriate	10/10/06
	Research screening tools		1/30/07
	Select existing tool to use or draft new tool		2/21/07
	8.2 Steering Committee to review screening tool	Steering Committee	2/28/07
	8.3 Workgroup to edit screening tool based on Steering Committee feedback	Workgroup	3/24/07
	8.4 Elicit input from CWS and ADS providers	Workgroup	4/21/07
	8.5 Workgroup to edit screening tool based on provider input	Workgroup	5/5/07
	8.6 Steering Committee to approve screening tool	Steering Committee	5/19/07
	8.7 Implement use of tool	CWS administrators and staff	On-going
Goal 9—Establish guidelines for referral followup	9.1 Convene workgroup to develop guidelines for referral followup	Representatives of ADS, CWS, dependency court, and any other agencies deemed appropriate	10/10/06
	Develop plan for referral followup		2/21/07
	9.2 Steering Committee to review and approve guidelines for referral followup	Steering Committee	2/28/07
	9.3 Implement guidelines for referral followup	Administrators and staff	On-going
Goal 10—Implement training for judges, attorneys and Other judicial staff on SUDs and children's issues	10.1 Convene workgroup to develop training and standards for judges, attorneys, and other judicial staff	Representatives of ADS, CWS, dependency court, and any other agencies deemed appropriate	10/10/06
	Research judicial training in other jurisdictions		1/20/07
	Conduct meeting with the Office of the Court Administrator and the State Bar Association to establish their buy in		1/27/2006
	Select or draft curriculum		4/28/07
	Draft training plan		4/28/07
	10.2 Steering Committee to review training curriculum and plan	Steering Committee	5/19/07
	10.3 Workgroup to edit curriculum and plan based on Steering Committee feedback	Workgroup	6/2/07
	10.4 Elicit input from the Office of the Court Administrator and the State Bar Association	Workgroup	6/30/07
	10.5 Workgroup to edit standards based on input from the Office of the Court Administrator and the State Bar Association	Workgroup	7/14/07
	10.6 Steering Committee to approve training curriculum	Steering Committee	7/21/07
	10.7 Train judges, attorneys, and other judicial staff	Identified Trainers	On-going

Goal 11—Implement Standards for inquiry by judges into screening for families	11.1 Convene workgroup to develop training and standards for judges, attorneys, and other judicial staff	Representatives of ADS, CWS, dependency court, and any other agencies deemed appropriate	10/10/06
	Research standards in other jurisdictions		1/20/07
	Conduct meeting with the Office of the Court Administrator and the State Bar Association to establish their buy in		1/27/07
	Select or draft standards		4/28/07
	11.2 Steering Committee to review standards	Steering Committee	5/19/07
	11.3 Workgroup to edit standards based on Steering Committee feedback	Workgroup	6/2/07
	11.4 Elicit input from the Office of the Court Administrator and the State Bar Association	Workgroup	6/30/07
	11.5 Workgroup to edit standards based on input from the Office of the Court Administrator and the State Bar Association	Workgroup	7/14/07
	11.6 Steering Committee to approve training curriculum	Steering Committee	7/21/07
	11.7 Train judges, attorneys, and other judicial staff	Identified Trainers	On-going
Goal 12—Implement standards for judges to order screenings when they have not taken place	12.1 Convene workgroup to develop training and standards for judges, attorneys, and other judicial staff	Representatives of ADS, CWS, dependency court, and any other agencies deemed appropriate	10/15/06
	Research standards in other jurisdictions		1/20/07
	Conduct meeting with the Office of the Court Administrator and the State Bar Association to establish their buy in		1/27/07
	Select or draft standards		4/28/07
	12.2 Steering Committee to review standards	Steering Committee	5/19/07
	12.3 Workgroup to edit standards based on Steering Committee feedback	Workgroup	6/2/07
	12.4 Elicit input from the Office of the Court Administrator and the State Bar Association	Workgroup	6/30/07
	12.5 Workgroup to edit standards based on input from the Office of the Court Administrator and the State Bar Association	Workgroup	7/14/07
	12.6 Steering Committee to approve training curriculum	Steering Committee	7/21/07
	12.7 Train judges, attorneys, and other judicial staff	Identified Trainers	On-going

Task 3: Develop a Communication Protocol

Systems interact with each other constantly and through a variety of mechanisms. Nonetheless, communication breakdowns, misunderstandings, and gaps are common experiences for agency staff and families alike. Effective communication is the ingredient common to values, principles, trust, and action. As noted throughout this guidebook, the key to quality services is not the tools that are used, but how information from tools and other sources is shared. The clearest test of interagency consensus is whether it works to communicate the status of both parents and their children because both are affected by abuse, neglect, and substance use disorders. Steering Committee and Subcommittee members need to identify key points in all systems where effective communication can and must take place, and they need to develop clear administrative policies and protocols for the proper exchange of confidential information.

The **Pathways of Communication Templates** on the following pages are designed to help staff move beyond preliminary discussions about communication and toward developing a communication protocol. They are intended to be suggestions, and each community will need to adapt the specific information to its own systems and procedures.

The page immediately following this page is the Overview template. It proposes a model for communication across the systems as a whole. The subsequent three pages provide breakout versions of the Overview template, depicting critical junctures of decisionmaking and detailed information that are examples of information that may be needed to be communicated across systems. They are **Pathways of Communication Templates for Determining Presence and Immediacy of an Issue, for Determining the Nature and Extent of the Issue, and for Treatment and Case Plans, Monitoring Change, Transitions, and Outcomes**.

The activities that occur within system are listed in the darker colored columns. The bridges between the systems are represented by the three lighter colored columns.

The Subcommittee or Steering Committee should consider each of these communication points and should adapt them to meet State or local needs. The templates provide a mechanism for staff to understand what activities each system is responsible for undertaking. Once these activities are understood, staff can determine who needs to know what, and when. Staff can then create policies and protocols to share information with family members and among staff.

The goal of communication should derive from serving the whole family and should reduce administrative burden on workers. Each of the communication bridges should be clearly defined, and the content of the information to be exchanged across bridges must be specified.

Pathways of Communication Template

Identification Through Community or Family Awareness of Signs, Symptoms and Behaviors

Family and Extended Family Members

Other Community Agencies

Alcohol and Drug Services

Child Welfare Services

Dependency Court

Screen

Child Abuse Report

Screening

Immediate Need Triage

In-person Safety Assessment

Community Based Family Support Services

Diagnosis

In-person Response/Risk Assessment

Detention/ Shelter Hearing

Multidimensional Assessment

Family Assessment

Treatment Plan and Services

Case Plan Development and Services

Jurisdiction Disposition Hearings

Treatment Monitoring and Transition Planning

Case Plan Monitoring, Permanency Determination

- Review Hearings
- Family Treatment Court Hearings
- Case Closures

Recovery Management

Family Well Being

Outcome Monitoring

Outcome Monitoring

Outcome Monitoring

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Pathways of Communication Template
for Determining Presence and Immediacy of an Issue

Identification Through Community or Family Awareness of Signs, Symptoms and Behaviors

Family and Extended Family Members

Other Community Agencies

Screening

Community Based Family Support Services

Observation or Awareness of Child's:
- Injury
- Lack of Medical Care
- Sexual Abuse
- Inadequate Education
- Neglect
- Excessive Punishment
- Lack of Food
- Harsh Treatment
- Other Service Needs

Results of AOD Screen and Observations of the Following by Parent or Other Individuals in the Home:
- Paraphernalia
- Smell of Alcohol or Drugs
- Slurred Speech
- Lack of Mental Focus
- Off Balance
- Needle Tracks
- Skin Abscesses
- Lip Burns
- Nausea
- Euphoria
- Hallucinations
- Slowed Thinking
- Lethargy
- Hyperactive

Alcohol and Drug Services

Screen

Immediate Need Triage

Diagnosis

Multidimensional Assessment

Treatment Plan and Services

Treatment Monitoring and Transition Planning

Recovery Management

Outcome Monitoring

Observation or Awareness of Child's:
- Injury
- Lack of Medical Care
- Sexual Abuse
- Inadequate Education
- Neglect
- Excessive Punishment
- Lack of Food
- Harsh Treatment
- Other Service Needs

Results of AOD Screen and Observations of the Following by Parent or Other Individuals in the Home:
- Paraphernalia
- Smell of Alcohol or Drugs
- Slurred Speech
- Lack of Mental Focus
- Off Balance
- Needle Tracks
- Skin Abscesses
- Lip Burns
- Nausea
- Euphoria
- Hallucinations
- Slowed Thinking
- Lethargy
- Hyperactive

Child Welfare Services

Child Abuse Report

In-person Safety Assessment

In-person Response/Risk Assessment

Family Assessment

Family Well Being

Outcome Monitoring

Court Reports Including Results of Screen and Observed Behaviors

Court Orders

Dependency Court

Detention/ Shelter Hearing

Outcome Monitoring

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Pathways of Communication Template
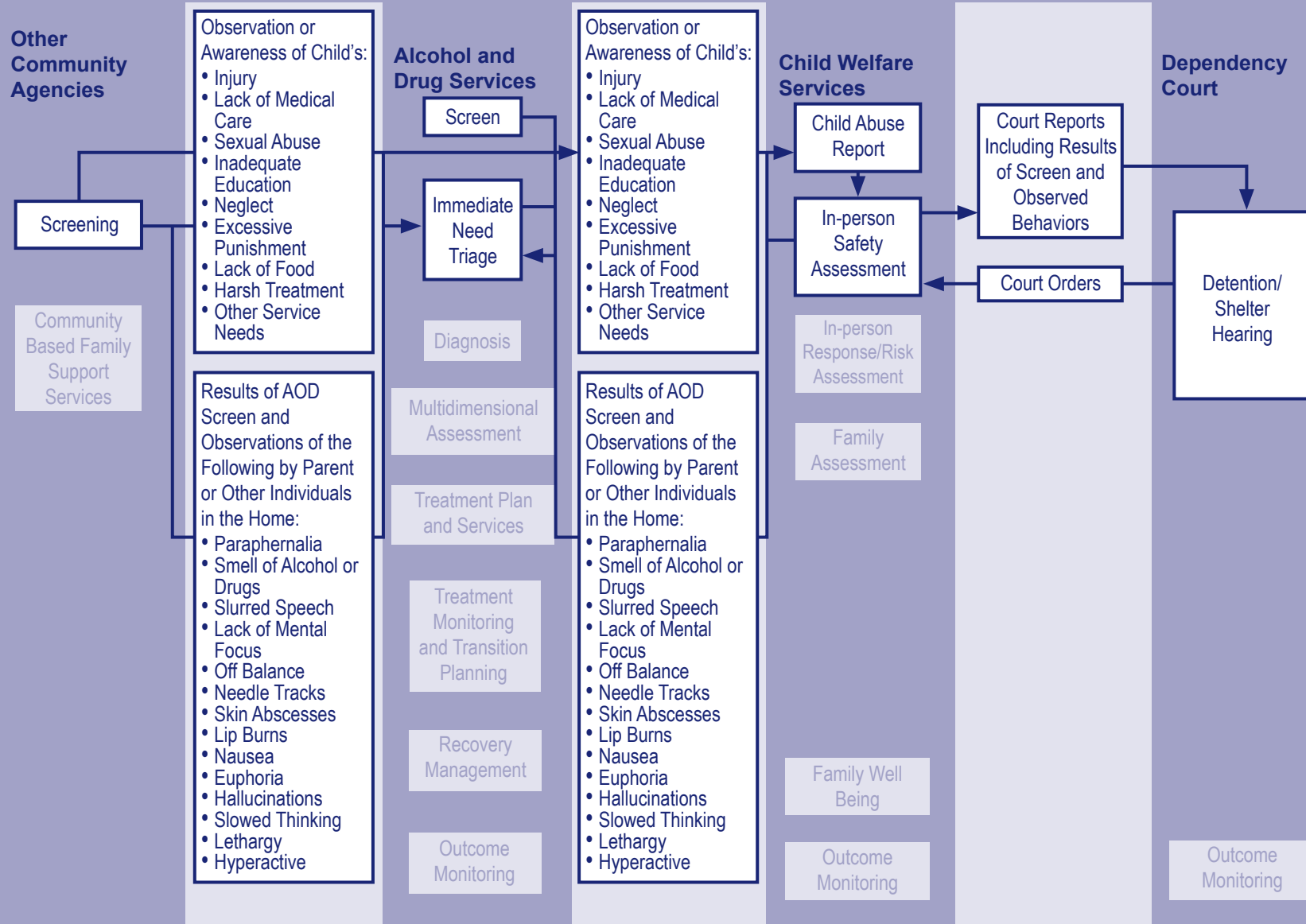## for Determining Presence and Immediacy of an Issue

Identification Through Community or Family Awareness of Signs, Symptoms and Behaviors

Family and Extended Family Members

Other Community Agencies

Alcohol and Drug Services

Child Welfare Services

Dependency Court

- Diagnostic Information
- Differentiation of Substance Use, Abuse, Dependence
- Patterns of Substance Use and History
- Frequency of Use
- Impact of Drug Toxicity
- How Does Alcohol/Drug Use Effect Parent (e.g. blackouts)
- Level of Impairment in Ability to Parent
- Extended Family, Family Strengths, Connections to Community and Resources
- Employment/Education Status
- Parent's Trauma History
- Assessment of Motivation and Engagement Level
- Child Risk Factors Evident During Use
- Parent's Perception of Relationship Between Substance Abuse/Dependency and their Ability to Parent
- Other Family Events (e.g. marriage, death, move, etc.)
- Does Inter-State Compact Apply?
- Treatment Recommendation:
    - Length of Treatment
    - Level of Care
    - Child Visitation Issues
- Additional Service Needs

Screen

Immediate Need Triage

Diagnosis

Multidimensional Assessment

- Treatment Plan
- Activities and Objectives
- Required Drug Testing
- Number Required and Type of Sessions

Screening

Community Based Family Support Services

Referral for Community Support Services

Treatment Plan and Services

Treatment Monitoring and Transition Planning

Recovery Management

Outcome Monitoring

Child Abuse Report

In-person Safety Assessment

In-person Response/Risk Assessment

Family Assessment

Case Plan Development and Services

Case Plan Monitoring, Permanency Determination

Family Well Being

Outcome Monitoring

Court Reports Including Diagnosis and Treatment Recommendation and Level of Care Determination

Court Orders

Detention/ Shelter Hearing

Jurisdiction Disposition Hearings

- Review Hearings
- Family Treatment Court Hearings
- Case Closures

Outcome Monitoring

- Nature and Precipitating Incidents
- Results of Operations and Screens
- Court Orders
- Criminal and Civil Court History
- Prior Child Abuse/Neglect Cases
- Use by Others in the Home
- Past or Present History of Violence
- Was Parent a CWS Dependent
- History of Mental Illness
- Is ICWA Applicable
- CWS Drug Testing Requirements
- Court Orders
- Parent' Perception of Issue
- Extended Family, Family Strengths, Connections to Community and Resources
- Assessment of How Children are Doing
- Results of Alternative Dispute Resolution

Pathways of Communication Template
for Determining Presence and Immediacy of an Issue

Identification Through Community or Family Awareness of Signs, Symptoms and Behaviors

Family and Extended Family Members

Other Community Agencies

Alcohol and Drug Services

Child Welfare Services

Dependency Court

Screen

Immediate Need Triage

Diagnosis

Multidimensional Assessment

Screening

Child Abuse Report

In-person Safety Assessment

In-person Response/Risk Assessment

Family Assessment

Detention/ Shelter Hearing

Jurisdiction Disposition Hearings

- Case Plan Activities, Objectives and Service Strategies
- Visitation Plan
- Required Drug Testing
- Requirements for Reunification
- Visitation Plan

- Treatment Plan, Activities, and Objectives
- Required Drug Testing
- Number and Type of Treatment Sessions Required

Compliance with Court Orders Progress in Meeting Treatment Objectives and Parenting Responsibilities

Community Based Family Support Services

Treatment Plan and Services

Treatment Monitoring and Transition Planning

Recovery Management

Outcome Monitoring

- Progress in Meeting Case Plan Objectives
- Changes in Visitation
- Scheduled Meetings with CWS Workers
- Child Has Been Moved to a New Placement
- Transfers of Case to New Workers
- Court Orders

Case Plan Development and Services

Case Plan Monitoring, Permanency Determination

Family Well Being

Outcome Monitoring

Outcome Data

Court Reports Including Progress in Meeting Treatment and Case Plans

Court Orders

- Review Hearings
- Family Treatment Court Hearings
- Case Closures

Outcome Monitoring

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Step Six: Monitoring and Evaluating Success

The Oversight Committee should charge the Steering Committee with monitoring collaborative efforts. Monitoring is about accountability, and accountability is the difference between an effective collaborative and just another meeting. While Monitoring Success is noted here as Step Six, it really needs to be planned from the beginning of the collaborative effort and included as an ongoing component of the work.

The monitoring process has two focal points:
- Evaluating the collaborative process; and
- Evaluating the benefit to families.

Information collected on both points should continually feed back into the work of the Oversight and Steering Committees and Subcommittees, so that both process and products can be modified based on this information.

Evaluating the Collaborative Effort

The Steering Committee should continually examine itself and the Subcommittees and should closely monitor progress in implementing activities specified in the plan of action. In order to have a foundation for evaluating how far the collaborative has come, it is useful to gather some baseline information. If the various Committees complete the *Collaborative Values Index* and the *Collaborative Capacity Inventory* early on in their work, as described earlier in this section, they can repeat those self-assessments periodically to ascertain whether there have been changes in perceptions about ability to collaborate.

Although it is important to monitor process, it is also important to monitor completion of work. Regular review of progress toward completed activities is essential to keeping the Committees on task, adjusting deliverables as needed, and reporting to the Oversight or Steering Committee and other stakeholders. An example of a Progress Report template, **Determining Presence and Immediacy**, based on the sample plan of action presented earlier, follows on the next page.

Conducting evaluations on an annual or semiannual basis is also beneficial because it allows for a more detailed review of the collaborative process. An example of an evaluation report format based on the sample plan of action follows the Progress Report template.

ADS, CWS, and Dependency Court SAFERR Collaborative
Progress Report
Determining Presence and Immediacy

SAMPLE

Activity/Tasks	Progress Report	Problem/Barriers	Product Modification	Next Steps
Statewide guidelines for ADS providers to ask questions about children				
Training for ADS providers on guidelines				
Online resource guide on services for children from families with SUDs				
Protocols for information sharing among ADS, CWS and the dependency court				
Training for CWS workers in identifying and screening for SUDs				
Pilot colocation of ADS workers in a CWS office				

Activity/Tasks	Progress Report	Problem/Barriers	Product Modification	Next Steps
Screen Out policy statement				
Standard SUD screening tool to be used by CWS workers				
Guidelines for referral followup				
Training for judges, attorneys, and other judicial staff on SUDs and children's issues				
Standards for inquiry by judges into screening for families				
Standards for judges to order screenings when they have not taken place				

SAMPLE

Deliverable	Due Date	Percent Complete	Revised Due Date
Statewide Guidelines for ADS Providers to Ask Questions About Children	**3/31/07**		
Convene workgroup on guidelines and training for ADS providers	10/10/06		
Research guidelines from other jurisdictions	12/16/06		
Draft guidelines	1/16/07		
Steering Committee to review guidelines	1/30/07		
Workgroup to edit guidelines based on Steering Committee feedback	2/13/07		
Elicit input from CWS and ADS providers	3/10/07		
Workgroup to edit guidelines based on provider input	3/24/07		
Steering Committee to approve guidelines	3/31/07		
Implement guidelines	Ongoing		
Training for ADS providers on Guidelines	**3/31/07**		
Convene workgroup on guidelines and training for ADS providers	10/10/06		
Research training curriculum	12/16/06		
Select or draft curriculum	1/16/07		
Draft training plan	1/16/07		
Steering Committee to review training curriculum and plan	1/30/07		
Workgroup to edit curriculum and plan based on Steering Committee feedback	3/10/07		
Elicit input from CWS and ADS providers	2/13/07		
Workgroup to edit training curriculum and plan based on provider input	3/24/07		
Steering Committee to approve training curriculum and plan	3/31/07		
Train ADS providers	Ongoing		

On-line Resource Guide on Services for Children from Families with SUDs	**2/28/07**		
Convene workgroup to develop online resource guide	10/10/06		
Conduct research on local, State, and national resources	12/16/06		
Identify web location for resource guide	12/16/06		
Identify Webmaster	12/16/06		
Draft Resource Guide	1/16/07		
Steering Committee to review resource guide	1/30/07		
Workgroup to make edits/additions based on Steering Committee feedback	2/13/07		
Create on-line format	2/28/07		
Post online resource guide	2/28/07		
Protocols for Information Sharing Among ADS, CWS and the Dependency Court	**2/28/07**		
Convene workgroup to develop guidelines for information sharing	10/10/06		
Review current practice of information sharing	12/16/06		
Review current information management systems	12/16/06		
Draft protocols for information sharing	2/21/07		
Steering Committee to review and approve protocol	2/28/07		
Implement protocol	Ongoing		
Training for CWS Workers in Identifying and Screening for SUDs	**3/31/07**		
Convene workgroup on Training for CWS workers	10/10/06		
Research training curriculum	12/16/06		
Select or draft curriculum	1/16/07		
Draft training plan	1/16/07		
Steering Committee to review training curriculum and plan	1/30/07		
Workgroup to edit curriculum and plan based on Steering Committee feedback	2/13/07		
Elicit input from CWS and ADS providers	3/10/07		
Workgroup to edit training curriculum and plan based on provider input	3/24/07		
Steering Committee to approve training curriculum and plan	3/31/07		
Convene workgroup on Training for CWS workers	Ongoing		

Pilot Colocation of ADS Workers in a CWS Office	**6/1/07**		
Convene workgroup on training for CWS workers and development of colocation pilot	1/20/07		
Research colocation models in other jurisdictions	4/28/07		
Explore interest among CWS offices	4/28/07		
Develop policies and procedures for pilot	5/19/07		
Steering Committee to review plan for pilot	5/19/07		
Steering Committee to select CWS office for pilot	5/19/07		
Final touches to plan for pilot	5/26/07		
Implement pilot	6/1/07		
Review success of pilot to date	12/15/07		
Review success of pilot and determine if going to scale with colocation	5/31/08		
Screen Out Policy Statement	**3/31/07**		
Convene workgroup to develop Screen Out policy and develop/select standard screening tool	10/10/06		
Research policies in other jurisdictions	1/30/07		
Draft Screen Out policy statement	2/21/07		
Steering Committee to review Screen Out policy	2/28/07		
Workgroup to edit policy based on Steering Committee feedback	3/24/07		
Steering Committee to approve policy	3/31/07		
Implement policy	Ongoing		
Standard SUD Screening Tool to be Used by CWS Workers	**5/19/07**		
Convene workgroup to develop Screen Out Policy and develop/select standard screening tool	10/10/06		
Research screening tools	1/30/07		
Select existing tool to use or draft new tool	2/21/07		
Steering Committee to review screening tool	2/28/07		
Workgroup to edit screening tool based on Steering Committee feedback	3/24/07		
Elicit input from CWS and ADS providers	4/21/07		
Workgroup to edit screening tool based on provider input	5/5/07		
Steering Committee to approve screening tool	5/19/07		
Implement use of tool	Ongoing		

Guidelines for Referral Follow Up	**2/28/07**		
Convene workgroup to develop guidelines for referral followup	10/10/06		
Develop plan for referral follow up	2/21/07		
Steering Committee to review and approve guidelines for referral followup	2/28/2006		
Implement guidelines for referral follow up	Ongoing		
Training for Judges, Attorneys, and Other Judicial Staff on SUDs and Children's Issues	**7/21/07**		
Convene workgroup to develop training and standards for judges, attorneys, and other judicial staff	10/10/06		
Research judicial training in other jurisdictions	1/20/07		
Conduct meeting with Office of the Court Administrator and the State Bar Association to establish their buy in	1/27/07		
Select or draft curriculum	4/28/07		
Draft training plan	4/28/07		
Steering Committee to review training curriculum and plan	5/19/07		
Workgroup to edit curriculum and plan based on Steering Committee feedback	6/2/07		
Elicit input from the Office of the Court Administrator and the State Bar Association	6/30/07		
Workgroup to edit standards based on input from the Office of the Court Administrator and the State Bar Association	7/14/07		
Steering Committee to approve training curriculum	7/21/07		
Train judges, attorneys, and other judicial staff	Ongoing		
Standards for Inquiry by Judges into Screening for Families	**7/21/07**		
Convene workgroup to develop training and standards for judges, attorneys, and other judicial staff	10/10/06		
Research standards in other jurisdictions	1/20/07		
Conduct meeting with the Office of the Court Administrator and the State Bar Association to establish their buy in	1/27/07		
Select or draft standards	4/28/07		
Steering Committee to review standards	5/19/07		
Workgroup to edit standards based on Steering Committee feedback	6/2/07		

Elicit input from the Office of the Court Administrator and State Bar Association	6/30/07		
Workgroup to edit standards based on input from the Office of the Court Administrator and the State Bar Association	7/14/07		
Steering Committee to approve training curriculum	7/21/07		
Train judges, attorneys, and other judicial staff	Ongoing		
Standards for Judges to Order Screenings When They Have Not Taken Place	**7/21/07**		
Convene workgroup to develop training and standards for judges, attorneys, and other judicial staff	10/15/06		
Research standards in other jurisdictions	1/20/07		
Conduct meeting with the Office of the Court Administrator and the State Bar Association to establish their buy in	1/27/07		
Select or draft standards	4/28/07		
Steering Committee to review standards	5/19/07		
Workgroup to edit standards based on Steering Committee feedback	6/2/07		
Elicit input from the Office of the Court Administrator and the State Bar Association	6/30/07		
Workgroup to edit standards based on input from Office of the Court Administrator and State Bar Association	7/14/07		
Steering Committee to approve training curriculum	7/21/07		
Train judges, attorneys, and other judicial staff	Ongoing		

Reasons why a deadline was not been met:

Changes in product deliverables:

Key accomplishments achieved:

Barriers encountered in the collaborative relationships:

Resources developed or discovered for collaborative work:

Fiscal and non-fiscal challenges anticipated in the future:

Evaluating the Benefit to Families

In developing the plan to evaluate the benefit to families, the Oversight and Steering Committees should explore existing data systems and determine what information about critical evaluation criteria or performance measures can be easily obtained. The Steering Committee or a Subcommittee should look at how data from different systems can be used to help all agencies understand the benefits to families they serve in common.

Federal data will likely be a useful resource for evaluating changes in families. In addition to other Federal data sources, the Steering Committee should review how its State scored on the Child and Family Services Review outcomes assessed by the Federal team in its most recent review. The Steering Committee should try to use those outcomes and the State's Program Improvement Plan to inform this collaborative initiative.

Key to evaluating the benefit to families is the development of collaborative outcome measures. Unless all partners are held jointly accountable to the outcomes, the collaborative will not succeed in creating "best practice" policies and practices. A critical aspect of successful collaboration is that each system feels the same level of accountability to improving family outcomes.

It is recommended that a professional evaluator be hired early in the process of designing the collaborative initiative. The insight a professional evaluator can provide regarding methodology, variables, potential analyses, and other aspects of the process can save program staff time and help ensure meaningful conclusions from data compiled.

Task 1: Develop Collaborative Outcome Measures

The Oversight Committee or Steering Committee may choose to develop collaborative outcome measures by selecting from measures already in use by each system, it may develop new outcome measures specifically for this project, or it may use both existing and new measures. The Federal Government has changed the way it views outcome measures and the paper *Child Welfare and Alcohol and Drug Treatment and Prevention Outcomes* included at the end of this section describes the outcome measures used by the Children's Bureau and the Center for Substance Abuse Treatment. In whatever way outcome measures are selected, the team should be able to use them in conjunction with State data systems to provide qualitative and quantitative information to illustrate the successes and shortcomings of their collaborative work.

The figure below is a logic model format to help Committees determine outcome measures. Completing the logic model as a group may facilitate an understanding of how the group's activities lead to desired outcomes and help to determine what should be evaluated. For more information on logic models and outcomes, see *Nonprofit Leadership Institute 2002 The Power of Evaluation: Achieving Service Excellence Outcomes What are They?* at *www2.uta.edu/sswmindel/Presentations/Handout%20NPLI.pdf*.

Inputs	→	Outputs		→	Outcomes – Impact		
		Activities	*Participation*		Short Term	Medium Term	Long Term

Situation

PRIORITIES

What We Invest	What We Do	Who We Reach	What the Short-Term Results Are	What the Medium-Term Results Are	What the Ultimate Impact Is

Assumptions

Environment
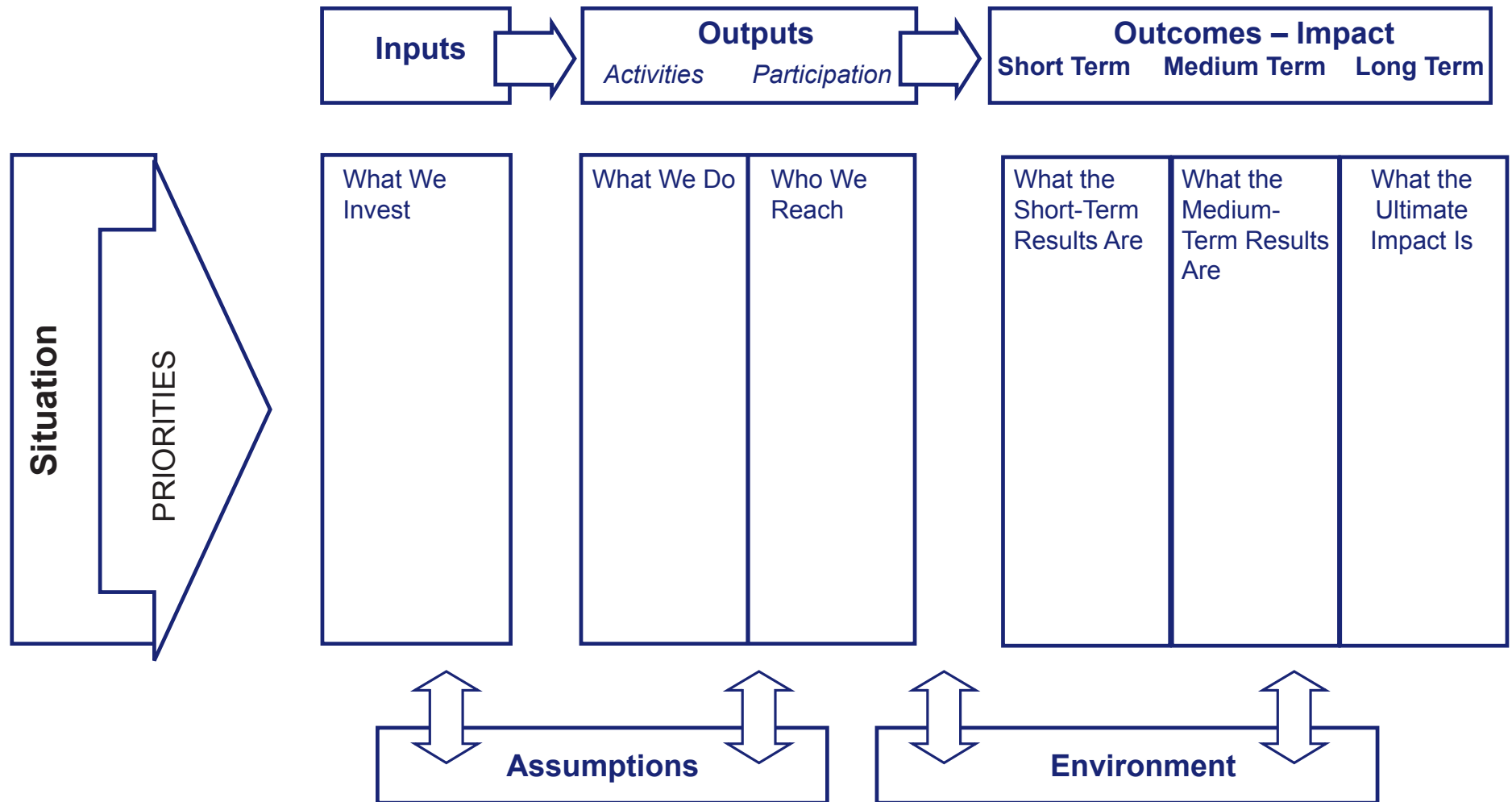
- **Situation:** the conditions that give rise to the program
- **Inputs:** the resources and contributions made to the effort
- **Outputs:** activities and products that reach the people who participate
- **Outcomes:** changes or benefits for individuals, families, groups, communities, organizations, and systems.
- **Assumptions:** beliefs we have about the program, the people, the environment, and the way we think the program will work
- **External Factors:** context and external conditions in which the program exists and which influence the success of the program

Supplemental Worksheets and Tools for Facilitators

The following pages provide samples of tools and other resources that may be useful to facilitators, Steering Committee members, and Subcommittee members. These include—

- The *Collaborative Values Inventory*;

- The *Collaborative Capacity Instrument*;

- The *Collaborative Values Inventory/Collaborative Capacity Instrument* Analysis;

- Principle statements developed by Sacramento County, California, Cuyahoga County, Ohio; and the NCSACW Consortium: Americam Public Human Services Association (APHSA), Child Welfare League of America (CWLA), National Association of State Alcohol and Drug Abuse Directors (NASADAD), National Council of Juvenile and Family Court Judges (NCJFCJ), and National Indian Child Welfare Association (NICWA).

- Child Welfare and Alcohol and Drug Treatment and Prevention Outcomes.

Collaborative Values Inventory

What Do We Believe About Alcohol and Other Drugs, Services to Children and Families, and Dependency Courts?

Many collaboratives begin their work without much discussion of what their members agree or disagree about in terms of underlying values. This questionnaire is a neutral way of assessing how much a group shares ideas about the values that underlie its work. It can surface issues that may not be raised if the collaborative begins its work with an emphasis on programs and operational issues, without addressing the important value issues affecting their work. Learning that a group may have strong disagreements about basic assumptions that affect its community's needs and resources may help the group clarify later disagreements about less important issues that are really about these more important underlying values.

After reviewing the results from a collaborative's scoring of the *CVI*, it is important to discuss the areas of common agreement and divergent views. That discussion should lead to a consensus on principles that the collaborative members agree can form the basis of State or local priorities for implementing practice and policy changes, leading to improved services and outcomes for families.

Identify your own role in your organization:

1. Staff Level:
☐ Frontline staff
☐ Supervisor
☐ Manager
☐ Administrator
☐ Other (specify): _____

2. Gender:
☐ Male
☐ Female

3. Area of Primary Responsibility:
☐ Substance Abuse Services
☐ Child Welfare Services
☐ Dependency Court Judicial Officer
☐ Attorney Practicing in Dependency Court
☐ Domestic Violence
☐ Mental Health
☐ Other (specify): _____

4. Age: _____ Years

5. Jurisdiction of Agency or Court:
☐ Federal Government/National
☐ State Office
☐ Within State Regional Office
☐ County
☐ Community-Based Organization
☐ Reservation
☐ Other (specify): _____

6. Race/Ethnicity:
☐ African-American
☐ Asian/Pacific Islander
☐ Caucasian
☐ Hispanic
☐ Native American
☐ Other: _____

7. Years of professional experience in my primary program area: _____

Circle the response category that most closely represents your extent of agreement with each of the following statements:

1. **Dealing with the problems caused by alcohol and other drugs would improve the lives of a significant number of children, families, and others in need in our community.**

   Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

2. **Dealing with the problems caused by alcohol and other drugs should be one of the highest priorities for funding services in our community.**

   Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

3. **Dealing with the problems of child abuse and neglect should be one of the highest priorities for funding services in our State.**

   Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

4. **Illegal drugs are a bigger problem in our community than use and abuse of alcohol.**

   Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

5. **People who abuse alcohol and other drugs have a disease for which they need treatment.**

   Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

6. **People who are chemically dependent have a disease for which they need treatment.**

   Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

7. **People who abuse alcohol and other drugs should be held fully responsible for their own actions.**

   Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

8. **There is no way that a parent who abuses alcohol or other drugs can be an effective parent.**

   Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

9. **There is no way that a parent who uses alcohol or other drugs can be an effective parent.**

   Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

10. **There is no way that a parent who is chemically dependent on alcohol or other drugs can be an effective parent.**

    Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

11. In assessing the effects of the use of alcohol and other drugs, the standard we should use for deciding when to remove or reunify children with their parents is whether the parents are fully abstaining from use of alcohol or other drugs.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

12. Parents who have been ordered to remain clean and sober should face consequences for noncompliance with those orders.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

13. Parents who are noncompliant with dependency court orders should face jail time as a consequence.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

14. We have enough money in the systems that respond to the problems of alcohol and other drugs today; we need to redirect the money to use it better.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

15. We should fund programs that serve children and families based on their results, not based on the number of people they serve, as we often do now.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

16. We should fund programs that treat parents for their abuse of alcohol and other drugs based on their results, not based on the number of people they serve, as we often do now.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

17. We should provide incentive funds and penalties to courts based on their results in meeting statutory timelines.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

18. If we funded programs based on results, some programs would lose some or all of their funding.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

19. In our community, agencies should involve people from the community and the court system in planning and evaluating programs that respond to the problems of substance abuse.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

20. In our community, agencies should involve people from the community in planning and evaluating programs that serve families affected by child abuse and neglect.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

21. In our community, dependency courts do a good job of involving people from the community in planning and evaluating services and programs in the dependency court.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

22. Judges have a responsibility to be involved with planning communitywide responses to the problems associated with alcohol and other drug use.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

23. Children of substance abusers who are also in children's services should be a high- priority group for targeted substance abuse prevention services.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

24. Substance abuse treatment outcome measures should include indicators regarding the safety, permanency, and well-being of the children of parents who are in their treatment programs.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

25. Child welfare service outcome measures should include indicators regarding the substance abuse recovery status of parents of the children they seek to protect.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

26. Child welfare service outcome measures should include indicators regarding the parents' ability to be effective parents.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

27. Persons who are in recovery and have successfully transitioned out of the child welfare system should play a significant role in supporting and advocating for parents in the child welfare and family court systems.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

28. Changing the system so that more services were delivered closer to the neighborhoods and communities would improve the effectiveness of services.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

29. Services would be improved if agencies were more responsive to the cultural differences between client groups.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

30. The problems of Native American children and families are significant in our community.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

31. **Our agencies and courts do a good job in responding to the needs of Indian children and families in the child welfare and treatment systems.**

    Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

32. **Services would be improved if all clients, regardless of income, who receive services made some kind of payment for the services with donated time, services, or cash.**

    Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

33. **In our community, the judges and attorneys in the dependency court and the agencies delivering services to children and families often are ineffective because they don't work together well enough when they are serving the same families.**

    Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

34. **The dependency courts should provide increased monitoring of parents' recovery as they go through substance abuse treatment, and should use the power of the court to sanction parents if they don't comply with treatment requirements.**

    Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

35. **The most important causes of the problems of children and families cannot be addressed by government; they need to be addressed within the family and by nongovernmental organizations such as churches, neighborhood organizations, and self-help groups.**

    Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

36. **Judges should be the leaders of collaboratives seeking to solve problems associated with substance abuse and child welfare.**

    Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

37. **Our judges' and attorneys' responses to parents with problems of addiction is generally appropriate and effective.**

    Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

38. **The problems caused by use of tobacco by youth are largely unrelated to the problems caused by the use of alcohol and other drugs by youth.**

    Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

39. **A neighborhood's residents should have the right to decide how many liquor stores should be allowed in their neighborhood.**

    Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

40. **The messages that youth receive from the media, TV, music, and other forms of entertainment are a big part of the problem of abuse of alcohol and other drugs by youth.**

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

41. **The price of alcohol and tobacco should be increased to a point where it pays for the damage caused in the community by use and abuse of these legal drugs.**

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

42. **I believe that the significant barriers to interagency cooperation would be resolved if children's services, substance abuse staff, and dependency court staff were involved in a comprehensive training program for child welfare staff.**

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

43. **I believe that confidentiality of client records is a significant barrier to allowing greater cooperation among alcohol and drug treatment, children's services agencies, and the courts.**

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

44. **I believe that publicly funded alcohol and drug treatment providers should give higher priority in allocating treatment slots than they do now to women referred from child protective services (CPS).**

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

45. **Judicial ethics should be interpreted to mean that judges not participate in collaborative efforts involving attorneys who may appear in their courts.**

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

46. **Attorneys who represent parents in dependency court proceedings have an ethical conflict if they advise parents either to admit that they have a substance abuse problem or to seek treatment prior to the court taking jurisdiction in a case. Parents' substance abuse admission could be negatively interpreted during the investigation of the child abuse and neglect allegations.**

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

47. **Some parents with problems with alcohol and other drugs will never succeed in treatment.**

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

48. **The proportion of parents who will succeed in treatment for alcohol and other drug problems is approximately (circle one).**

0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

49. **The proportion of parents in substantiated CPS cases who will succeed in family services, regain custody of their children, and not reabuse or reneglect is (circle one).**

0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

50. **The most important causes of problems affecting children, families, and others in need in our community are (circle only three):**

A lack of self-discipline   The level of violence tolerated by the community

A loss of family values   Lack of skills needed to keep a good job

Racism   The harm done by government programs

Drug abuse   Too few law enforcement personnel

Mental illness   Fragmented systems of service delivery

Domestic violence   Deteriorating public schools

Alcoholism   The way the welfare program works

Poverty   Children born and raised in single-parent homes

Child abuse   A lack of business involvement in solutions

Low intelligence   Too few jails and prisons

Illiteracy   Inadequate support for families of low income who work

The drug business   Economic changes that have eliminated good jobs

Incompetent parenting   An overemphasis upon consumer values

Illegal immigration   Media concentration on negatives

Other: _____

Collaborative Capacity Instrument

Reviewing and Assessing the Status of Linkages Across Alcohol and Drug Treatment, Child Welfare Services, and Dependency Courts

This tool is intended to be used as a self-assessment by State and/or local jurisdiction alcohol and other drug (AOD) service and child welfare service (CWS) agencies and dependency courts* who are preparing to work with each other or who may be seeking to move to a new level of cooperation after some initial efforts. The questions have been designed to elicit discussion among and within both sets of agencies and the court about their readiness for closer work with each other.

Responses from this assessment should be tabulated and distributed, along with the total from all participants, to each State team. The results can be used to compare the jurisdiction with the matrix of progress in linkages (see "Framework and Policy Tools for Improving Linkages between Alcohol and Drug Services, Child Welfare Services and Dependency Courts" at *http://ncacsw.samhsa.gov*) and to prioritize any needed action. The NCSACW has the ability to tabulate these responses via the Internet for interested sites.

Identify your own role in your organization:

1. Staff Level:
☐ Frontline staff
☐ Supervisor
☐ Manager
☐ Administrator
☐ Other (specify): _____

2. Gender:
☐ Male
☐ Female

3. Area of Primary Responsibility:
☐ Substance Abuse Services
☐ Child Welfare Services
☐ Dependency Court Judicial Officer
☐ Attorney Practicing in Dependency Court
☐ Domestic Violence
☐ Mental Health
☐ Other (specify): _____

4. Age: _____ Years

5. Jurisdiction of Agency or Court:
☐ Federal Government/National
☐ State Office
☐ Within State Regional Office
☐ County

6. Race/Ethnicity:
☐ African-American
☐ Asian/Pacific Islander
☐ Caucasian
☐ Hispanic

*Dependency court is used in this document to include the courts that have jurisdiction in cases of child abuse or neglect, or both, and include judicial officers as well as the attorneys who represent parents, children, social services, and the State.

☐ Community-Based Organization   ☐ Native American

☐ Reservation   ☐ Other: _____

☐ Other (specify): _____

7. Years of professional experience in my primary program area: _____

Circle the response category that most closely represents your extent of agreement with each of the following statements:

I. Underlying Values and Principles of Collaborative Relationships

1. **Our State has included the judicial officers and attorneys from the dependency court as partners in the development of new approaches to serving parents with substance abuse problems in the child welfare system.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

2. **Our State alcohol and other drug (AOD) and CWS agencies and dependency courts have used a formal values assessment process to determine how much consensus or disagreement we have about issues related to AOD use, parenting, and child safety.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

3. **Our State AOD and CWS agencies and dependency courts have negotiated shared principles or goal statements that reflect a consensus on issues related to families with AOD-related problems in child welfare and the dependency court.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

4. **Our State has prioritized parents in the CWS system for receipt of AOD treatment services.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

5. **In our State, CWS staff and the courts view alcohol abuse as being as important as other drugs as a contributing factor in child abuse and/or neglect.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

6. **Our State has discussed and developed responses to the conflicting timeframes associated with CWS, Temporary Assistance for Needy Families (TANF), and AOD treatment and child development.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

1. **Our State has developed a joint AOD-CWS-Dependency Court policy on its approach to standardized screening and assessment of substance abuse issues among families in child welfare.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

2. **Our State has successfully outstationed AOD workers at CPS offices and/or the dependency court to help with screening and assessment of clients.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

3. **Our State has multidisciplinary service teams who include both AOD and CWS workers.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

4. **Our State has developed coordinated AOD treatment and CPS case plans.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

5. **Our State supplements child abuse and neglect risk assessment with an indepth assessment of AOD issues and their impact on each family member.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

6. **Our State's child welfare intake process is able to identify prior AOD treatment episodes based on previously negotiated information-sharing protocols.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

7. **Our State's AOD intake process identifies parents who are involved in the CWS system based on previously negotiated information-sharing protocols.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

8. **Our State's AOD providers have sufficient information about the child welfare case to conduct quality assessments among families referred by child welfare to treatment.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

9. **Our State routinely documents AOD factors from its screening and assessment process in the information system.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

10. **When our AOD treatment providers assess clients, they routinely include questions about children in the family, their living arrangements, and child safety issues.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

11. **Our State routinely monitors the implementation and the quality of its screening and assessment protocols.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

III. Daily Practice—Client Engagement and Retention in Care

1. **Our State's CWS staff have the skills and knowledge to talk with their clients about their AOD use and related problems.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

2. **Our State's AOD staff have the skills and knowledge to talk with their clients about child safety and CWS involvement.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

3. **Our State's dependency court judges have the skills and knowledge they need to talk with their clients about child welfare and substance abuse issues.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

4. **Our State's dependency court attorneys have the skills and knowledge they need to talk with their clients about child welfare and substance abuse issues.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

5. **Our systems have assessed common dropout points when clients in care leave the system before completing treatment.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

6. **Our systems have implemented integrated case plans that include the substance abuse recovery plan integrated or linked with the child welfare case plan.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

7. **Our dependency court system has adequate access to treatment monitoring information to determine whether parents are progressing through treatment in a timely way.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

8. **Our State's dependency court system has realistic expectations for CWS parents with AOD problems (e.g., approach to relapse and drug testing issues).**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

9. **Our State's CWS staff provide outreach to clients who do not keep their initial AOD appointment or drop out of treatment.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

10. **Our dependency court staff follow up with the substance abuse treatment program that the parent is ordered to attend if a parent fails to keep a court date.**

    Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

11. **Our State AOD staff track the status of their clients' progress in the CWS system.**

    Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

12. **Our State has developed and trained our staff in approaches with clients that improve rates of retention in treatment once they enter it.**

    Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

13. **In our State, CWS and AOD agencies have agreed on the level of information about clients' progress in treatment that will be communicated from treatment agencies to CWS workers and the courts.**

    Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

14. **In our State, there is an adequate system for monitoring jointly agreed-upon outcomes of child welfare, substance abuse, and dependency court programs and interventions.**

    Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

15. **In our State, client relapse typically leads to a collaborative intervention to reengage the client in treatment and to reassess child safety.**

    Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

16. **In our State, drug testing is used effectively and in conjunction with a treatment program to monitor clients' compliance with treatment plans.**

    Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

17. **Rate your State's AOD treatment services in the following areas:**

	Poor		Fair		Excellent
Gender specific	1	2	3	4	5
Culturally relevant	1	2	3	4	5
Geographically accessible	1	2	3	4	5
Family focused	1	2	3	4	5
Age-specific responses to children's needs	1	2	3	4	5
Adequacy of adolescent treatment	1	2	3	4	5

18. **Rate your State's AOD treatment services in the following areas:**

	Poor		Fair		Excellent
Gender specific	1	2	3	4	5
Culturally relevant	1	2	3	4	5
Geographically accessible	1	2	3	4	5
Family focused	1	2	3	4	5
Age-specific responses to children's needs	1	2	3	4	5
Adequacy of adolescent treatment	1	2	3	4	5

IV. Daily Practice—Services to Children

1. **Our State has implemented substance abuse prevention and early intervention services for most children in the CWS system.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

2. **Our State targets children of substance abusers in the child welfare system for specialized substance abuse prevention programming.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

3. **Our State ensures that all children in the child welfare system have a comprehensive mental health assessment that includes screening for developmental delays, neurological effects of prenatal AOD exposure, and the emotional and mental effects of their parents' substance use.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

4. **Our State ensures that all children in CWS are screened for:**

a) **Neurological effects of prenatal substance exposure**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

b) **Developmental delays associated with parental substance abuse**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

c) **Emotional and mental health problems associated with parental substance abuse**

Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

d) **Substance use disorders**

Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

5. **Our State's Independent Living Program includes significant content on the impact of AOD use.**

Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

6. **Our State has developed a range of programs for children of parents who have substance abuse problems that are targeted on the special developmental needs of these children.**

Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

7. **Our State is familiar with national models of prevention and intervention for children affected by AODs.**

Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

V. Joint Accountability and Shared Outcomes

1. **Our State's AOD agency has identified system outcomes and has communicated them to the CWS agency and the dependency court.**

Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

2. **Our State's CWS agency has identified system outcomes and has communicated them to the AOD agency and the dependency court.**

Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

3. **Our State's dependency court has identified system outcomes and has communicated them to the AOD and CWS agencies.**

Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

4. **Our State AOD and CWS agencies and the courts have developed shared outcomes for CWS AOD involved families and have agreed on how to use this information to inform policy leaders.**

Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

5. Our State has developed outcome criteria in their contracts with community-based providers (who serve CWS–AOD clients) to measure their effectiveness in achieving shared outcomes.

    Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

6. Our State has shifted funding from providers who are less effective in serving clients in the CWS–AOD systems to those who are more effective.

    Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

7. In our State, CWS–AOD involved parents are referred to parenting programs that have demonstrated positive results with this population.

    Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

8. Our State CWS agency shares accountability with its AOD counterpart for successful treatment outcomes for their mutual clients.

    Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

9. Our State AOD agency shares accountability for positive child safety outcomes for clients who have enrolled in treatment programs.

    Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

10. In our State, drug testing is used in the court system as the most important indicator of clients' status in resolving their AOD problem.

    Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

VI. Information Sharing and Data Systems

1. Our State has assessed its data system to identify gaps in monitoring clients involved in CWS and AOD systems.

    Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

2. Our State's data system can retrieve the percentages of families that receive services in AOD and CWS agencies.

    Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

3. Our State has identified the confidentiality provisions that affect CWS–AOD and dependency court connections and has devised means of sharing information while observing these regulations.

    Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

4. **Our State has developed formal working agreements with the courts that include how child welfare and treatment agencies will share information about clients in treatment with the court system.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

5. **Our State consistently documents AOD factors related to the case in our management information system.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

6. **Our State's AOD services have supplemented the alcohol and drug data system to generate data on their clients' children and their clients' CPS involvement.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

7. **Our State has developed the capacity to automate data about the characteristics and service outcomes of the clients who are in CWS and AOD caseloads.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

8. **Our State is using data that can track CWS–AOD clients across information systems to monitor system outcomes.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

VII. Training and Staff Development

1. **Our State CWS ensures that all managers, supervisors, and workers receive training in working with families affected by AODs.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

2. **Our State AOD agency ensures that its staff and providers receive training in working with families in the CWS system.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

3. **Our State has trained court staff in the principles of effective drug treatment and gender specific services for mothers.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

4. **Our State has trained attorneys who practice in the dependency court regarding effective advocacy and basic education regarding substance abuse and addiction.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

5. **Our State has developed joint training programs for AOD, CWS, and court staff and providers to learn effective methods of working together.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

6. **Our State has a multiyear staff development plan that includes periodic updates to the training and orientation received by the staff of both CWS and AOD agencies on working together.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

7. **Our State has training programs that include cultural issues to improve staff's cultural relevance and competency in working with diverse AOD–CWS client groups.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

8. **Our State has revised the State university and social work preservice educational programs so that future staff are prepared to work across systems on substance abuse and child welfare issues.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

9. **Foster parents, guardians, kinship placement providers, and group home providers are sufficiently trained to work on issues related to families with substance abuse problems.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

10. **Training programs regarding substance abuse, child welfare, and dependency court issues that are offered in our State are multidisciplinary in their approach and in their delivery.**

    Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

VIII. Budgeting and Program Sustainability

1. **Our State CWS agency currently uses a portion of its funding for AOD treatment services (excluding drug testing).**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

2. **Our AOD treatment agencies currently use a portion of their funding for services to improve clients' parenting skills.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

3. **Our AOD treatment agencies currently use a portion of their funding for children development screenings for AOD effects on children of their clients.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

4. **Our State uses a portion of its TANF allocations to fund programs for AOD–CWS clients.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

5. **Our State's CWS and AOD agencies and dependency courts have jointly sought funding for pilot projects to work more closely together.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

6. **Our State has identified the full range of potential funding from all sources that could support the changes needed to work more closely across CWS–AOD agencies.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

7. **Our State has identified whether Federal waivers would be appropriate to fully utilize available funds for families in the CWS–AOD systems.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

8. **Our State has a multiyear budget plan to support integrated CWS–AOD services.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

9. **Our courts have sought additional funding to take dependency drug court programs to a countywide scale of operations.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

IX. Working With Related Agencies

1. **Clinical services to address mental health and trauma issues are included in comprehensive assessments and case plans for all families.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

2. **Domestic violence advocacy and services are included in comprehensive assessment and case plans for all families in the CWS and AOD service systems.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

3. **Our State ensures that primary health care and dental care are available for families in the child welfare and AOD service systems.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

4. **Specialized health services for parents with substance abuse problems regarding HIV AIDS, Hepatitis C, and other diseases frequently transmitted among intravenous drug users are accessible in our State.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

5. **Our State CWS staff know how to identify and link families with the support services that are frequently needed by CWS–AOD-involved clients (e.g., transportation, child care, employment, and housing) and make effective referrals to those agencies.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

6. **Our State routinely assesses for rates of referral and service completions for all clinical and supportive services needed by families and monitors barriers to access for these services.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

7. **Our State AOD staff and providers know how to identify and link CWS-involved families with other services that are frequently needed services (e.g., transportation, child care, family violence services, and mental health services) and make referrals to those agencies.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

8. **Our State has AOD support and recovery groups that include a special focus on CWS and child safety issues.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

9. **Our State coordinates with law enforcement, AOD, and CWS to meet the needs of parents and their children affected by the criminal justice system (e.g., visitation for children with incarcerated parents and treatment while parents are incarcerated).**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

X. Working With the Community and Supporting Families

1. **Our State has developed strategies to recruit broad community participation in addressing the needs of AOD–CWS- and dependency court-involved families.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

2. **Our State includes community members in its planning and program development for ubstance abuse issues in child welfare and dependency court services.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

3. **In our State, prevention of child abuse and neglect and substance abuse operates at the community level as well as statewide.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

4. **Our State has developed a formal mechanism to solicit support and input from community members and consumers, and this mechanism is widely used.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

5. **CWS and AOD staff members have access to up-to-date resource directories to locate family support centers and resources.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

6. **Communitywide accountability systems or "report cards" are used to monitor AOD and CWS issues with specific indicators for both systems.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

7. **Our State assists in supporting sober living communities and housing for parents in recovery.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

8. **Consumers, parents in recovery, and program graduates have an active role in planning, developing, implementing, and monitoring services for families with substance abuse problems in the child welfare system.**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

9. **Our State provides aftercare services to parents in the AOD and CWS systems that include the full array of family income support programs (Earned Income Tax Credit (EITC), Child Support, State Children's Health Insurance Program (SCHIP), Food Stamps, Housing Subsidies, and others).**

   Disagree   Somewhat Agree   Agree   Not Sure/Don't Know

Use of the Collaborative Values Inventory (CVI)

As directed by the introduction of the CVI, all team members should fill the instrument out anonymously and submit it to the persons assigned to tabulate the responses. When possible, team members should complete the survey in time for tabulation and analysis to be done in advance of a team meeting that is designed to discuss the responses. This advance response can be done online if the team has such resources.

When advance submission and analysis are not possible, depending on staffing resources and the format of the day's agenda, in some cases it will be possible to provide participants with feedback. Ideally, in a 1- to 2-day workshop, providing feedback should be done as early in the day as possible. A simple, preformatted Excel chart and graph can be used for each question, with tabulators entering the results of each survey in the charts. This process will yield a series of bar graphs that can then be shown to the participants later in the day, or at a subsequent meeting.

The power of the survey is to show graphically and anonymously how much consensus or disagreement exists within the group. A chart that looks like the one below reveals consensus. Clicking on the chart will show the format that underlies it and that would need to be prepared from participants' responses:
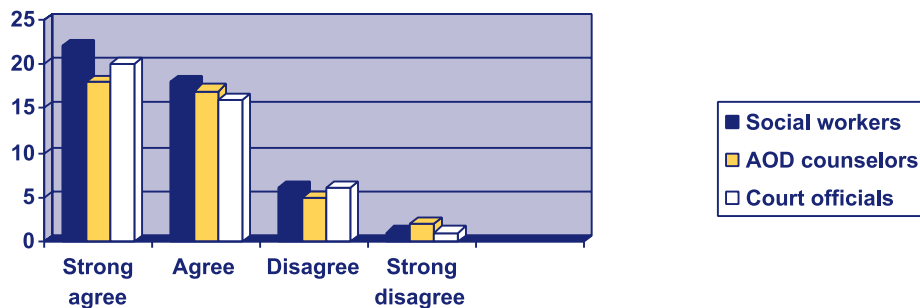
But a chart that looks like the one below reveals significant disagreement among all participants and across different groups as well:
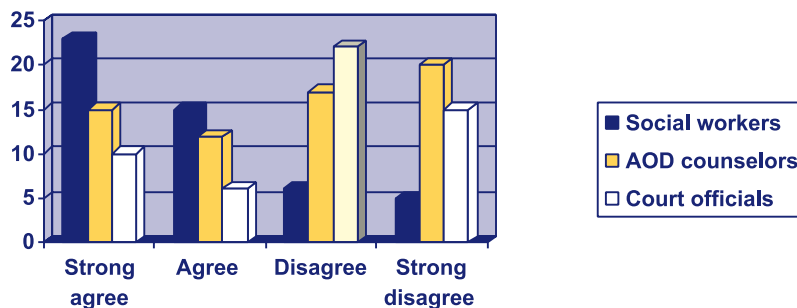
Analysis of the Results

Multiple levels of analysis are possible with the *CVI,* including–

- An overview of the questions on which agreement and disagreements are most evident among the entire group of respondents;

- An analysis of how different professional groups and other subdivisions among the respondents agree and disagree with other groups;

- A statistical analysis of whether the differences are significant based on profession, age and experience of respondents, and other characteristics of the participants; and

- A statistical analysis of whether there are any patterns among the responses that suggest some topics are connected in the attitudes of the respondents.

The latter two kinds of analysis can be provided by local university faculty, loaned executives from local corporations, or staff of local nonprofits familiar with statistical analysis.

Once this analysis has identified the areas of strongest consensus and those in which disagreements are most visible, the task is to develop a narrative that summarizes the strengths of consensus and the challenges of disagreement. The narrative may discuss underlying reasons for the disagreement, such as differences in training and educational backgrounds, recent crises, or funding shifts that may affect team members' responses, or other factors that help explain the responses. Facilitation of discussion of these issues requires skill and careful pacing; facilitators should not attempt to dive immediately into the areas of greatest disagreement and resolve them. In some cases, small group discussions among same-profession or same-agency teams may make it easier to surface and understand disagreements. Facilitators also should point out areas of consensus as collaborative strengths, which the group can build on in their work together.

Use and Analysis of the Collaborative Capacity Instrument (CCI)

The *CCI* has been used in numerous conferences and regional workshops in which teams from State and local governments have filled out the capacity self-assessment as the opening element of a thorough discussion of an interagency team's strengths and problems. The questions in the *CCI* cover all 10 dimensions of the linkages framework developed by the NCSACW for assessing the components of collaborative (see Section IV, Appendix 1, Matrix of Progress in Linkages Among Alcohol and Drug and Child Welfare Services and the Dependency Court System, in "Framework and Policy Tools for Improving Linkages between Alcohol and Drug Services, Child Welfare Services and Dependency Courts" at *http://ncacsw.samhsa.gov*). The format allows team members to make their own ratings on where the team has formed effective working relationships across agency lines. The questions have been designed to elicit discussion among and within both sets of agencies and the courts about their readiness for closer work with each other.

Responses from this assessment should be tabulated in a spreadsheet that shows scores for each question, broken out by respondents from different agencies. This overview of the responses should then be distributed. The results can be used to compare the jurisdiction with the "Matrix of Progress in Linkages Among Alcohol and Drug and Child Welfare Services and the Dependency Court System" and to prioritize any needed action. Team members facilitating the completion of the CCI and analyzing responses need to determine whether they have the resources to collect and analyze responses online.

The analysis should review at least three different facets of the responses:

- Responses grouped by agency and professional background, for example, compare the perceptions of the child welfare staff on budgeting issues with those of the substance abuse counselors and the courts;

- Responses grouped by topic area, for example, compare how positive the participants' responses are on daily practice issues compared with their views of interagency cooperation on joint training; and

- Responses grouped by participants' own characteristics, such as tenure, role in organization, ethnicity, and age.

When teams come together and begin discussion of the responses, strong facilitation is needed in order to ensure that the discussion focuses on the most useful areas to explore. The facilitator should not only point out areas of agreement and disagreement, but also encourage members of the group to explain why they ranked capacity higher in certain areas than others. This process will go better if the initial discussion is positive, for example, raising the question of why a majority of participants rated an area high, rather than starting first with the areas that appear to be lower rated problem areas. Once the group has become accustomed to sharing its attitudes across agency lines, the discussion can move toward the more problematic areas.

Current Research Examining the Reliability of the CVI and the CCI

Dr. Laurie Drabble, Assistant Professor, San Jose State University College of Social Work, will be studying both the CVI and the CCI as part of a larger research project. There are three primary aims of the research project on "Pathways to Collaboration: Understanding the Role of Values and System-Related Factors that Contribute to the Adoption of Promising Practices Between Child Welfare and Alcohol and Drug Systems:"

1. Factor analysis and reliability testing of both the *CVI* and the *CCI*;
2. Examination of areas of commonality and difference between ADS and CWS systems based on data using *CVI* and *CCI* instruments (from approximately 300 respondents representing 11 counties in California); and
3. Exploration of factors that help or hinder collaboration (from a subset of California counties).

The first aim, which includes factor analysis and reliability testing of the *CVI*, will be conducted to explore how the items on the inventory may interrelate to define key "factors" or underlying dimensions of the construct of "values" that impact collaboration. This process also will help identify items that are the strongest measures of these different dimensions as well as items that may not work well and that might be dropped in a future version of the inventory. Finally, the reliability tests will help evaluate the internal consistency of the instruments, or how the items that make up the instrument fit together. All of this will help in the process of refining the instruments and considering how they may best be used in the future.

Examples of Principle Statements

SACRAMENTO COUNTY
DEPENDENCY DRUG COURT PLANNING
PROPOSED VALUES AND WORKING PRINCIPLES
August 2000

1. Alcohol and other Drug (AOD) abuse negatively affects the well being of children, families and communities.

2. Effectively addressing AOD abuse and related problems among families involved in CWS and the Dependency Court system would contribute to better results for children and their families.

3. Most AOD/CWS involved families can reduce risk in their lives and achieve self-sufficiency, particularly when they have access to a full continuum of prevention and treatment services that are tailored to their needs.

4. Interventions and decision-making for AOD/CWS involved families should be based on a thorough assessment, which includes addressing the impact of AOD use on child safety, child development, parental competency and self-sufficiency.

5. Removal of children from AOD involved families should only occur when there are no other options to ensure the child's safety.

6. AOD/CWS parents must be held accountable for maintaining expectations of compliance with case plans and court orders, while at the same time, treated with dignity, understanding and fairness.

7. While sobriety is a necessary goal for parents who abuse or are dependent upon AOD, other measures of client success must be acknowledged and valued.

8. Sustained abstinence must be demonstrated prior to decision making about family reunification when AOD use is identified as a contributing risk factor in the court petition.

9. The use of sanctions is appropriate when done in conjunction with treatment monitoring and balanced against the potential negative impact on children and families.

10. Empowered individuals are capable of defining their needs, identifying their strengths, building solutions and taking charge of their own change process.

11. A wide range of treatment modalities, including narcotic replacement therapy (e.g. methadone treatment), are effective, especially when appropriately matched to client needs.

12. Parents and children respond best to services, which are family focused, culturally sensitive and address a broad array of family needs.

CUYAHOGA COUNTY
BASIC TENETS AND PHILOSOPHY OF START

Those involved with the ADAPT project spent much time clarifying their basic values and assumptions about their work and were pleased with the foundation that they developed. In developing START, we further clarified and supplemented those tenets as follows.

1. We acknowledge that addiction is a disease that requires total abstinence. We support the recovery philosophy and understand that relapse may occur, requiring modified and/or intensified services.

2. We believe that the neglect and abuse of children is often associated with addiction. The potential for losing custody of a child can be the key to bringing a parent into treatment.

3. We understand that other needs of the parent are often rooted in addiction, so that initial services should be directed toward assessment and treatment of the addiction.

4. We believe that a sober, supportive living environment is critical to the recovery process.

5. We are aware that no one agency has the resources and expertise to respond adequately to the needs of the parent who is addicted and who has abused or neglected children.

6. We are committed to modifying agency policies or procedures to support a family's participation in a treatment plan with all service providers.

7. We commit ourselves to a family team approach to work cooperatively, together with the parents and the children, to develop and implement treatment/case plans to meet each family member's individual needs.

8. We believe that keeping the parents and children closely connected is an essential factor in enhancing or preserving their relationship.

9. When a child must be removed from his or her family for protection, we believe the child has the right to frequent visits with the family during the parent s treatment.

10. We agree to work cooperatively toward reunification of the family and child as quickly as the child's protection can be assured.

11. We believe that both the family and the child have the right to continuity of health care services.

12. We are committed to creative approaches to child care, improving parenting skills, building family support systems, etc. for those willing to enter treatment.

Synthesis of Cross System Values and Principles:

A National Perspective

Introduction

The purpose of this statement is to guide the collaborative efforts of NCSACW's Consortium members as they work together to improve systems and practice for families with substance use disorders who are involved in the child welfare and family judicial systems by assisting local and State agencies and tribal governments.

Family members who have substance use disorders undermine family stability and negatively affect child safety, well-being, psychological and emotional development.

Substance abuse prevention, treatment, and recovery support need to be delivered to family members in the context of other issues, such as providing parenting skills classes; addressing mental and physical health needs; providing housing, education, employment, and nutrition services; and addressing domestic violence and criminal justice issues. It is important that sufficient resources and systems are in place to provide families with an adequate chance to recover from substance use disorders through immediate and effective service delivery.

This document reflects the shared values and principles of the NCSACW Consortium Member Organizations and forms the basis for developing collaborative solutions for identified cross-system issues in order to improve outcomes for children and families.

Background

A number of resources were thoughtfully reviewed in order to develop this document, which represents the "best thinking" that has resulted in multiple efforts at both the State and National level to establish shared cross-system values and guiding principles. Among the resources reviewed are:

- AACAP/CWLA Values and Principles for Mental Health and Substance Abuse Services and Supports for Children in Foster Care (2001)

- NASADAD Policy Guide on Collaborative Models for State Alcohol and Other Directors and Child Welfare Administrators (Nardini, 2004)

- NAPCWA Guidelines for a Model System of Protective Services for Abused and Neglected Children and Their Families (1999, an affiliate of APHSA)

- NCJFCJ - Key Principles for Permanency Planning for Children (October 1999)

- Building a Better Collaboration: Facilitating Change in the Court and Child Welfare System (S. Dobbin, Ph.D., S. Gatowski, Ph.D., and D. Maxwell, Ph.D., NCJFCJ, April 2004)
  Courts, Agencies and Communities Working Together: A Strategy for Systems Change, National Judicial Curricula Series (NCJFCJ, 2000)

- NICWA Principles of Collaboration (2001)

- NCSACW Ten-Element Framework for System Linkages among Alcohol and Drug and Child Welfare Services and the Dependency Court System (2003)

- NCSACW Collaborative Values Inventory (2003)

Shared Values and Guiding Principles

Joint Accountability and Shared Outcomes

- The child welfare agency has accepted a shared role in facilitating recovery outcomes for its clients and the AOD treatment agency has accepted a shared role for facilitating child safety for the children of its clients and the court has accepted responsibility for monitoring the outcomes for children and families in the court system.

- All three systems have a shared role in achieving safety, permanency and well-being outcomes for children and families. Outcome data from across the three systems will be used to inform policy leaders and communities to develop, fund, and prioritize services that are known to be effective in improving outcomes.

Principles of Daily Practice

- AOD treatment will be available and accessible for children and families who suffer from a substance use disorder and/or co-occurring disorder.

- There is no "wrong door" for accessing services and creating opportunities for children and families to receive court, agency, and community-based services within their local service systems.

- It is our professional responsibility to provide all children and their families with access to the timeliest, most appropriate, and most effective treatment/prevention services and supports to children and their families in the least intrusive environment possible to ensure the best outcomes.

- Field practice and service delivery will be:

  - child-focused

  - family-driven

  - culturally appropriate

  - strengths-based

  - age-appropriate

  - community-centered

- A continuum of prevention, intervention, treatment and recovery supports are incorporated into the daily practice of all three systems.

- A cross-systems multi-disciplinary team approach will be used to treat children and families in need of services.

- Given the complexity of serving children and families, it is crucial to have a comprehensive array of services.

Information and Data Sharing

- Professionals and caregivers at both the state and community level need to develop common knowledge and shared values about child protection and AOD issues in order to assist children and families with AOD problems to achieve positive outcomes.

- Federal, State, and Tribal government confidentiality laws and HIPAA Privacy provisions will guide and direct the client information sharing process between the AOD and child welfare systems, the courts, and other related systems.

- Information systems are needed that can be linked to share information and monitor family and treatment outcomes, and enable decision makers to manage resources and monitor performance.

- Memorandum of Understandings (MOU) will be jointly prepared across systems to guide system collaboration and information sharing and communications protocols.

Training and Staff Development

- Services and supports for families affected by substance abuse disorders in the child welfare and the court systems will be provided by knowledgeable, skilled service providers who understand the cultural diversity of the families and communities they serve.

- Policies will support culturally competent service delivery in procedures, outreach, advocacy, and training throughout the service delivery system, and incorporates knowledge of ICWA and tribal governments.

- Competencies - Federal and state confidentiality laws and HIPAA Privacy provisions will guide and direct the client information sharing process between the AOD and child welfare systems, the courts, and other related systems.

- Community colleges, universities, graduate and law schools need to develop and offer classes that satisfy professional accreditation requirements.

- Professionals in these fields need to pariicipate in cross and joint-training opportunities.

Budgeting and Sustainability

- It is essential to coordinate services and funding streams (flexible, joint, multiple) across systems to maximize the use of limited resources. Planning across systems makes better use of limited dollars and reduces potential duplication of services while increasing the availability of services and supports for the child and family.

- Sustainability is fostered by cross-system coordination and joint advocacy for the availability of sufficient resources in each system to adequately serve families who have co-occurring problems affecting their parenting, family stability, and risks to children.

Working with Related Agencies

- Collaboration is an essential element to effectively achieving the jointly identified outcomes of multiple systems. This approach requires a commitment to effective communication a willingness to be non-judgmental, and an understanding of how other systems work.

- Communications by and about collaborators must be respectful and positive and any collaboration issues and concerns need to be expressed and resolved privately between collaborating entities.

- As appropriate, a family's substance use disorder will be addressed when working with related agencies, such as health care providers, housing, employment, education, domestic violence advocacy, and mental health services; and when working with the family involved in other courts such as domestic violence, criminal, and delinquency.

Working with the Community and Families

- When services are being designed and funding priorities are being set, family and community input needs to be part of the process.

- The family will be part of the process at each level of planning, service delivery, and evaluation.

Child Welfare and Alcohol and Drug Treatment and Prevention Outcomes

Children's Bureau's Children and Family Services Review Outcomes

Safety Outcomes

Children are first and foremost, protected from abuse and neglect.
Children are safely maintained in their homes whenever possible and appropriate.

Permanency Outcomes

Children have permanency and stability in their living situations.
The continuity of family relationships and connections is preserved for children.

Child and Family Well-Being Outcomes

Families have enhanced capacity to provide for their children's needs.
Children receive appropriate services to meet their educational needs.
Children receive adequate services to meet their physical and mental health needs.

Center for Substance Abuse Treatment Substance Abuse Prevention and Treatment Block Grant Voluntary Treatment and Prevention Performance Measures

Treatment Performance Measures

Employment Status—The change in percentage of *all clients receiving treatment* who reported being employed (including part-time) at discharge.

Living Status—The change in percentage of *all clients receiving treatment* who reported being homeless at discharge.

Criminal Justice Involvement—The change in percentage of persons arrested in the last 30 days at discharge for *all clients receiving treatment*.

Alcohol Use—The change in percentage of *all clients receiving treatment* who reported abstinence at discharge.

Other Drug Use—The change in percentage of *all clients receiving treatment* who reported abstinence at discharge.

Infectious Diseases—Degree to which the Single State Agency provides and/or coordinates delivery of appropriate infection control practices within its service system for substance abuse treatment and prevention services.

Social Support of Recovery—The change in percentage of *all clients receiving treatment* who reported participation in one or more social and/or recovery support activity at discharge.

Retention—Length of stay (in weeks), Average number of services per client, and proportion of clients completing treatment.

Prevention Performance Measures

Number of people served by: age, gender, race/ethnicity
Number of services, by service type
Number and percent of evidenced-based programs and strategies
Perception of risk/harm of substance use
Attitudes about substance use
30 day substance use

Reference

Young, N. K., & Gardner, S. L. (2002). *Navigating the pathways: Lessons and promising practices in linking alcohol and drug services with child welfare* (SAMHSA Publication No. SMA 02-3752). Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.

Appendix B

Fact Sheets

Fact Sheet 1—The Extent of People's Involvement With Alcohol and Drug Services, Child Welfare Services, and the Dependency Court Across Systems

Relatively few empirically sound studies or nationally representative data exist on the number of children in either child welfare services (CWS) or dependency courts who are impacted by their parents' substance abuse or dependence. The two systems that could systematically monitor this population, CWS and substance abuse treatment, are not required in the Federal data systems to capture the data elements that would identify families receiving services in both systems. Several States have added those data elements to their automated data systems; however, they are not accumulated at the Federal level.

Therefore, estimating the number of families affected by substance use disorders and child abuse and/or neglect is extrapolated based on analyzing data collected in specific studies and applying those findings to national statistics of alcohol and drug services and child abuse and neglect. States and communities assessing their own systems' responses may want to take a similar approach using prevalence data and their own State or community's statistics on overall numbers of cases. Therefore, this fact sheet presents the national systems data, the data on the prevalence of the population that crosses over between systems, and explains the sources of the estimates.

Alcohol and Drug Treatment - 2004

- 1.88 million adults were admitted to the public treatment system (U.S. Department of Health and Human Services [DHHS], Office of Applied Studies [OAS], 2006).

- 590,261 (31.5% of 1.84 million) were women (DHHS, OAS, 2006).

- 1.09 million parents (59% of 1.88 million) are estimated to be those of minor children (Hser et al., 2003; Ahmed, 2006).

- 295,000 parents (27.1% of 1.09 million) are estimated to have had one or more children removed by CWS (Hser et al., 2003).

- 108,000 parents (36.6% of 295,000) are estimated to have had their parental rights terminated for at least one child (Hser et al., 2003).

Because there are no national data on the number of children of persons in substance abuse treatment, the percentage of parents of minor children is taken from two sources: the California Treatment Outcome Project (CalTOP) study and Center for Substance Abuse Treatment's (CSAT's) Treatment Outcomes and Performance Pilot Studies (TOPPS-II). The CalTOP study, California's implementation of CSAT's TOPPS-II, found that 60% of persons in treatment were parents (Hser et al., 2003). The cross-State analysis of the TOPPS-II study included primary data from 16 States and also found that 58.5% of persons admitted to treatment had a child younger than age 18 (Ahmed, 2006). Applying those prevalence data to the annual number of adults admitted to treatment results in the estimate that 1.09 million parents of minor children were admitted to substance abuse treatment in 2004.

The Hser et al. (2003) study also found that 27.1% of parents had one or more children removed from their custody and that 36.6% of those parents with a child who was removed had their parental rights terminated.

Applying the percentage of parents with a child removed (27.1%) to the 1.09 million parents in treatment results in 295,000 parents in substance abuse treatment with a child who has been placed in protective custody. Of those parents, approximately 108,000 (36.6%) had their parental rights terminated.

However, the percentage of parents varied significantly by the type of treatment they received. Among parents with a child removed by child protective services (CPS), 29% in outpatient programs, 53% in residential programs, and 80% in narcotic treatment (primarily methadone maintenance) had their parental rights terminated. Similar analyses of the TOPPS-II data set by Ahmed (2006) found that 22% of parents in the 16-State data set had a child removed by CPS and that only 10% of those had their parental rights terminated. However, 36.6% of parents had parental rights terminated or a child removed. In the cross-State data set, termination of parental rights also varied by type of treatment program. Of parents with a child removed by CPS, 66% of those in outpatient programs, 29% in residential care, 3% in narcotic treatment, and 1% in other programs had their parental rights terminated (Ahmed, 2006).

Child Welfare Services - 2004

- 5.5 million children were reported for abuse or neglect DHHS, Administration on Children, Youth and Families [ACYF], 2006a).
- 3.5 million children received an investigation (62.7% of referrals made to CPS) (DHHS, ACYF, 2006b).
- 1.24 million children received postinvestigation services (DHHS, ACYF, 2006c).
- 872,000 children (47.8% of those receiving an investigation or assessment) were victims of neglect (64.5%); physical abuse (17.5%); sexual abuse (9.7%); emotional or psychological abuse (7%); medical neglect (2.1%); and other (14.5%) (DHHS, ACYF, 2006d).
- 268,000 children entered out-of-home care (DHHS, ACYF, 2006c).
- One-third to two-thirds of families in child welfare services are affected by substance use disorders (DHHS, 1999).
- In a study of children served in their home, an estimated 11% of children had a caretaker who met diagnostic criteria of substance dependence (Gibbons, Barth, & Martin, in press).
- Studies using a case review method have found that a range of 43% (Murphy et al., 1991) to 79% (Besinger, Garland, Litrownik, & Landsverk, 1999) of children had a parent with a substance use disorder).

The data on the number of children who received postinvestigation are derived from the Children's Bureau's report that states that 62.7% of children reported (5.5 million) received an investigation (DHHS, ACYF, 2006). The percentages of children by type of victim do not add up to 100% because children can be found to be victims of multiple types of abuse and/or neglect.

In one nationally representative study conducted with families, the children remained in the home and caregivers were assessed for substance use disorder with a diagnostic tool using criteria to determine substance dependence (Gibbons, Barth, & Martin, in press). They found a rate similar to the approximately 11% rate of parental substance use disorders in the general population (DHHS, 1999).

Studies conducted using case review procedures specifically looking for notations of substance use problems among parents of children placed in protective custody have found rates from 43% (Murphy et al., 1991) to 79% (Besinger et al., 1999).

Based on these percentages, it is estimated that 66,440 children (872,000 child victims less 268,000 children who were placed in custody x 11%) were victims of child abuse and/or neglect and received in-home services and had parents who would have met criteria for substance dependence.

It is estimated that 115,240 to 211,720 child victims in out-of-home care (268,000 child victims served out of home x 43% and x 79%) had parents with a substance use disorder.

Dependency Court - 2002

- 1.81 million juvenile court cases were filed (Snyder & Sickmund, 2006a).
- 1.62 million delinquency cases were filed in juvenile court (Snyder & Sickmund, 2006b).
- 193,200 cases (about 12% of 1.62 million) were for drug-related offenses (Snyder & Sickmund, 2006).
- The total number of dependency cases filed is not known; however, 268,000 children were court involved because of placement in foster care (DHHS, ACYF, 2006e).
- The number of children who were court involved but not removed from parents' custody (often referred to as "in home" cases), and for whom a petition alleging parental abuse or neglect was filed in court, is not known.

The national number of child abuse and/or neglect court cases in a given year is not known. Cases filed in the juvenile court are recorded for juvenile offenses; the number of total cases filed was derived from the total juvenile offender cases added to the number of children placed in out-of-home care who would have had a court case filed as a dependent of the court. The national number of court cases filed in which the child is not removed from the home (i.e., court-order in-home cases) is not known. Each case represents a new referral to juvenile court for one or more offenses. A youth may be involved in more than one case in a year. However, it is not known how many children are represented in these court cases because the Juvenile Court Statistics series does not provide a count of individual juveniles brought before juvenile courts.

The figure below, **Children and Parents in Three Systems**, illustrates how each system interacts with the other for part of the population it serves. While the overlap across the three systems is extensive, none of the systems have a specific mandate to differentially address the portion of parents and families with substance use disorders.

Children and Parents in Three Systems

5.5 Million
Children Reported for
Abuse and Neglect

1.81 Million Juvenile and
Dependency Court Cases Filed

1.24 Million Children
Received Post
Investigation Services

268,000 Removed
From Home or
Placed in
Foster Care

268,000
Dependency
Court

1.61 Million
Juvenile
Offenders

294,000
27% of Parents
in Treatment
in CPS

1.085 Million (59%)
Parents with Minor Children

40% without
Minor Children

Estimated Percentage
Substance Abuse Involved

1.84 Million
Substance Abuse
Treatment Admissions

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Fact Sheet 2—Special Issues During Pregnancy

Estimating the number of infants who were exposed to substances in the prenatal period has been conducted in two primary ways: (1) collecting information about substance use from pregnant women or conducting drug tests on them and (2) testing infants at birth. The results vary based on the timing of the verbal screen with the mother, the type of drug test conducted, and the method used to test the infant (e.g., urine or meconium at birth). Each of these methods measures exposure to the substance and does not quantify or assess the number of babies who may be affected by the mothers' substance use.

There are several Federal efforts to monitor substance use among pregnant and recently pregnant women. There are no ongoing national efforts to document the number of substance-exposed infants or those who are identified as substance affected, but several site-specific studies have been conducted. These estimates of prenatal *exposure* to drugs and alcohol include—

- *National Survey on Drug Use and Health (NSDUH)*. The latest Federal data available from the NSDUH report on 2003 to 2004 annual averages of substance use by pregnant women. The NSDUH found that 4.6% of pregnant women aged 15 to 44 used illicit drugs in the past month. Rates varied by length of gestation, however; 8% of first trimester women, 3.8% of second trimester women, and 2.4% of third trimester women reported past month illicit drug use (U.S. Department of Health and Human Services [DHHS], 2005).

  Alcohol use was reported by 11.2% of pregnant women, with 22.2% of women in their first trimester reporting alcohol use and with the rates declining to 7% and 4.9% in the second and third trimesters, respectively. Binge drinking, five or more drinks on the same occasion, was reported by 4.5% of pregnant women. Again, rates varied by length of gestation, with 10.6% of first trimester women, 1.9% of second trimester women, and 1.1% of third trimester women reporting binge drinking (DHHS, 2005).

  Projecting these percentages to the approximately 4 million infants born each year results in a wide range of estimated substance-exposed infants, depending on substance and trimester of use (see Table 1) (DHHS, 2005).

Table 1: Substance Use by Pregnant Women by Length of Gestation, and Estimated Number of Infants Exposed (2003-2004 annual average)			
Substance Used (past month)	1st Trimester	2nd Trimester	3rd Trimester
Any Illicit Drug	8.0% women 327,440 infants	3.8% women 155,534 infants	2.4% women 98,232 infants
Alcohol Use	22.2% women 908,646 infants	7.0% women 286,510 infants	4.9% women 200,557 infants
Binge Alcohol Use	10.6% women 433,858 infants	1.9% women 77,767 infants	1.1% women 45,023 infants

From the same NSDUH data set, cigarette use was reported by 18% of pregnant women. In contrast to other substance use, which declines as the pregnancy progresses, cigarette use by trimester went from 22.7% in the first trimester, down to 13.4% in the second trimester, and then increased to 18% in the third trimester (DHHS, 2005). Prior studies based on this annual survey have found similar rates of substance use. For example, Ebrahim and Gfroerer (2003) estimated that in 1998 there were 202,000 pregnancies exposed to illicit drugs, 1,203,000 pregnancies exposed to cigarettes, and 823,000 pregnancies exposed to alcohol.

Rates of substance use among pregnant women also vary by age groups, with both past month illicit drug and alcohol use highest among teenagers. For instance, 16% of pregnant teens aged 15 to 17 reported past month illicit drug use, compared to 7.8% of those aged 18 to 25 and 2.1% of pregnant women aged 26 to 44. The trend was similar for alcohol use, though the differences were not quite as stark: 14.9% of pregnant teens aged 15 to 17 drank alcohol in the past month, compared to 10.6% of young women aged 18 to 25 and 11.3% of those aged 26 to 44. And, there was a similar trend among those reporting binge drinking, with 8.8% of pregnant teens 15 to 17 reporting binge drinking, compared to 5.1% of those 18 to 25 and 3.8% of those ages 26 to 44. And more than one-fourth (26%) of pregnant teens aged 15 to 17 and 28% of young women aged 18 to 25 reported past month cigarette use, compared to 11.7% of pregnant women aged 26 to 44 (DHHS, 2005). Table 2 summarizes these data.

Table 2: Substance Use by Pregnant Women by Age
(2003-2004 annual average)

Substance Used (past month)	Age Group		
	15-17	18-25	26-44
Any Illicit Drug	16.0%	7.8%	2.1%
Alcohol Use	14.9%	10.6%	11.3%
Binge Alcohol Use	8.8%	5.1%	3.8%
Tobacco Use	26.0%	28.0%	11.7%

The NSDUH also provides information beyond substance use to capture the number of individuals who need alcohol or drug treatment for substance *abuse* or *dependence*. Table 3 shows the results of an analysis using the 2003 NSDUH public use file on the percentage of females classified as needing alcohol or drug treatment, by pregnancy status (Substance Abuse and Mental Health Services Administration, 2005).

Table 3: Percentage of Females Aged 15-44
Classified as Needing Treatment by Pregnancy Status: 2003
(Source: Online Analysis of NSDUH Public Use File)

Needed Treatment in Prior Year for:	Pregnant	Not Pregnant
Alcohol or Illicit Drug Use	8.6%	10.4%
Illicit Drug Use	4.6%	4.0%
Alcohol Use	5.4%	8.1%

- *Fetal Alcohol Syndrome Surveillance Network (FASSNet)* and *State-Based FAS Prevention Program.* From 1997 to 2003, the Centers for Disease Control and Prevention (CDC) funded FASSNet, a statewide, population-based surveillance network to determine the prevalence of Fetal Alcohol Syndrome (FAS) within a geographically defined area. The five States participating in FASSNet were Alaska, Arizona, Colorado, New York, and Wisconsin. CDC studies from FASSNet showed FAS prevalence rates ranging from 0.2 to 1.5 cases per 1,000 live births in different areas of the United States (CDC, 2005)

  Other prenatal alcohol-related conditions, such as alcohol-related neurodevelopmental disorder (ARND) and alcohol-related birth defects (ARBDs) are believed to occur about three times as often as FAS (CDC, 2005). Though the FASSNet cooperative agreements with five States ended in 2003, its methodology has been adapted for use by the CDC's more recently funded FAS Prevention Program, which includes cooperative agreements with seven States. The seven States currently participating in the FAS Prevention Program are Colorado, Michigan, Minnesota, Missouri, Oregon, South Dakota, and Wisconsin (Miller et al., 2002). The CDC also monitors the prevalence of alcohol use among women of childbearing age through the Behavioral Risk Factor Surveillance System (BRFSS) survey.

- *Screening During Pregnancy.* In a study of more than 7,800 pregnant women enrolled in prenatal care clinics in five communities who were screened for substance use with the 4P's Plus©, approximately one-third (32.7%) had a positive screen. Four of the communities conducted followup assessments on all women with a positive screen and found that 15% of those continued to use substances after learning of the pregnancy (Chasnoff et al., 2005).

- *The Pregnancy Risk Assessment Monitoring System (PRAMS).* PRAMS, currently used in 32 States, collects data based on self-reported maternal behaviors and experiences that occur before, during, and shortly after pregnancy. Through cooperative agreements between the CDC and these 32 State governments, information on the use of alcohol and tobacco before and during pregnancy is compiled; questions on illegal drug use are included in the survey at the discretion of the State (Beck, Johnson, Morrow, Lipscomb et al., 1999).

  In some of these States, maternal substance use is reported at levels that corroborate States' other estimates and national survey data. For instance, PRAMS indicates that during their last trimester of pregnancy 3% to 8% of women used alcohol and 5% to 14% used tobacco (Beck, Morrow, Lipscomb, Johnson et al. 2002).

- *Infant Development, Environment, and Lifestyle (IDEAL) Study.* This longitudinal study is used to assess the outcomes associated with prenatal methamphetamine exposure. Participating sites were selected because of their known high rates of methamphetamine problems and include Los Angeles, CA; Des Moines, IA; Tulsa, OK; and Honolulu, HI. The prevalence of drug use has been determined by both mothers' self-report of substance use during pregnancy and testing of infants' meconium at birth. The results of the IDEAL study, which are not representative of the country as a whole, were collected in 2004. These data have been compared to the National Pregnancy and Health Survey (NPHS) that was collected in 1992 to 1993. Nearly half (44%) of the methamphetamine users had used other illicit drugs. Table 5 shows the results (Arria et al., 2006).

Table 5: Infant Development, Environment, and Lifestyles (IDEAL) and the National Pregnancy and Health Survey (NPHS)		
Substance	IDEAL (2004)	NPHS (1992-1993)
Alcohol	22.8%	18.8%
Tobacco	25.4%	20.4%
Marijuana	6.0%	2.9%
Methamphetamine	5.2%	0.1%
Any Illicit Drug	10.7%	5.5%

When the figures in each table are evaluated together, the data can be summarized as follows:

- An estimated 8% to 11% of the 4.1 million live births (in 2004) involved prenatal exposure to illegal drugs.

- Binge alcohol drinking ranges from nearly 11% of women in the first trimester to 1% in the third trimester.

- Prenatal exposure to alcohol includes an estimated 22% of pregnant women during the first trimester and 5% of women in the third trimester.

- Tobacco use by pregnant women exposes approximately one-quarter of babies with mothers younger than age 26.

- When tobacco data are included, the three types of exposure—prenatal use of illicit drugs, alcohol, and tobacco—are the basis for the statement that "more than one million" children are affected by prenatal substance exposure (McGourty & Chasnoff, 2003). This figure differs from the 400,000 to 440,000 estimated infants who test positive, because the smaller figure measures only prenatal use that can be detected at a point in time—birth—whereas the surveys that are the basis for the larger figure cover prenatal substance use during the entire period of pregnancy.

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Fact Sheet 3—Research Studies on the Prevalence of Substance Use Disorders in the Child Welfare Population

Despite the recent attention to the prevalence of parental substance use disorders among the families in child welfare services, there are few national data on the number of children in foster care due to parental substance use disorders. Studies that have examined the prevalence of substance abuse among the child welfare population have found widely varying rates. Estimates range from 40% to 80% of families involved with child welfare having substance abuse problems, although no established methods are available to measure this nationally (Young, Gardner, & Dennis, 1998; Semidei, Radel, & Nolan, 2001). The U.S. Department of Health and Human Services (DHHS) in its Report to Congress in 1999 (DHHS, 1999) stated that between one-third and two-thirds of children in the child welfare system were affected by substance use disorders. They attributed the lower number to those cases in which children were not removed from the parents' care and the larger percentage to those cases in which children were placed in protective custody.

The wide variance in estimates found in studies is attributed to many factors including:

- the population studied (e.g., in-home versus out-of-home cases, urban versus nonurban, and foster care versus those being investigated for allegations of abuse or neglect);
- the definition of the substance use disorder (any use versus criteria of substance abuse or dependency);
- the method used to determine substance involvement (e.g., risk assessment measures, prospective assessment tools, or retrospective case reviews);
- whether the substance use is a primary or secondary contributing factor in the child welfare case;
- which program area families are participating in(e.g., family preservation services when children have remained in the home versus adoption services when parental rights have been terminated); and
- the method of analysis being used.

Only one published study has estimated the prevalence of substance use disorders among child welfare-involved families in which the children have not been removed from the parent(s)' custody (often referred to as "in-home" cases). The data come from the National Study on Child and Adolescent Well-Being (NSCAW), which has collected data from a nationally representative sample of children in child welfare services (Gibbons, Barth, & Martin, in press).

The NSCAW research protocol included assessing caregivers' substance dependence using the Composite International Diagnostic Interview Short Form (CIDI-SF) and questions from the child welfare worker interview. The CIDI-SF evaluates criteria of substance abuse or dependence in the year before the data collection. Among caregivers retaining custody of their children, 9.6% had a problem with alcohol or drugs according to the child welfare worker assessment, and only 3.9% were alcohol or drug dependent according to the CIDI-SF. Overall, 11.1% of caregivers whose children live at home with them had a substance abuse problem (Gibbons et al., in press). This rate is lower than what has generally been estimated (Semidei et al., 2001) and is similar to the percentage of children in the general population (11%) who are living with a parent who is alcoholic or needs treatment for illicit drug abuse (DHHS, 1999). The prevalence rate may be lower because the CIDI-SF measures dependence, not use or abuse, and is limited to the past 12 months. In a group of families receiving Temporary Assistance to Needy Families, Phinney and colleagues (2005) found that "very few respondents satisfy criteria for

drug (3.4%) or alcohol (4.1%) dependence in any given year, but that a significant group (20.5%) had a disorder at some point in their lifetime."

Another analysis of the NSCAW examined the prevalence of substance abuse problems among caregivers of different race/ethnicities who had retained custody of their children (Libby et al., 2006). Rates of substance abuse problems were found to be lowest among Hispanic (6.1%) and American Indian (7.5%) caregivers. African American (11.3%) and Caucasian (13.2%) caregivers had the highest prevalence of substance abuse problems based on child welfare worker reports.

It is important to note that child welfare workers in the NSCAW study did not identify a substance abuse problem among 61% of caregivers who met *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM IV)*, criteria for alcohol or drug dependence (Gibbons et al., in press). Child welfare workers were even more likely to miss potential alcohol or drug problems among caregivers who used but were not dependent on the substance. In addition, child welfare workers were significantly more likely to identify substance abuse problems with open in-home cases compared to closed in-home cases (Gibbons, et al., in press).

Among cases in which children have been removed, a higher percentage of parental substance use disorders is often reported. Over the last decade, several studies reported substance use with various methods and operational definitions of substance abuse; a selection of these studies is summarized chronologically below.

The NSCAW study found that among children who were in out-of-home care, 46.1% of their caregivers had a problem with alcohol or drugs according to the child welfare worker assessment. This finding compares to 10% of the in-home caregivers having an active alcohol or drug problem (DHHS, 2005).

For parental substance abuse to be included in their study, Murphy and colleagues required that substance abuse be noted in reports from a psychiatrist or psychologist or in a court-ordered screening (Murphy et al., 1991). In their sample of 206 cases from Boston, they found that in 43% of the cases, at least one of the parents had a documented problem with either alcohol or drugs. The percentage rose to 50% when they included allegations of substance use in the court report. Alcohol, cocaine, and heroin were the three most frequently mentioned abused substances. Parents with documented substance abuse were significantly more likely than non-substance-abusing parents to have been referred previously to child protective agencies, to be rated by court investigators as presenting a high risk to their children, to reject court-ordered services, and to have their children permanently removed (Murphy et al., 1991).

A study by the U.S. General Accounting Office (GAO) in 1994 found that in random samples of case files in California, New York, and Pennsylvania, 78% of foster children's cases that were reviewed had at least one parent who was abusing drugs or alcohol (GAO, 1997). At the request of the Senate Finance Committee, another study by the GAO reviewed case records in Los Angeles and Chicago in 1998. The GAO report estimated that about two-thirds of all foster children in both California and Illinois had at least one parent who abused drugs or alcohol, and most had been doing so for at least 5 years. Most of these parents abused one or more drugs, such as cocaine, methamphetamines, and heroin (GAO, 1998).

Besinger and colleagues (1999) operationally defined substance abuse to include any known history of substance abuse and therefore found relatively higher rates of substance-abusing parents in their study. They studied case records of 639 urban children placed in out-of-home care due to maltreatment and reported that 79% of children in foster care had a parent with "parental substance abuse."

McNichol and Tash (2001) reported that the percentage of children in specialized foster care with a primary reason of parental substance abuse was 14%. Another 76% of children were "affected in some way by parental substance abuse."

Sun and colleagues (2001) explored the impact of caregiver alcohol and other drug use (AOD) on child protective services (CPS) case substantiation among 2,756 families from the Department of Family and Youth Services in a Nevada county. They found that 11% of investigated cases and 16% of substantiated cases had an indication of caregiver AOD use. In addition, the authors found that CPS cases with indications of AOD use were more likely to be substantiated than cases without AOD use. The authors attributed the low prevalence rate to the fact that social workers in Nevada are not required to document AOD use in their case records.

A similarly low rate of 11.2% for caregiver substance abuse was found among 447 children in kinship care in a large urban southeastern county while under CPS supervision (Rittner & Dozier, 2000). Women who delivered newborns who were substance exposed represented 32.9% of total complaints. Caregivers were considered substance abusers if records referred to arrests for possession of substances, if paraphernalia were found at the residence, or if evaluations provided by substance abuse programs indicated substance abuse histories. The requirement of possession or paraphernalia may explain the low prevalence rates found in this study. It is unclear why the prevalence rate would be so low when the substance abuse treatment evaluations were also used. It is possible that some caregivers in this study may not have completed an AOD assessment or that CPS failed to inform the treatment provider that the caregiver was being referred because of suspected substance abuse. Thus, if the caregiver denied having a substance abuse problem, the AOD treatment provider would have no information to justify further assessment.

Finally, in a recent study using a random sample of 443 children with substantiated child abuse or neglect cases in an urban setting, Jones found that 68% of the children had mothers who abused alcohol or drugs and that 37% of the children had mothers who abused both alcohol and drugs (Jones, 2005).

It is important to note that the prevalence of the substance use disorder does not yet tell us the nature and extent of the substance use disorders and, more important, how the parents' substance use might be affecting the risk or safety factors associated with the child abuse or neglect. The prevalence of substance use disorders alone does not provide sufficient information on which to base decisions about the custody status of children or how parents' substance use disorder must be addressed in the case plan so that reunification might occur. To emphasize this point, the data on the cocaine/crack and methamphetamine epidemics and their relationship to child welfare caseloads will be examined.

The number of methamphetamine users has increased over the past several years and has spread from the West throughout the Midwest and into the Eastern States. In 2003, according to the National Survey on Drug Use and Health, 607,000 persons reported methamphetamine use in the prior 30 days (DHHS, OAS, 2004). In the same survey, 2.281 million persons reported cocaine use in the prior 30 days, indicating that the number of methamphetamine users was considerably smaller than the number of cocaine users (DHHS, OAS, 2004). Despite the relatively rapid increase in methamphetamine use across the Nation, the population of children in out-of-home care in the country has been on a steady decline since 1999, with 523,000 children in care in 2003.

Summary

- In a study of the prevalence of substance abuse and dependence in a representative sample of in home cases, a lower level of prevalence was found than has previously been reported;

- Caseworkers misidentified caregivers with a substance use disorder most of the time; and

- Case reviews and various methodologies among cases in which children have been removed generally report two-thirds to three-quarters of cases are affected by parental substance use.

Although finding substance use disorders alone does not constitute substantiated child abuse or neglect, knowledge about these disorders is essential to assess contributions they may make to risks for children, and such findings always represent an opportunity for treatment.

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Appendix C

Understanding the Needs of Children in Families Involved in the Child Welfare System Who Are Affected by Substance Use Disorders

Understanding the Needs of Children in Families Involved in the Child Welfare System Who Are Affected by Substance Use Disorders

Introduction and Purpose

The impact of parental alcohol and drug use and abuse on children creates complex and sometimes controversial issues. Research on the effects of prenatal and postnatal exposure to alcohol, tobacco, and other drugs has produced limited and conflicting results. A key challenge to this research has been determining the impact of prenatal exposure versus postnatal environmental risks, as well as differentiating the effects of specific substances and specific doses of substances. Despite these challenges, there is substantial evidence that children who are prenatally substance exposed or experience postnatal environments impacted by parental substance use disorders (SUDs) are at risk for poor developmental outcomes. (The term "substance use disorders (SUDs) is more precise and indicates diagnostic criteria of the *Diagnostic and Statistical Manual (DSM)* of substance abuse or dependency.) In addition, increases in the number of children in out-of-home care throughout the late 1980s and 1990s have been attributed to increased drug use among pregnant women (Lester, Andreozzi, & Appiah, 2004).

This appendix highlights how parental substance use disorders can affect children both prenatally and postnatally, how to improve screening of children by raising awareness of signs to look for in children, and provides information about potential referral sources for assessments and services.

Most studies have estimated that 10% to 20% of children who were prenatally exposed to alcohol and/or drugs enter the child welfare system around the time of birth and about one-third of them enter out-of-home care within the first few years (U.S. Department of Health and Human Services [DHHS], 1999). These children are more likely to have mothers who have had previous involvement with the child welfare service system and to have siblings in foster care (McNichol, 1999). In addition, once in foster care, children from families with substance use disorders are more likely to remain there than are maltreated children from families without those disorders (DHHS, 1999). Inconsistent parenting and a chaotic family life can be a primary effect of substance use disorders, which result in children lacking safe, predictable home environments.

Importance of Federal Legislation

Major pieces of legislation highlight the importance of timely screening and intervention with children whose parents have substance use disorders, as well as the importance of communicating the needs of children across service systems.

There are several provisions in the Adoption and Safe Families Act (ASFA) of 1997 regarding the timing of case processing. Two provisions that have potential impact on families with substance use disorders are (1) that child welfare agencies develop a permanency plan within 12 months after a child enters foster care, and (2) that States initiate proceedings to terminate parental rights if the child has been in out-of-home care for 15 of the most recent 22 months. Although 12 or 15 months is a long time in the life of a child, it is a relatively short time in the recovery process of a parent who is emerging from a history of years, or even decades, of alcohol and/or drug abuse. Without intervention, the child's unaddressed needs may impede a parent's recovery or interfere with the timely resolution of the child's permanent plan. In addition to the time limits on reunification under ASFA, the Federal legislation's "fast track" provision gives States the option of bypassing efforts to reunify families in certain egregious situations. Depending on how a State views parental substance use disorders, there is the possibility that they will

fast track termination of parental rights for these families, particularly those in which an infant has been prenatally exposed to illicit drugs.

Another recent legislative change with implications for screening and assessment of children is the Child Abuse Prevention and Treatment Act (CAPTA), as reauthorized in the Keeping Children and Families Safe Act of 2003. CAPTA amendments include new requirements for responding to the identification of infants known to be prenatally exposed to drugs. States must assure through a certification that they are operating a statewide program relating to child abuse and neglect, or have in effect a State law, which includes policies and procedures for appropriate referrals to child protection service systems. The State law also includes policies and procedures for other appropriate services that address the needs of infants born and identified as affected by illegal substance abuse or withdrawal symptoms resulting from pre-natal drug exposure. This law further includes a requirement that health care providers involved in the delivery or care of such infants notify the child protective service system. CAPTA amendments state that such notification shall not be construed to establish a definition under Federal law of what consti-tutes child abuse, or require prosecution for any illegal action. However, they require the development of a plan of safe care for the infant. Even though screening of infants is generally conducted by hospital personnel, child welfare agencies will require access to effective screening and assessment information so that the plan of care can be developed and implemented.

Multiple Opportunities for Interventions

Figure 1 (below) illustrates the intervention points for services and supports needed by children and their families: (1) pre-prenatal (i.e., health and conditions of parents prior to pregnancy); (2) prenatal; (3) the birth event itself; (4) the perinatal period of newborns; and (5) infancy, preschool, middle childhood, and adolescence. At each of these intervention points, there is an opportunity to intervene to achieve a healthy birth, progress in child development, and parents' recovery. If the opportunity is missed at one stage—for example, if prenatal care does not result in a non-substance-exposed birth—the challenge is to seek another opportunity at the next stage.

Figure 1: Policy and Practice Intervention Points for Children and Families

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┌─────────────────────────────┐
│ 1. Promote awareness of      │
│    effects of prenatal       │
│    substance use             │
└─────────────────────────────┘
              │
              ▼
┌─────────────────────┐     ┌─────────────────────┐
│ 2. Screen pregnant   │────▶│ 2. Initiate enhanced │
│    women for         │     │    prenatal services │
│    substance use     │     └─────────────────────┘
└─────────────────────┘               │
              │                        │
              ▼                        │
┌─────────────────────┐               │
│ 3. Screen newborns   │               │
│    for substance     │               │
│    exposure          │               │
└─────────────────────┘               │
              │                        │
              ▼                        ▼
┌─────────────────────┐     ┌─────────────────────┐
│ 4. Ensure newborn's  │◀───▶│ 4. Respond to        │
│    safety and respond│     │    immediate needs of│
│    to newborn's needs│     │    family members    │
└─────────────────────┘     └─────────────────────┘
              │                        │
              ▼                        ▼
┌─────────────────────┐     ┌─────────────────────┐
│ 5. Identify and      │     │ 5. Identify and      │
│    respond to needs  │◀───▶│    respond to ongoing│
│    of                │     │    needs of family   │
│                      │     │    members           │
│ Infant  Preschooler  │     └─────────────────────┘
│ Child   Adolescent   │
└─────────────────────┘
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This context of *sequences of multiple opportunities* highlights the critical importance of prenatal services, but the fact is that most prenatally exposed infants' exposure is not detected and the great majority of these infants go home with their birth mothers. This reality underscores the importance of ongoing screening, as well as effective links among the several agencies involved in prenatal and pediatric care and their connections to interventions for parents. Effective screening practices and communication among multiple agencies, as noted in all the sections of the SAFERR guidebook, are the key to success with children's services as well.

Of equal importance, however, is the difficulty of separating out substance abuse effects from the many other effects of poverty, parental mental illness, violence and trauma, and other co-occurring issues in

the family. Intervention must be aimed at the right problem, and sometimes, when multiple issues need to be addressed, a single-focused program approach can become part of the problem itself, by ignoring critical facets of the child's and family's reality.

Prenatal Substance Exposure: Extent of the Problem

The latest Federal data available from the National Survey on Drug Use and Health (NSDUH) report on 2003 to 2004 annual averages of substance use by pregnant women. As summarized in Table 1, the NSDUH found that 4.6% of pregnant women aged 15 to 44 used illicit drugs in the past month. Rates varied by length of gestation, however, with 8% of first trimester women, 3.8% of second trimester women, and 2.4% of third trimester women reporting past month illicit drug use.

Alcohol use was reported by 11.2% of pregnant women, with 22.2% of women in their first trimester reporting alcohol use and the rates then declining to 7% and 4.9% in the second and third trimesters, respectively. Binge drinking, five or more drinks on the same occasion, was reported by 4.5% of pregnant women. Again, rates varied by length of gestation, with 10.6% of first trimester women, 1.9% of second trimester women, and 1.1% of third trimester women reporting binge drinking (Substance Abuse and Mental Health Services Administration [SAMHSA], 2005).

Projecting these percentages to the approximately 4 million infants born each year results in a wide range of estimated substance-exposed infants depending on substance and trimester of use.

Table 1: Substance Use by Pregnant Women by Length of Gestation, and Estimated Number of Infants Exposed (2003-2004 annual average)			
Substance Used (past month)	*1st Trimester*	*2nd Trimester*	*3rd Trimester*
Any Illicit Drug	8.0% women 327,440 infants	3.8% women 155,534 infants	2.4% women 98,232 infants
Alcohol Use	22.2% women 908,646 infants	7.0% women 286,510 infants	4.9% women 200,557 infants
Binge Alcohol Use	10.6% women 433,858 infants	1.9% women 77,767 infants	1.1% women 45,023 infants

From the same NSDUH data set, cigarette use was reported by 18% of pregnant women. In contrast to other substance use, which declines as the pregnancy progresses, cigarette use by trimester went from 22.7% in the first trimester, down to 13.4% in the second trimester, and then increased to 18% in the third trimester (SAMHSA, 2005). Prior studies based on this annual survey have found similar rates of substance use. For example, Ebrahim and Gfroerer (2003) estimated that in 1998 there were 202,000 pregnancies exposed to illicit drugs, 1,203,000 pregnancies exposed to cigarettes, and 823,000 pregnancies exposed to alcohol; the study used data from the 2000 National Household Survey on Drug Abuse.

Rates of substance use among pregnant women also varied by age groups, with past month illicit drug and alcohol use highest among teenagers. For instance, 16% of pregnant teens aged 15 to 17 reported past month illicit drug use, compared to 7.8% of those aged 18 to 25 and 2.1% of pregnant women aged

26 to 44. The trend was similar for alcohol use, though the differences were not quite as stark: 14.9% of pregnant teens aged 15 to 17 drank alcohol in the past month, compared to 10.6% of young women aged 18 to 25 and 11.3% of those aged 26 to 44. And more than one-fourth (26%) of pregnant teens aged 15 to 17 and 28% of young women aged 18 to 25 reported past month cigarette use, compared to 11.7% of pregnant women aged 26 to 44 (SAMHSA, 2005).

It is important to note that these estimates of alcohol and drug use during pregnancy and the number of substance-exposed infants are likely lower than what actually occurs, due to individuals underreporting substance use and limited screening and testing done by physicians and hospitals. In one large-scale study of newborns in a high-risk urban obstetric population, 44% tested positive for illegal drugs, while only 11% of mothers admitted to illegal drug use (Ostrea, Brady, Gause, Raymundo, & Stevens, 1992).

A study assessing the long-term effects of methamphetamine exposure on children recently published estimates on the prevalence of use by pregnant women. The sites included in the study are Des Moines, Honolulu, Los Angeles, and Tulsa. These cities are known to have higher rates of methamphetamine use; thus, the results are not representative of the country as a whole. Researchers used mothers' self-report or drug testing of the infant's meconium to ascertain the prevalence of substance exposure. They found that 25% of pregnant women smoked tobacco, 22.8% drank alcohol, 10% had used any illicit drug with 6% using marijuana, 5.2% used methamphetamine, and 1.3% used barbiturates (Arria et al., 2006).

Prenatal alcohol exposure can lead to changes in brain structure and have long-term consequences for the children as well as societal costs (Riley & McGee, 2005). It has been estimated that between 2,000 and 8,000 babies are born with Fetal Alcohol Syndrome (FAS) (0.2 to 2.0 per 1,000 live births) (May & Gossage, 2001). The estimate of Fetal Alcohol Spectrum Disorders is 1% of live births or approximately 40,000 babies each year (Sampson et al., 1997). The financial cost of substance use during pregnancy, attributed primarily to extended hospital stays, has been estimated at between $22.3 million and $125 million per year (James Bell Associates, 1993). The cost of medical care, special education, and residential care for persons with mental retardation has been estimated at $1.6 million for each person with FAS (Lupton, Burd, & Harwood, 2004).

Screening for Use During Pregnancy (prenatal or at birth)

In an ideal situation, screening for prenatal substance exposure would happen well before birth through high-quality prenatal care, so that the use of alcohol, tobacco, and/or drugs is treated and the impact to the unborn child reduced. It has been noted that if alcohol use is detected and treated, and use stopped by the third trimester, the rate of fetal alcohol syndrome can be reduced (Little, Young, Streissguth, & Uhl, 1984). Similarly, if a pregnant woman using cocaine is able to stop her drug use, the medical complications commonly seen with prenatal cocaine exposure such as premature birth are significantly reduced (Chasnoff, Griffith, MacGregor, Dirkes, & Burns, 1989). However, the identification of use and abuse of alcohol and/or drugs by pregnant women is one of the most often missed diagnoses in prenatal care (Chasnoff, Neuman, Thornton, & Callaghan, 2001). Many factors contribute to the infrequency of detection of use and abuse during pregnancy including a physician's lack of knowledge about substance abuse and addiction or how to respond if use and/or abuse is detected; misconceptions about the liability surrounding treating pregnant women with substance use disorders; and bias in testing and a physician's personal beliefs about whether or not the patient is likely to be using or abusing substances (Chasnoff et al., 2001; Lester et al., 2004).

In addition to the physician-focused factors that reduce the likelihood of detecting substance use and/or abuse among pregnant women is the fact that many pregnant women who use drugs receive little or no

prenatal care. One key reason for this lack of prenatal care is fear on the part of the pregnant woman of punitive action and/or the possible loss of custody of the child as a result of her drug use (Lester et al., 2004). Because quality prenatal care is such a critical factor in increasing the likelihood of good birth outcomes, everything possible should be done to ensure that the physician's office is seen as a safe and supportive resource to all pregnant women.

Because of barriers regarding the identification of substance use and abuse during pregnancy, many instances of prenatal substance exposure are left undetected until birth, and whether or not it is even detected at that point is dependent on many other factors including hospital policies, medical staff bias, and methods of screening. Screening at birth can be implemented through either a universal (everyone is tested at birth) or targeted (selective testing as determined by risk factors selected by the institution) approach. Each approach has its limitations, including the possibility that a hospital using universal testing could deter use of that hospital by mothers giving birth to infants who have been substance exposed, and the significant bias possible in deciding who is screened under a targeted approach (Ondersma, Simpson, Brestan, & Ward, 2000; Lester et al., 2004).

This discussion leads to a final note about the context of screening during pregnancy: these data, combined with what is known about hospital screening practices, make clear that the great majority of children who are prenatally exposed to alcohol, tobacco, or other drugs go home with their birth parents with these effects totally undetected. One analysis suggests that as many as 95% of all prenatally exposed children—children whose mother used alcohol, tobacco, or other drugs at some point during her pregnancy—are not detected by screening methods at birth (Gardner & Otero, 2004). The screening methods discussed below include tools that can be used prenatally or at the time of birth or shortly thereafter.

Commonly Used Screening Tools

As discussed in Section III of this guidebook, "Collaborative Practice at the Frontline," the issues specific to screening for substance use during pregnancy are most often germane to prenatal care staff and physicians. However, child welfare agencies 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.

Prenatal substance exposure can be screened for in a variety of ways. Most commonly, the methods used, either alone or in combination, include:

- Verbal screen with mother;
- Review of mother's history and medical records;
- Observation of mother and/or newborn; and
- Drug testing (urine, blood, hair, or meconium).

Verbal Screens

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 (see Section III for additional information on specific screening tools for prenatal care 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 (Morse, Gehshan, & Hutchins, 1997; Chasnoff et al., 2001). The summary of these and other tools, including information on the tools' features, strengths, and concerns, can be accessed at *http://www.nofas.org/healthcare/screen.aspx*.

Review of History/Medical Records and Observation

A review of the mother's history and medical records may reveal a previous substance-exposed birth or other potential risk factors including a history of substance abuse or dependence. The observation of the mother and infant by a trained professional may reveal signs of substance exposure such as indications of substance use disorder in the mother (e.g., the smell of alcohol, withdrawal symptoms, and needle punctures), or tremors or irritability in the newborn (more signs of exposure in infants are detailed below).

Drug Testing

Urinalysis testing at birth has traditionally been the most common technique for identifying prenatal substance exposure (Lester et al., 2004; Ondersma et al., 2000). However, this method of testing is limited, since the detection of substances in urine is only possible for a few days after use. Such a test does not provide information about use throughout pregnancy if a mother has stopped use as the birth of her child draws closer.

Because of the limitations of urinalysis, scientists have been working to find more effective testing methods. Both meconium (the first stool eliminated by the newborn) and hair analysis have shown promising results for detecting substance use over a broader window of time (Lester et al., 2004; Chan, Caprara, Blanchette, Klein, & Koren, 2004; Ondersma et al., 2000). Meconium analysis is seen as superior to traditionally used biological matrixes such as blood and urine because it is a discarded material for which collection is easy and noninvasive. In addition, meconium is a cumulative matrix in which substances accumulate from the 13th week of gestation through birth, allowing for a much greater window of opportunity for detection (Chan et al., 2004). Hair begins to develop in a newborn at approximately 6 months' gestation, with substances accumulating in the hair shaft and remaining there until the hair is cut, thus allowing for the possible detection of substances used during the last 3 months of pregnancy (Chan et al.).

Postnatal Alcohol/Drug Environment

Children from families with substance use disorders not only face the risk of prenatal substance exposure, but can also be exposed to a harmful postnatal environment. Approximately 11% of children in the United States (8.3 million) live with at least one parent who is an alcoholic or in need of treatment for the abuse of illicit drugs. An estimated 2.3 million of these children live with a parent who abuses both alcohol and illicit drugs (DHHS, 1999). Postnatal risk factors associated with parental substance use disorders include a parent who may still be involved in a chaotic lifestyle of drug- and/or alcohol-seeking behavior, such as illicit drug sales or drug manufacturing, and a lack of adult interpersonal support systems. Postnatal drug use by parents may expose children to violent or traumatic events, the effects of living in poverty, lack of parental education, lack of proper health care, and inconsistent caregivers.

The growing body of literature on the effects of childhood trauma underscores the continuing effects of this overlapping problem as it is affected by parents' substance abuse. Recent work conducted by treatment centers that are part of the National Child Traumatic Stress Network has documented how child development can be affected by childhood trauma (Schnoll & Wilford, 1997). Parental mental illness is another important postnatal risk factor, because maternal depression is associated with serious cognitive and social-emotional outcomes for children (Karr-Morse, Brazelton, & Wiley, 1997).

When a postnatal environment becomes so severe that a child must be removed from the family for abuse or neglect, the child may also be subjected to various risk factors associated with multiple out-of-home placements and inconsistent caregiving environments. Children placed in foster care who have been prenatally exposed to alcohol and/or drugs often place higher demands on caregivers, resulting in foster parent burnout and a higher rate of returning those children to the child welfare system (Burry, 1999). These children face difficulty in forming meaningful attachments with a primary caregiver. The lack of development of secure attachment early on is shown to result in subsequent behavioral problems for children (Kronstadt, 1991). It should also be noted that a substantial number of children who are removed from parents with substance use disorders remain within their own family environments, with some of these children placed with relatives who are part of the overall family system affected by alcohol, drugs, and co-occurring problems.

A Note on Issues Related to Methamphetamine Production

In looking at the postnatal environment, special consideration must be given to the issues related to manufacturing, distribution, and trafficking of methamphetamine. Methamphetamine is relatively inexpensive and easy to make, and children may be exposed to dangers of home-based labs, including the risks of lab-related explosions and fires, exposure or ingestion of the toxic chemicals and waste products associated with methamphetamine production, and exposure to the highly psychoactive stimulant itself. The developing brain and other organ systems of children are more susceptible than adults to the damages caused by the chemicals and drugs resulting in neurological and developmental problems (Drug Endangered Children Resource Center, 2000).

Prenatal Substance Exposure and Postnatal Environment Factors: Consequences for Children

To understand the forces influencing the futures of children exposed to alcohol and drugs, it is necessary to assess many different factors that affect their lives. The consequences of alcohol and drug use are the products of a complex interchange of biological, psychological, and sociological events. The complexity of screening and assessment for these children is compounded by two realities: (1) there is no absolute profile of developmental outcomes based on a child's exposure to parents' substance use, abuse, or dependence (Chasnoff, 1997); and (2) other problems arising in parental behavior, competence, and disorders interact with substance use, abuse, and dependence to cause multiple co-occurring problems in the lives of these children.

Although prenatal substance exposure has been noted to be "…the single largest preventable cause of developmental compromise of American Children today (Malanga & Kosofsky, 2003)," research is both complex and tentative on the short- and long-term effects of prenatal exposure on children. In addition to the lack of consensus of the short- and long-term impacts of parental substance use disorders on children, it is difficult to determine the independent effects of a single substance on brain development, or the effects of prenatal exposure weighed against the child's postnatal environment (Malanga & Kosofsky, 2003; Chiriboga, 2003; Lester et al., 2004; Kronstadt, 1991; Mathis, 1998). These difficulties

arise because substance use during pregnancy is most commonly polydrug use (more than one substance), with illegal substance use being combined with the use of alcohol and/or cigarettes, and is often accompanied by a lack of proper nutrition, other medical complications, and no prenatal care.

At the same time, postnatal environmental risk factors, such as inadequate parenting skills and support, violence, living in poverty, and parental mental illness, have been shown to result in or exacerbate developmental and behavioral problems in children (Carta et al., 2001; Ondersma et al., 2000; Kronstadt, 1991). In the same way that environmental factors can negatively impact the development of a child, longitudinal research on the developmental effects of prenatally exposed children suggests that a stable, nurturing postnatal environment can ameliorate many of the negative effects of prenatal exposure (McGourty & Chasnoff, 2003).

Lester and his colleagues describe three types of consequences of maternal use of alcohol, tobacco, and illegal drugs (MATID) on child development:

- *Immediate drug effects*—the direct teratogenic consequences, or those that can cause birth defects, of MATID exposure occurring during the first year prior to postnatal environmental effects becoming salient;
- *Latent drug effects*—also direct teratogenic effects that affect brain functioning but do not become relevant until later in development; and
- *Postnatal environment effects*—environmental factors such as sociodemographics, caregiving context (such as mother's stress or neighborhood safety) and style, and caregiver characteristics (both risk and protective factors) (Lester et al., 2004).

Although it may be hard to separate the effects of prenatal substance exposure and a child's postnatal environment, children whose parents have substance use disorders are at an increased risk for disabilities and have a higher incidence of demonstrable disabilities, as well as involvement with the child welfare service system (Lagasse & Lester, 2000; National Center on Addiction and Substance Abuse, 1999; Byrd, Neistadt, Howard, & Brownstein-Evans, 1999; DHHS, 1999). Below is a discussion of commonly noted consequences of parental substance use disorders on children, designed to inform alcohol and drug, child welfare, and court professionals.

Fetal Alcohol Syndrome (FAS)

In contrast to the mixed results in research on prenatal exposure to illicit drugs, alcohol use during pregnancy has shown to have clear and demonstrable impacts on the child. FAS is one of the most widely recorded problems associated with alcohol use during pregnancy (Lester et al., 2004). Individuals with FAS exhibit a pattern of neurological, behavioral, and cognitive deficits that affect growth, learning, and socialization and consist of the following four major components:

- A characteristic pattern of facial abnormalities, including small eye openings, indistinct or flat philtrum (the midline groove in the upper lip that runs from the top of the lip to the nose), and a thin upper lip;
- Growth deficiencies, including low birth weight;
- Brain damage, including a small skull at birth, structural defects, and neurologic signs such as impaired fine motor skills, poor eye-hand coordination, and tremors; and
- Maternal alcohol use during pregnancy (SAMHSA Fetal Alcohol Spectrum Disorders Center of Excellence, 2004, February).

The behavioral and cognitive impacts associated with FAS can include the following:

- *Global functioning*—global limitations on learning and problem solving and lower IQ;
- *Executive functioning*—the way information is organized and activities planned, for example, remembering all the steps required for a specific task or the order of those steps;
- *Auditory processing*—inability to effectively understand a sequence of sounds, affecting the understanding of language and remembering instructions and simple problems;
- *Visual/spatial skills*—disabilities in the perception of visual information and understanding spatial relationships, affecting fine and gross motor skills and handwriting;
- *Specific math disability*—difficulty learning arithmetic and other math concepts;
- *Memory*—difficulty learning new information and retrieving stored information; and
- *Attention*—different from the effects of attention deficit hyperactivity disorder, there may be a difficulty learning new information being focused on and in shifting attention to another task, or multitasking (Streissguth, Barr, Kogan, & Bookstein, 1996).

While an estimated 0.5 to 3 cases per 1,000 births per year (2,000 to 12,000 births) result in a child with FAS (May & Gossage, 2001), not all individuals exposed to alcohol in utero are later diagnosed with FAS. However, nearly 40,000 babies are born per year within the broader category of Fetal Alcohol Spectrum Disorders (FASD). The term "FASD" is used to describe individuals with FAS as well as those with behavioral, cognitive, and other deficiencies who do not have the physical facial abnormalities of individuals with FAS. FASD is not a clinical diagnostic term but refers to the following conditions: FAS, alcohol-related birth defects, and alcohol-related neurodevelopmental disorder (ARND). Alcohol-related birth defects can include abnormalities of the heart, eyes, ears, kidneys, and skeleton (e.g., holes in the heart, underdeveloped kidneys, and fused bones) (SAMHSA Fetal Alcohol Spectrum Disorders Center of Excellence, 2006, January). Because many of the deficiencies seen in individuals with ARND are similar to those seen as a result of exposure to other substances, they will not be detailed here but are included in the discussion in the following section.

ARND and Other Effects of Parental Substance Use Disorders

Child development occurs along a continuum including prenatal/birth/newborn (0 to 1), toddler/preschool (2 to 5), middle childhood (6 to 12), and adolescent (13 to 18). Each of these developmental phases brings specific tasks and challenges to the developing child. For example, brain development occurs at the fastest rate throughout the prenatal and toddler stages. Critical social-emotional developmental tasks occur in infancy as a child bonds with caregivers and develops secure attachments. The preschool child has unique challenges to acquire language and cognitive skills and to develop autonomy and prosocial behaviors, while physical and motor skills are advancing. Middle childhood brings increased physical challenges and cognitive maturation. A major transition in this phase occurs as children adapt to the educational environment and new peer influences in their widening social circle. In adolescence, youth develop cognitive skills that advance their moral development and ability to reason while seeking independence and identity, but youth lack full executive function control of impulsivity. As a result, this time increasingly becomes one of exploration, risk taking, and sexual experimentation.

When the impacts of parental substance use disorders on children are observed or assessed, it is important to take note of the chronological age of the child and the child's expected corresponding stage of development. Screening and assessment protocols must be geared to the specific developmental level of the child being screened or assessed. Knowing the developmental skills that are expected will help determine whether or not a child is exhibiting deficits or delays. Attending to the child's current

developmental phase is important, because behaviors that may be considered appropriate at one stage may be considered maladaptive at a different developmental phase. Further, children from families affected by substance use disorders may not go through the developmental continuum in the normal sequential phases. For example, children in middle childhood may display inappropriate attention-seeking behaviors with strangers because of their lack of attachment to a primary caregiver as infants and toddlers.

When staff have been given basic understanding of child development, observing or screening for the effects of alcohol and drugs on children is possible. The ability to observe or screen for effects of alcohol and drugs on children may not be feasible for people with no training. Research has shown that these effects can manifest themselves in multiple areas, including—

- Physical Health Consequences
- Lack of Secure Attachment
- Psychopathology
- Behavioral Problems
- Poor Social Relations/Skills
- Deficits in Motor Skills
- Cognition and Learning Disabilities

It is important to note that the deficits or delays exhibited by children who have been substance exposed may arise at different times in the child's development. For example, many of the physical health consequences detailed below are likely to be noticed in a newborn, whereas cognitive and learning disabilities are more likely to become apparent in school-aged children. Also, there is not consensus on how short-term effects may translate into longer term consequences. Because a child exhibits negative outcomes as a newborn does not predict that the child will suffer long-term dysfunction. Outcomes for children will depend upon a variety of dynamics including the child's postnatal environment and exposure to other risk factors. It should also be noted that children may have some of these defects for reasons other than prenatal exposure to substances.

Physical Health Consequences

Children who have been prenatally exposed to alcohol, tobacco, and drugs often exhibit a variety of physical health consequences including being born prematurely and having lower birth weights, lengths, and head circumferences (National Institute on Drug Abuse, 2001). Premature birth and low birth weight are important factors in a child's overall health and development, and these children are more likely to have serious medical problems that often require extended periods of hospitalization (National Resource Center for Respite and Crisis Care Services, 1997). Newborns who have been prenatally exposed may appear to be in great distress. They may be jittery, suffer from tremors, and become irritable with mild environmental stimuli. Their muscles may be unusually stiff; they can exhibit prolonged persistence of early reflexes, cry a great deal, and have trouble feeding and falling and staying asleep (Kronstadt, 1991). There is evidence that prenatal exposure to alcohol alters brain development, causing cell loss, gross reductions in brain size, and altered connections between brain regions and the ability for communication among neurons (Sher, 2004; Chen, Maier, Parnell, & West, 2003).

A further set of health problems may result from the parents of these children being unable to keep regular pediatric appointments and to keep track of immunizations and medical records.

Lack of Secure Attachment

As toddlers, these children are often seen to be less securely attached to their caregivers than children who have not been substance exposed. Their inability as infants to achieve a calm state, or to tolerate touch, may impede mutual interaction with their primary caregiver and may affect their capacity to form secure attachments (Ondersma et al., 2000; Kronstadt, 1991). This lack of attachment may be exhibited in the child moving from one adult to another, showing no preference for any one in particular, or in seeking response from all adults. The child may also overreact to separation from a primary caregiver (National Resource Center for Respite and Crisis Care Services, 1997).

Psychopathology

Children who have been prenatally exposed to alcohol and drugs have been shown to display a variety of psychopathologies, including attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD) (Lester et al., 2004). They tend to exhibit more internalizing behaviors, including anxiety, depression, and somatic complaints, than nonexposed children (Delaney-Black et al., 2000; Chasnoff et al., 1998; Goldschmidt, Richardson, Cornelius, & Day, 2004). In addition, they may appear passive and apathetic (Kronstadt, 1991). In most cases, it is important to review birth parents' mental health status—which may be difficult for children who have been adopted or in long-term foster care— to ensure that children are not misdiagnosed as ADHD when bipolar, autistic spectrum disorders or other psychopathologies with genetic components may be present.

Behavioral Problems

These children may possess poor internal controls, lack tolerance for frustration and stress, and have difficulty delaying gratification. These issues may result in the expression of their wants, needs, and fears in inappropriate behaviors such as frequent temper tantrums or aggression (National Resource Center for Respite and Crisis Care Services, 1997; Kronstadt, 1991; Mathis, 1998; Chasnoff et al., 1998). They may exhibit aggressive and antisocial behaviors, such as conduct disorder, oppositional defiant disorder, and delinquency (Lester et al., 2004). In addition, they may be easily distracted, behave impulsively, have trouble focusing their attention, and have difficulty organizing their behavior (Kronstadt, 1991; Mathis, 1998). When these deficits are not recognized in early assessment and diagnoses during the preschool period, they may be detected in behavior problems that occur in early or middle elementary school, when schools' rules of acceptable behavior prove difficult for these children to obey consistently.

Poor Social Relations/Skills

Prenatally exposed children may exhibit poor social skills and adjustment (Kronstadt, 1991). Despite a drive to connect with adults, they may often have problems with their peers, showing deficits in their interpersonal relations (Schonfeld, 2003). As children grow older, their deficits in socio-emotional functioning may become more apparent, especially with regard to social judgment, interpersonal skills, aggression, and antisocial behavior (Jacobson & Jacobson, 2003). They may find it difficult to sustain relationships, since their drive to control their environment at times leads to their being overcontrolling in their relations with peers and unable to read signals about peers' responses to them.

Deficits in Motor Skills

These children may exhibit difficulties with gross or fine motor skills (Lester et al., 2004). A difficulty with gross motor skills may be exhibited through problems with swinging, climbing, throwing, catching, jumping, running, and balancing (National Resource Center for Respite and Crisis Care Services, 1997). Below-average handwriting may be an obvious indicator of problems with fine motor skills.

Cognition and Learning Disabilities

Learning problems may be some of the most common and lasting disabilities experienced by children from families with substance use disorders. These children may exhibit delayed receptive and expressive language development, difficulties with expressive language articulation, poor performance on memory and verbal tests, impairments in executive functioning, poor task organization and processing, and poor academic skills (Lester et al., 2004; Kronstadt, 1991; National Resource Center for Respite and Crisis Care Services, 1997). Figurative language and metaphors may be very hard for them to decode, and they may have a very literal approach to language. In school, understanding multiple directions and recording them accurately may be very difficult, due to their difficulty in filtering out different stimuli. They may be easily annoyed by other children, due to sensory overload. It may also be difficult for them to connect actions and consequences logically (Emory School of Medicine Maternal Substance Abuse and Child Development, n.d.).

It is important to remember that while a child who has been prenatally exposed to alcohol, tobacco, or drugs may display some of the characteristics noted above, there is no guarantee that in utero exposure will lead to these negative consequences. And again, the positive and negative impact of the postnatal environment cannot be ignored. Because many postnatal risk factors can contribute to similar developmental problems in a child, the combined influence of biological factors, prenatal substance exposure, and the postnatal environmental risk and protective influences must be examined simultaneously.

Special Concerns for Youth

Prevalence of Substance Use/Abuse Among Youth

The 2005 National Survey on Drug Use and Health (NSDUH) reported that in 2005, of youth ages 12 to 17 years old, 16.5% admitted to current alcohol use or use in the past
30 days. Current binge drinking (5 or more drinks on one occasion) at least once in the past 30 days was reported by 9.9%. Of the youth surveyed, 9.9% admitted to current illicit drug use in the past month. Current (past month) alcohol use was slightly higher among females (17.2%) than among males (15.9%), but males (10.1%) reported illicit drug use at a higher rate than females (9.7%). The NSDUH report also noted that 142,000 youth received treatment in a specialty facility for an illicit drug use problem and that 119,000 youth received treatment at a specialty facility for an alcohol use problem (SAMHSA, 2006).

Special Concerns for Children From Families With Substance Use Disorders

Alcohol and drug, child welfare, and court professionals working with families affected by substance use disorders should be mindful of the potential for a child's own substance use, abuse, or dependence in addition to the impact of the parental substance use disorders on that child. Children who have been prenatally exposed to alcohol, tobacco, and/or drugs, as well as those who have been raised in an

environment in which substance use and/or abuse is present, have an increased likelihood for their own substance use and addiction.

Children of alcoholics have been found to be three to four times likelier to develop alcoholism than children whose parents are not alcoholics (Children of Alcoholics Foundation, n.d.). Studies have also shown a link between mothers who smoked and/or drank during pregnancy and their children being more likely to smoke and drink as adolescents (Lester et al., 2004). In a 14-year followup study, prenatal alcohol exposure was linked more often to adolescent alcohol use and the negative consequences associated with its use than was a family history of alcohol problems (Baer, Barr, Bookstein, & Sampson, 1998). In addition, being the victim of child abuse and neglect is considered a precursor to developing a substance use disorder (DHHS, 1999).

Also of importance is children's experience in out-of-home care and their increased likelihood of developing their own substance use disorder. The National Survey on Drug Use and Health (NSDUH) conducted by the Substance Abuse and Mental Health Services Administration has found that youth who had ever been in foster care were more likely to use illicit substances and more likely to need drug treatment than youth who had never been in foster care. Based on analyses of the 2002 and 2003 survey among youth aged 12 to 17, 37.6% of youth who had ever been in foster care used alcohol in the prior year and 33.6% had used illicit drugs. This finding compares to 34.4% of non-foster-care youth using alcohol and 21.7% using illicit drugs (OAS, 2005).

About 10% of youth who had ever been in foster care needed treatment for alcohol problems, 13% needed treatment for illicit drugs, and 17.4% needed treatment for either alcohol or drugs. These findings compare to much lower rates among youth who had not been in foster care; only 5.9% needed treatment for alcohol, 5.3% needed treatment for illicit drugs, and 8.8% needed treatment for either alcohol or drugs (OAS, 2005).

Substance Use/Abuse Screening for Youth

Screening with youth should be used to uncover the potential of a serious substance-related problem. Positive indicators on a screen should be followed by a referral for a full assessment with a professional trained in assessing youth. Screening should be looked at as a process, rather than just the administration of a single tool. It should include the examination of multiple domains related to the youth's self and environment, including family history, social/peer group, mental health, and child abuse/neglect. While many screening tools provide cutoffs in scoring to assist in the decision to make a referral, these results should be used in conjunction with other observations and indications that there may be substance use disorders, including family history of disorders and prenatal substance exposure. For adolescents at high risk for substance use disorders, it is recommended that a negative screening result be followed up with a reevaluation in approximately 6 months (SAMHSA, 1999).

A list of screening tools commonly used with adolescents can be found in Appendix D on substance abuse screening tools. Also included are several diagnostic and assessment tools to provide an understanding of the types of tools used by professionals trained in assessment.

Self-Harm and Suicide

Adolescents affected by substance use disorders are also at risk for harming themselves and for committing suicide. These issues too often manifest themselves among youth who also have mental illness. Studies indicate that more than 90% of suicide victims have a mental or substance use disorder

(McKeon, 2005). In addition, the combination of childhood trauma, particularly childhood sexual abuse, and mental illness have been shown to increase suicide risk (Goldsmith, Pellmar, Kleinmann, & Bunney, 2002).

Suicide rates in the United States among adolescents rose steadily from the 1950s, and then leveled off in the 1990s and began declining. There is some evidence more recently that this trend has ended and that teen suicide rates are now essentially flat. More frequent female attempts at suicide are typically contrasted with more frequent male successes. Teens between the ages of 15 and 19 are the highest risk group (President's New Freedom Commission on Mental Health, 2003).

Children and adolescents who are suicidal report intense emotional distress including depression, anger, anxiety, hopelessness, and worthlessness. They report feeling that they are unable to change frustrating circumstances and to find solutions to their problems (Kienhorst, De Wilde, Diekstra, & Wolters, 1995; Ohring et al., 1996). Another class of risk factors is related to family discord often characterized by poor communication, disagreements, and lack of common values, goals, and activities.

In an extensive study of suicides in Utah, the agencies that victims had most frequently had contact with prior to their suicide were the juvenile justice and child protective services agencies, which led the researchers to the conclusion that suicide prevention efforts should focus on institutions, rather than individuals (Silverman & Felner, 1995). In this group, 63% of the suicide victims had contact with the juvenile justice agency, and of those, 54% were substance related. In 27% of completed suicide cases, the individual or a family member had been referred to child protective services. Of the individuals referred, 83% were victims of abuse. Only 5% to 20% of suicide completers were in psychiatric treatment at the time of their deaths (Gray et al., 2002).

Suicide risk is difficult to assess (Goldsmith et al., 2002). Any assessment instrument should be used in combination with professional and clinical judgment. While suicide risk is difficult to assess, there is evidence that adolescents provide accurate information about their suicidal thoughts and direct questioning using a nonthreatening approach suggested for screening. The questions should include information about (1) previous suicide attempts; (2) recent, serious, suicidal preoccupations; (3) depression; or (4) complications of alcohol and substance use. Youth identified as being at risk should be referred to mental health professionals for further assessment and treatment (Shaffer & Craft, 1999).

The term "self-harm," or "self-injury," is another issue that seems to disproportionately affect adolescents. Included under the term is a broad range of behaviors one inflicts upon oneself, including cutting, burning, hitting the body with an object or fists, biting, bruising, and ingesting toxic substances. While the majority of research on self-harm has been conducted in Europe, it is estimated that in the United States, almost 3 million people, most of whom are adolescents, engage in self-injury (University of Michigan Health System, 2003). An Australian study found that 6.2% of Year 10 and Year 11 students (11.1% of the female respondents) had a lifetime history of self-injury (De Leo & Heller, 2004).

As noted in the Australian study, adolescent females are more likely to engage in self-harm than are males. Self-harming behaviors cut across a wide range of familial, cultural, and economic backgrounds. Some constants that do exist among those who self-harm are depression, anxiety, low self-esteem, feelings of guilt, emptiness, numbness, invalidation, and an inability to cope with emotions (Selekman, 2002; Martinson, 2002). A history of abuse is common among individuals who engage in self-injury; however, not all who self-injure were abused. In nonabuse instances, it appears that feelings of invalidation and a lack of role models for coping may be enough of a precursor (Selekman, 2002).

Self-harm is intentional, impulsive, and repetitive (University of Michigan Health System, 2003). Self-harming behaviors release endorphins into the bloodstream, resulting in a pleasurable or numbing sensation that takes away the unpleasant thoughts or feelings the individual has been feeling. This endorphin effect can become addictive to adolescents trying to cope with the emotions and stresses of their lives (American Association for Marriage and Family Therapists, 2002). Indications that an adolescent might have a problem with self-harm include—

- Cut or burn marks on their arms, legs, and abdomens;
- Finding knives, razor blades, box cutters, and other sharp objects hidden in the teen's bedroom;
- Regularly locking herself or himself up in the bedroom or bathroom after a bad day at school, negative encounters with peers, and family conflicts for lengthy periods of time;
- The family physician, a teacher, or other adult observes cut or burn marks, or that the teen appears to be regularly removing bodily hairs;
- The teen's peers cut or burn themselves; and
- Reports from a sibling indicating that he or she found blood encrusted razors or caught the teen in the act of self-injuring (American Association for Marriage and Family Therapists, 2002).

Therapeutic approaches exist, and more are being developed, to help individuals who engage in self-harm to develop new coping mechanisms to replace the self-harming behaviors. It is believed that once the self-harming behaviors can be stabilized, work can be done on the issues that underlie the self-harm. In addition, research into the use of medications that reduce depression, anxiety, and stabilize mood for those who self-harm is being conducted (American Self-Harm Information Clearinghouse, n.d.).

Referral Resources

As children from families with substance use disorders can be affected both by the physiological effects of alcohol and drugs and the psychological and social effects of living in a family in which alcohol and drugs are used and/or abused, a multiservice response from a wide variety of disciplines, including child welfare, alcohol and drug, mental health, primary health, domestic violence, education, and juvenile justice is needed.

Services for children vary across jurisdictions. Some jurisdictions may have services that are designed to specifically work with children from families with substance use disorders, while others may be able to work with these children through services created to serve other vulnerable children. Each State or community will need to assess what resources are available to them for referral of children for further assessment and services. Examples of resources that might be available include:

- Early Intervention Services
- Mental Health Services
- School-Based Resources
- Substance Abuse Treatment

Early Intervention Services

Providers of early intervention services might include child care; Head Start and Early Head Start, and prekindergarten/preschool programs. In the case of children who have received an early diagnosis of special needs, regional developmental disabilities agencies may provide services to both parents and

children; some home visiting programs that are based in maternal and child health agencies may also have links with services for children with special needs.

An additional resource available to young children and their parents is services available under Part C of the Individuals with Disabilities Education Act (IDEA). Congress established this program in 1986 to—

- Enhance the development of infants and toddlers with disabilities;
- Reduce educational costs by minimizing the need for special education through early intervention;
- Minimize the likelihood of institutionalization, and maximize independent living; and
- Enhance the capacity of families to meet their child's needs (National Early Childhood TA Center, 2006, January).

Part C of IDEA is a Federal grant program that supports States in operating comprehensive statewide programs of early intervention services for children ages birth through 2 years, who have disabilities, and their families. Currently, all States and eligible territories are participating in the program, and receive annual funding based upon census figures of the number of children age birth to 2 years old in their general population. The Federal requirements under Part C specify the minimum components that must be included in a comprehensive statewide early intervention system. However, there is some discretion in setting criteria for eligibility, including whether or not to serve children at risk. As a result, eligibility and services can differ significantly from State to State. Each State and territory must designate a lead agency. Lead agencies also can vary from State to State but typically include departments of health/public health/human services, education, and mental health/mental retardation. The following link provides information about lead agencies in each State and territory: *http://www.nectac.org/partc/ptclead.asp*.

Mental Health Services

Children from families with substance use disorders may qualify for services under their local children's mental health department. Many jurisdictions provide a system of care (SOC) to children with serious emotional disorders who are in need of mental health services under the federally funded grant program Comprehensive Community Mental Health Services Program for Children and Their Families. Since 1992, this program has funded 92 sites across the country. The program promotes the development of service delivery systems based upon the following philosophies:

- Mental health service systems should be driven by the needs and preferences of the child and family, and address these needs through a strength-based approach;
- The focus and management of services should occur within a multiagency collaborative environment and be grounded in a strong community base;
- The services offered, the agencies participating, and the programs generated should be responsive to the cultural context and characteristics of the populations served; and
- Families should be partners in the planning, implementing, and evaluating of the system of care (Center for Children's Mental Health Services, 2004).

A 2001 report on promising practices from the SOCs detailed that services supporting the mental health of young children should include the following components:

- *Family-Centered*—designed around the family's strengths, needs, and preferences;
- *Individualized*—respecting family's race, ethnicity, culture, socioeconomic background, values, and beliefs;

- *Comprehensive*—provide a variety of interventions to meet the developmental, physical health, and mental health needs, and address the needs of the whole family;
- *Community-Based*—including informal supports that exist in the community and in settings familiar to the child and family, such as in the home or daycare center;
- *Coordinated*—services provided by multiple agencies or disciplines;
- *Based on Developmental Needs*—awareness of age-appropriate behavior and cognitive and social development; and
- Built on Strength and Resilience—designed to promote resiliency in children, to enhance self esteem, to improve coping skills, and to increase positive social supports (Simpson, Jivanjee, Koroloff, Doerfler, & Garcia, 2001).

School-Based Resources

Schools have multiple roles in responding to substance use, abuse, and dependence by their students and as these problems affect their students. Schools are critical venues for identifying and responding to conditions related to the effects of substance use disorders on children's lives. Child welfare professionals, as well as all other professionals who work with children outside a school setting, need to understand how schools can respond to the needs of children and youth affected by substance disorders.

In general, schools are far more focused on adolescent patterns of use, abuse, and dependence than the academic and behavioral effects of parents' and caretakers' substance use disorders on their children. Schools are sometimes focused on substance abuse and violence prevention programs aimed at preteen or adolescent groups while underestimating the importance of intervention and treatment programs for younger students whose parents and caretakers are involved with alcohol and drugs in ways that affect students' learning and behavior.

For the youngest, pre-school-aged children, the effects of parental substance use disorders may begin to show up as a result of developmental screening. The effects may occur when parents take a child to be assessed. Under Federal special education legislation, every school district is obligated to identify, locate, and evaluate all children between the ages of birth and 21 who may need special education and related services. Anyone (a parent, teacher, service provider, and others) may request that a child be considered for special education, and most professionals, including doctors, mental health workers, and counselors must notify the State Superintendent of Public Instruction of any child who appears to be disabled but is not receiving special education services. If a child is younger than 5 years old, the school district will likely refer the family to a local referral and evaluation agency (After the evaluation, a disabled child may be provided with specific programs and services to address his or her special needs. The Individuals with Disabilities Education Act (IDEA) defines "children with disabilities" as individuals between the ages of birth and 21 with one or more of 10 specific categories of disabilities (Council for Exceptional Children, 1998).

Assessments may also happen when a child is taken into the child welfare or mental health systems as a result of a referral for abuse or neglect. The Early Head Start program mentioned above has worked on making a "good handoff" to school districts that their "graduates" will be attending, and emphasizes continuity of care for children identified in preschool settings.

Those school districts that operate or work closely with school-based or school-linked health centers have an additional resource to assist with the task of identifying children affected by their own or their parents' substance use disorders, but staff in such centers need the training to identify these disorders.

In studies of adolescents receiving mental health services, about half had a co-occurring substance use disorder (Greenbaum, Foster-Johnson, & Petrila, 1996). The study found that depression and conduct disorders were the most frequent mental disorders diagnosed in the presence of a substance use disorder. School personnel and their collaborating partners must be able to differentiate between mental illness and substance use disorders, while recognizing the substantial overlap.

For children in adolescence who are 14 or older, the Individuals with Disabilities Education Act (IDEA) requires that the Individual Education Plan (IEP) team consider vocational and advanced-placement needs and courses, and any needed involvement with noneducational agencies that provide vocational and other support services for individuals with disabilities. For some children, Section 504 plans may provide a less rigorous approach to accommodations required by children with special needs, such as more time for homework and changes in the ways tests are given.

While the discussion above highlights some of the common referral sources available throughout the country, every jurisdiction will have its own set of services. It is important for alcohol and drug, child welfare, and court professionals to become familiar with the resources available to vulnerable children and their families in their area. The following are a number of national resources providing further information on children and families affected by substance use disorders.

Substance Abuse Treatment Services

The advancement of specialized substance abuse treatment for adolescents—treatment different from that offered to adults—has emerged in the field over the past 20 years. Since then, many programs for treating adolescents have been established. Until recently, however, little was known regarding which of the programs or treatment strategies were effective.

To address this lack of information, in 1997 the Center for Substance Abuse Treatment (CSAT) began by sponsoring the Cannabis Youth Treatment (CYT) study. Under CYT, CSAT supported the operation and evaluation of several programs that used one of five theory-based models to treat adolescent marijuana use. The research found that these models substantially reduced adolescent substance abuse.

In 1998, CSAT launched the Adolescent Treatment Models (ATM) project. The ATM project evaluated a range of promising existing programs for adolescents. Models evaluated included inpatient, residential, and outpatient programs. The ATM study was not restricted to marijuana. Overall, the ATM programs produced fairly substantial reductions in substance use, emotional problems, and illegal activities in the year after admission. For example, there was a 56% to 60% reduction in the number of days adolescents used drugs.

An e-mail discussion group called the Society for Adolescent Substance Abuse Treatment Effectiveness listserv—an outgrowth of the ATM project—facilitates ongoing conversation and sharing of information. The listserv is open to anyone in the field. To learn more about the listserv for the Society for Adolescent Substance Abuse Treatment Effectiveness, e-mail Donna Williams at dwilliam@samhsa.hhs.gov.

For additional information about the CYT and ATM studies, please visit *http://www.samhsa.gov/samhsa_news/VolumeXI_2/article8.htm*.

There are some other steps that States and counties can take to facilitate access to substance abuse treatment. For example, adolescent substance abuse treatment is an optional service under the State

Children's Health Insurance Program (SCHIP). Covering these services under SCHIP removes a financial barrier to entering treatment.

Federal Medicaid regulations require States to offer "Early, Periodic, Screening, Diagnosis, and Treatment" (EPSDT) services to all Medicaid recipients younger than age 21. EPSDT was established to ensure that young Medicaid recipients receive routine health checks, screenings for possible illnesses, and a range of preventive and treatment services. Many States and communities have used EPSDT services to enhance their adolescent programs and to ensure that youth in the child welfare system have access to substance abuse treatment.

Resources

The **Administration on Children and Families (ACF)** supports 61 University Centers for Excellence in Developmental Disabilities, Education, Research, and Service (UCEDDs), which can be accessed through *http://www.aucd.org/aucd_aboutuce.htm*.

ACF's **Head Start Bureau** has information about the program including grants and services, resources for families and communities, and research. This information can be accessed at *http://www.acf.hhs.gov/programs/hsb/*.

The **Center on the Social and Emotional Foundations for Early Learning** is a national center dedicated to strengthening the capacity of child care and Head Start programs to improve the social and emotional outcomes of young children. The Web site for the center is *http://csefel.uiuc.edu*.

The **Substance Abuse and Mental Health Services Administration** supports a variety of services and technical assistance centers related to children and adolescents. They include the following:

- The **Center for Mental Health Services (CMHS)** operates the National Mental Health Information Center at 1-800-789-2647. The Center has a variety of fact sheets and information available. The Center's Web site is at *http://www.mentalhealth.samhsa.gov*.

- The **National Technical Assistance Center for Children's Mental Health** at Georgetown University at *http://gucchd.georgetown.edu/programs/ta_center/index.html* is an excellent resource for children with special mental health needs.

- The **Substance Fetal Alcohol Spectrum Disorders (FASD) Center of Excellence** for technical assistance, information, and training on FASD *http://fascenter.samhsa.gov/*.

- The **Center for Substance Abuse Prevention** has developed the Children's Program Kit: Supportive Education for Children of Addicted Parents. This multimedia education kit is geared toward substance abuse treatment staff, community groups, and schools. The kit can be obtained through the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686 or *http://www.ncadi.samhsa.gov*.

- SAMHSA's **National Registry of Evidence-based Programs and Practices (NREPP)**. The NREPP Web site serves as a comprehensive resource for learning about and/or implementing model programs. The programs featured on the Web site have been tested in communities, schools, social service organizations, and workplaces across the country, and have provided evidence that they have prevented or reduced substance abuse and other related high-risk behaviors. The NREPP Web site can be accessed at *http://modelprograms.samhsa.gov/template.cfm?page=default*.

- The **National Child Traumatic Stress Network (NCTSN)**. Its purpose is to improve the quality, effectiveness, provision, and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events *http://www.nctsnet.org/nccts/nav.do?pid=abt_main*.

- The **Center for Substance Abuse Treatment** operates a Web-based facility locator for substance abuse services. The locator can be accessed at *http://www.findtreatment.samhsa.gov/*.

  ○ CSAT has approved **Treatment and Assessment Protocols for Adolescent Treatment**. They can be accessed at *http://www.chestnut.org/LI/apss/CSAT/protocols/*.

  ○ In partnership with the ACF, the Substance Abuse and Mental Health Services Administration supports the **National Center on Substance Abuse and Child Welfare (NCSACW)**. The Center provides technical assistance to States and communities to improve outcomes for families affected by substance use disorders in the child welfare and dependency court systems *http://ncsacw.samhsa.gov*.

The Department of Education has a number of offices that may provide useful information about services to children who are vulnerable. These include:

- The **Office of Special Education and Rehabilitative Services (OSERS)**. OSERS assists in educating children with disabilities and rehabilitating adults with disabilities and conducts research to improve the lives of individuals with disabilities regardless of age. OSERS can be accessed at *http://www.ed.gov/about/offices/list/osers/index.html?src=oc*.

  ○ The **Office of Special Education Programs (OSEP)** under OSERS is dedicated to improving results for infants, toddlers, children, and youth with disabilities ages birth through 21 by providing leadership and financial support to assist States and local districts. OSEP supports a variety of technical assistance resources, and can be accessed at *http://www.ed.gov/about/offices/list/osers/osep/index.html?src=mr*.

    ■ The **Center for Evidence-Based Practice: Young Children with Challenging Behavior** is funded by OSEP. The center is dedicated to promoting the use of evidence-based practice to meet the needs of young children who have, or are at risk for, problem behavior, and can be accessed at *http://challengingbehavior.fmhi.usf.edu/index.html*.

    ■ The **National Early Childhood Technical Assistance Center** provides information on the early childhood provisions of the Individuals with Disabilities Act (IDEA) and can be accessed at *http://www.ectac.org/*.

    ■ The **National Center on Educational Outcomes** provides national leadership in the participation of students with disabilities in national and State assessments, standards-setting efforts, and graduation requirements, and can be accessed at *http://education.umn.edu/nceo/*.

    ■ The **Center for Effective Collaboration and Practice** is designed to improve services to children and youth with emotional and behavioral problems by helping communities create schools that promote emotional well-being, effective instruction, and safe learning, and supporting effective collaboration at the local, State, and national levels. More information is available at *http://www.air.org/cecp/about.htm*.

- The **National Dissemination Center for Children with Disabilities** provides information on disabilities in children and youth; programs and services for infants, children, and youth with disabilities; IDEA; No Child Left Behind, the Nation's general education law; and research-based information on effective practices for children with disabilities. More information is available at *http://www.nichcy.org/index.html*.

- The **Office of Safe and Drug-Free Schools (OSDFS)**. OSDFS supports efforts to create safe schools, respond to crises, prevent drug and alcohol abuse, ensure the health and well-being of students, and teach students good citizenship and character. OSDFS can be accessed at *http://www.ed.gov/about/offices/list/osdfs/index.html?src=oc*.

  ○ The **Health, Mental Health, Environmental Health, and Physical Education (HMHEHPE)** under OSDFS administers programs that promote the health and well-being of students and families as outlined in Title IV, Safe and Drug-Free Schools and Communities Act (SDFSCA), authorized by the Improving America's Schools Act of 1994. Programs authorized under this legislation provide financial assistance for activities that promote the health and well-being of students in elementary and secondary schools, and institutions of higher education. HMHEHPE can be accessed at *http://www.ed.gov/about/offices/list/osdfs/programs.html#health*.

  ○ The **Drug-Violence Prevention (DVP) State Programs** group under OSDFS administers Title IV, SDFSCA, authorized by the Improving America's Schools Act of 1994 and other programs related to developing and maintaining safe, disciplined, and drug-free schools. Programs authorized under this legislation provide financial assistance for drug and violence prevention activities in elementary and secondary schools, and institutions of higher education. DVP State Programs can be accessed at *http://www.ed.gov/about/offices/list/osdfs/programs.html#health*.

  ○ The **Drug-Violence Prevention (DVP) National Programs** group administers Title IV, SDFSCA authorized by the Improving America's Schools Act of 1994 and other programs related to developing and maintaining safe, disciplined, and drug-free schools. Programs authorized under this legislation provide financial assistance for drug and violence prevention activities in elementary and secondary schools, and institutions of higher education. DVP National Programs can be accessed at *http://www.ed.gov/about/offices/list/osdfs/programs.html#health*.

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Appendix D

Examples of Screening and Assessment Tools for Substance Use Disorders

Examples of Screening and Assessment Tools
for Substance Use Disorders

This appendix provides information about and samples of screening and assessment tools for substance use disorders. In the description of each tool, the definition follows the tool acronym.

These tools should be used to support ongoing processes that involve regular communication among staff and between staff and families. Tools by themselves do not provide answers to complicated issues such as substance use disorders and child maltreatment. They can, however, contribute to decisions about whether problems exist, the nature and extent of those problems and what actions all three systems—child welfare, alcohol and drug, and court— should take to address problems.

Screening Tools for Substance Use Disorders

Screens for substance use disorders tend to fall into two categories: brief screens of six or fewer items that can be asked orally in the context of an interview or other exchange or longer written questionnaires that are completed by the respondent. Both types are provided here. The oral screens may be more practical for fieldwork and home visits; however, in office settings, the written screens could be employed to collect information while people are waiting for appointments or used as a means by which clerical or other staff can collect information.

None of the standard screens address the issue of immediacy in terms of requiring immediate action. Issues of whether immediate actions are required are more likely to involve observations indicating intoxication or withdrawal or indications of impaired functioning. A combination of observational information plus results from systematic screening would be one strategy for formulating a basis for immediate action as well as assessing the need for further diagnostic assessment.

These screening tools provide information to answer the questions "Is there a substance abuse issue? What is the immediacy of the issue?" They include information about screening tools for adults and adolescents. This list is in alphabetical order based on the tool acronym.

In addition, the Center for Substance Abuse Treatment (CSAT) has approved *Treatment and Assessment Protocols for Adolescent Treatment*. They can be accessed at *http://www.chestnut.org/LI/apss/CSAT/protocols/*

ADULT SUBSTANCE USE SURVEY (ASUS)

The ASUS (Adult Substance Use Survey) is a 64-item self-report survey designed to assess an individual's perceived alcohol and other drug use. This survey also provides a brief mental health screen by including questions that might indicate problems of emotional or mood adjustment. Scales measuring antisocial tendencies, perceptual defensiveness, and motivation are also included. This multivariate instrument is part of the Standardized Offender Assessment package in a number of States, including Colorado.

Administrative Issues	64 items Paper-and-pencil self-administered or orally administered Time required: 8 to 10 minutes to administer, less than 5 minutes to score
Scoring	Scored by tester No computerized scoring or interpretation available
Clinical Utility	Norms available The items are face valid, so the client is clear about what is being asked. Items that are difficult to understand can be reworded by the tester, or explained, so that the most accurate information is obtained. The defensiveness scale is a helpful tool to measure the extent to which the client is able to report information openly and honestly, or whether information is being distorted by perceptual defensiveness. This screen also can be readministered over the course of the treatment process, to ascertain whether clients' level of defensiveness has decreased, and whether their perception of their substance use and its effects has changed.
Copyright	Copyrighted
Cost	Test and manual are free; training module costs $75.
Source	Center for Addiction Research and Evaluation, Inc. (CARE) 5460 Ward Road, Suite 140 Arvada, CO 80020 Phone: 303-421-1261

ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

The AUDIT (Alcohol Use Disorders Identification Test) was developed by the World Health Organization to identify persons whose alcohol consumption has become harmful or hazardous to their health. The AUDIT is not designed to identify substance use disorders according to diagnostic criteria. The AUDIT is designed for written administration, but is short enough to be read to a respondent for oral administration. This test is among the more widely used screens, but its utility in identifying whether an individual is likely to meet diagnostic criteria is not clear.

Administrative Issues

10 items, 3 subscales
Pencil-and-paper self-administered or interview
Time required: 2 minutes
Administered by health professional or paraprofessional
Training required for administration. A detailed user's manual and a videotaped training manual explain proper administration procedures, scoring, interpretation, and clinical management.

Scoring

Time required: 1 minute
Scored by hand
No computerized scoring or interpretation available
Norms available
Normed on heavy drinkers and alcoholics
An easy-to-use brochure has been designed to guide the interviewer and to assist with scoring and interpretation.

Clinical Utility

The AUDIT screening procedure is linked to a decision process that includes brief intervention with heavy drinkers or referral to specialized treatment for patients who show evidence of more serious alcohol involvement. This screening procedure assesses risky drinking rather than the presence of a diagnosable disorder other than alcohol use disorder. The AUDIT does not screen for drugs.

Copyright

Copyrighted

Cost

Test and manual are free; training module costs $75.

Source

Programme on Substance Abuse
World Health Organization
1211 Geneva, Switzerland
or Thomas F. Babor
Alcohol Research Center
University of Connecticut, Farmington, CT

CAGE

The CAGE, a very brief screen, is probably the most widely used and promoted for the detection of alcohol problems in the United States. It is one of the screens most consistently promoted for use among medical professionals to identify individuals likely to have substance use disorders.

Administrative Issues	Four items Paper-and-pencil self-administered or orally administered Time required: less then 1 minute Administered by professional or technician No training required for administration, easy to learn, easy to remember, easy to replicate
Scoring	Time required: instantaneous A total score of 2 or more indicates the need for further assessment. Scored by tester No computerized scoring or interpretation available Norms available
Clinical Utility	The CAGE is a favorite of physicians and nurses because of its brevity. It is not based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)* and therefore does not discriminate between abuse and dependence, is relatively insensitive to women, and is subjective; relies on the individual's ability to experience guilt and one of the four items identifies only late stage alcohol problems. Some of the items address abuse and dependence criteria but, because of some of the limitations, may not be the optimal screen for most child welfare applications. In its original form, it does not screen for drug-related problems.
Copyright	No copyright. Published in the *American Journal of Psychiatry*
Cost	None
Source	Copies can be found on a number of Internet sites or by obtaining the original 1974 publication.

CAGE–AID Modification

The CAGE has been modified to screen for drug as well as alcohol problems by adding "or use (using) drugs" to the original questions. Some versions of the modification screen for drugs only; most screen for both. The CAGE–AID demonstrates all limitations of the CAGE, and there are many different variations in the language of the items, including even changes in the original CAGE items. Like the CAGE, the modification should be considered a less than an optimal screening instrument for most child welfare applications.

CRAFFT

The CRAFFT is a six-item screen for both alcohol and drug use among adolescents. This screen focuses more on risky drinking than on diagnostic issues and does not discriminate between risky drinking, abuse, and dependence.

Administrative Issues	Six items, "yes/no" answers Paper-and-pencil self-administered or orally administered Scored by tester No computerized scoring or interpretation available Norms unavailable
Scoring	Time required: less than 1 minute Two or more "yes" answers indicate need for further assessment Scored by tester No computerized scoring or interpretation available
Clinical Utility	The CRAFFT, a relatively new instrument (2002), screens for both alcohol and drug problems but focuses more on risky drinking than on diagnosing abuse or dependence. Only three of the six items are related to the DSM-IV diagnostic criteria for substance use disorders. One of six items ("Have you ever ridden in a car driven by someone (including yourself) who was "high" or who was using alcohol or drugs?") has potential for increasing positive responses and lowering specificity.
Copyright	Copyrighted by Children's Hospital Boston, 2001
Cost	No cost, but approval for copies must be obtained from the Center for Adolescent Substance Abuse Research (CeASAR), Children's Hospital Boston
Source	www.CeASAR-Boston.org

DRUG ABUSE SCREENING TEST (DAST)

All the DAST (Drug Abuse Screening Test) versions screen for problems with the use of drugs only. The DAST-10 (Drug Abuse Screening Test-10) is the shortened and more commonly used version of a 20-item (DAST-20) or the original 28-item version. The DAST is sometimes combined with the AUDIT or other alcohol screens to cover both alcohol- and drug-related problems. Items apply to over-the-counter, prescription, and illicit drugs. Studies have documented reliability with Spanish versions.

Administrative Issues

10 items, 0 subscales
Paper and pencil self-administered or orally administered
Time required: 2 minutes
Administered by professional or technician
No training required for administration, easy to learn

Scoring

Time required: 1 minute
Scored by hand
A total score of 3 or more indicates the need for further assessment
Scored by tester
No computerized scoring or interpretation available
Norms available

Clinical Utility

The original DAST 28-item questionnaire has been modified to a 20-item version, and to the most commonly used version, a 10-item version, the DAST-10. The items cover most of the abuse and some dependence *DSM-IV* criteria, and this questionnaire is more focused on diagnosis than the AUDIT. The items are designed for a timeframe covering the last 12 months. In order to do a comprehensive substance use disorder screen, the DAST must be paired with a second instrument that screens for alcohol use disorders.

Copyright

Copyrighted

Cost

$12.95 for a package of 100

Source

Centre for Addiction and Mental Health
33 Russell Street
Toronto, Ontario, Canada M5S 2S1

DRUG USE SCREENING INVENTORY-REVISED (DUSI-R)

The DUSI-R (Drug Use Screening Inventory-Revised) is a commercially available 159-item screening instrument that provides scores in 10 domains: alcohol and drug use, behavior patterns, health status, psychiatric disorder, social competence, family system, school performance, work adjustment, peer relationships, and leisure and recreation. Adult and adolescent versions are available, but norms are available only for the adolescent version.

Administrative Issues	159 items, 11 subscales Paper-and-pencil self-administered or by computer Time required: 20 to 45 minutes Administered by professional or technician No training required for administration
Scoring	Time required: manual time not specified if scored by tester Computerized administration, scoring, and interpretation available Norms listed as available for adolescents, but only the listed reference has a sample of only 25 adolescents.
Clinical Utility	No diagnostic cut-scores are provided; clinicians must make such decisions. Promotional materials suggest that the instrument can also be used to monitor change.
Copyright	Copyrighted by The Gordian Group
Cost	$3 per paper copy or $495 for the computer version
Source	The Gordian Group P.O. Box 1587 Hartsville, SC 29550 Phone: 843-383-2201 Web site: www.dusi.com

The MAST (Michigan Alcohol Screening Test) is a 25-item screen developed in 1971 and with the CAGE has been one of the most widely used to screen for diagnosable abuse or dependence. Briefer versions have been developed including the Brief-MAST (10 items), the Malmo Modification of the MAST, or Mm-MAST (9 items), and the Short MAST, or SMAST (13 items). There is also a geriatric version, the MAST-G. The original instrument is long for a screen, but the shorter versions should be viewed as distinct instruments in terms of validity.

Administrative Issues	25 items, 0 subscales
	Paper-and-pencil self-administered or interview
	Time required: 10 minutes
	Administered by practitioner or self
	No training required for administration
Scoring	Time required: 10 minutes
	Scored by staff
	No computerized scoring or interpretation available
	Norms available
Clinical Utility	The MAST focuses on alcohol only and therefore must be paired with an instrument like the DAST that screens for drug disorders. It is long for a screening instrument. It screens for "alcoholism," a non-diagnostic term, and is not based on the diagnostic criteria of the *DSM-IV*. This instrument makes assumptions that can lead to erroneous conclusions (e.g., "Have you ever attended an AA meeting?" assumes that attendance was due to the respondent's problems and not the problems of a relative or as part of a professional experience). Some items are only appropriate for late stage alcohol problems, but others are more subjective.
Copyright	No copyright
Cost	$5 for a copy; no fee for use
Source	Melvin L. Selzer, M.D.
	6967 Paseo Laredo
	La Jolla, CA 92037

MASSACHUSETTS YOUTH SCREENING
INSTRUMENT-VERSION 2 (MAYSI-2)

The MAYSI-2 (Massachusetts Youth Screening Instrument-Version 2) is a 52-item, true–false questionnaire designed for screening youth between the ages of 12 and 17 entering the juvenile justice system. The questionnaire is designed to detect problem areas in need of attention, but does not purport to be diagnostic in its scales. Some of the problem areas incorporate more than one diagnostic category (e.g., affective and anxiety disorders).

Administrative Issues	Pencil-and-paper questionnaire or as automated CD or online questionnaire Time required: about 10 minutes Administration by nonclinical staff or online A Spanish language version is available for the paper version.
Scoring	Pencil-and-paper scoring materials for scoring by hand Computerized scoring for CD-ROM and online versions
Clinical Utility	The MAYSI-2 has been developed as part of a research project, but it appears to have utility in detecting problem areas in need of attention such as suicidal ideation, thought disturbance, and traumatic experiences as well as indications of substance abuse. Some areas, as noted previously, are combined into a single scale.
Copyright	Copyrighted
Cost	$60 for manual
Source	Professional Resource Press P.O. Box 15560 Sarasota, FL 34277-1560 E-mail: orders@prpress.com

PERSONAL EXPERIENCE SCREENING QUESTIONNAIRE (PESQ)

The PESQ (Personal Experience Screening Questionnaire) is a 40-item substance abuse screening instrument to be used with 12 to 18 year olds. The PESQ includes a scale that measures the severity of the drinking problem, drug use history, select psychosocial problems, and response distortion tendencies. Norms for populations of normal juvenile offenders and drug abusers are available.

Administrative Issues	40 items, 3 subscales: Problem Severity, Psychosocial Items, and Drug Use History Pencil-and-paper self-administered Time required: 10 minutes Administered by self No training required for administration
Scoring	Time required: 5 minutes Automatically scored as administered, using AutoScore Test No computerized scoring or interpretation available Norms available Normed on school sample, school clinic sample, drug clinic sample, and juvenile offender sample
Clinical Utility	This brief screen helps service providers make appropriate referrals. It is especially useful in schools, juvenile detention facilities, medical clinics, and other settings where routine screening rather than indepth assessment is the goal. Reliability studies show internal consistency. Content, criterion, and construct validity have been derived.
Copyright	Copyrighted by Western Psychological Services, 1991 Reprinted by permission of the publisher
Cost	$70 per kit (25 administrations)
Source	Western Psychological Services 12031 Wilshire Boulevard Los Angeles, CA 90025-1251 Phone: 310-478-2061

RAPID ALCOHOL PROBLEMS SCREEN (RAPS4)

The RAPS4 (Rapid Alcohol Problems Screen) is a four-item screen designed to detect alcohol dependence in emergency room patients. Unlike screens designed to detect risks related to use, the RAPS4 attempts to identify those individuals who meet diagnostic criteria for alcohol dependence.

Administrative Issues	Four items Orally administered Time required: 2 minutes Administered by professional or technician No training required for administration, easy to learn
Scoring	Time required: 1 minute Scored by hand No computerized scoring or interpretation available or necessary
Clinical Utility	Some research on the RAPS4 indicates that it performs better than the CAGE, AUDIT, Brief-MAST, and TWEAK in the identification of dependence. The developer of the tool has published extensively on its use in emergency medical settings.
Copyright	For oral administration, copyright seems irrelevant.
Cost	None
Source	Public Health Institute, Alcohol Research Group 2000 Hearst Avenue Berkeley, CA 94709 E-mail: ccherpitel@arg.org

SUBSTANCE ABUSE SUBTLE SCREENING INVENTORY, 3RD EDITION (SASSI-3)

The SASSI-3 (Substance Abuse Subtle Screening Inventory, 3rd Edition), is one of the most widely used proprietary screening tools in the United States. This tool is different from others; it contains subtle items described as more effective in identifying early stage chemically dependent individuals or those in denial or deliberately trying to conceal their chemical dependency pattern. The tradeoff is possibly lower sensitivity because of the subtle items. It is one of the longer screens. It also contains validity subscales, such as a defensiveness scale, which provides a measure of credibility to the individual's responses. It is available in both adult and adolescent versions.

Administrative Issues

78 items, 8 subscales, including an antisocial scale
Paper-and-pencil formats, in computerized versions and online
Time required: 15 to 20 minutes
Administered by professional or trained staff
Extensive training required
Requires completion of a two-page prequalification form

Scoring

Time required: 10 minutes
Hand or computerized scoring
Interpretation and support available

Clinical Utility

Scores are graphed, which provides decision rules
and recommended level of intervention
Available in Spanish
More complex, lengthy, and costly than brief oral screens

Copyright

Copyrighted by Glenn Miller, May 1985

Cost

$115 to $160 for starter kits for paper-and-pencil version; $215 to $260 for computer version; online, $12 per administration with discounts for volume

Source

The SASSI Institute
201 Camelot Lane
Springville, IN 47462
Phone: 800-726-0526
Web site: www.sassi.com

SUBSTANCE ABUSE SUBTLE SCREENING INVENTORY-ADOLESCENT (SASSI-A)

The SASSI-A (Substance Abuse Subtle Screening Inventory-Adolescent) is one of the most widely used proprietary screening tool use in the United States. This tool is different from others; it contains subtle items described as more effective in identifying early stage chemically dependent individuals or those in denial or deliberately trying to conceal their chemical dependency pattern. The tradeoff is possibly lower sensitivity because of the subtle items. It is one of the longer screens. It also contains validity subscales, such as a defensiveness scale, which provides a measure of credibility to the individual's responses. It is available in both adults and adolescent versions.

The adolescent version of the SASSI uses strategies and scales similar to the ones in the adult instrument, detailed below.

Administrative Issues	78 items, 8 subscales, including an antisocial scale
	Paper-and-pencil formats, in computerized versions and online
	Time required: 15 to 20 minutes
	Administered by professional or trained staff
	Extensive training required
	Requires completion of a two-page prequalification form
Scoring	Time required: 10 minutes
	Hand or computerized scoring
	Interpretation and support available
Clinical Utility	Scores are graphed, which provides decision rules and recommended level of intervention
	Available in Spanish
	More complex, lengthy, and costly than brief oral screens
Copyright	Copyrighted by Glenn Miller, May 1985
Cost	$115 to $160 for starter kits for paper-and-pencil version; $215 to $260 for computer version; online, $12 per administration with discounts for volume
Source	The SASSI Institute
	201 Camelot Lane
	Springville, IN 47462
	Phone: 800-726-0526
	Web site: www.sassi.com

TRIAGE ASSESSMENT FOR ADDICTIVE DISORDERS (TAAD)

The TAAD (Triage Assessment for Addictive Disorders) is a brief, 31-item structured interview designed as a screen or triage instrument. The items cover all *DSM-IV* constructs for abuse and dependence for alcohol and generically for other drugs. This screen is designed to provide one of three conclusions: (1) identify obvious cases and provide initial documentation to support a diagnosis; (2) rule out clear negative cases; and (3) target questionable or possible positive cases for further assessment. The timeframe is the previous 12 months.

Administrative Issues	Designed as an interview, not a paper-and-pencil instrument to be completed by the respondent As a triage instrument, presents more definitive findings than a screen Time required: about 10 minutes Can be administered by anyone with good interviewing skills, but interpretation is reserved for qualified, licensed professionals
Scoring	Time required: 2 to 3 minutes Results can be coded in a template in back of the interview Interpretation is reserved for qualified, licensed professionals
Copyright	Copyrighted by Norman G. Hoffmann, Ph.D., 1995
Cost	$11.50 for administration guide; $62.50 for a package of 30 forms
Source	Evince Clinical Assessment P.O. Box 17305 Smithfield, RI 02917 Phone: 800-755-6209; 401-231-1993 E-mail: evinceassessment@aol.com

TWO-ITEM CONJOINT SCREENING TEST (TICS)

The TICS (Two-Item Conjoint Screening Test) is a two-item screen developed for use in primary care settings. The two items are well chosen regarding the *DSM-IV* diagnostic criteria for substance dependence and tend to be among the items included in longer screens. This test can be easily administered verbally from memory and incorporated into other interviews. With only two items, the screen is not likely to provide a means of adjusting scoring to vary sensitivity and specificity.

Administrative Issues	Two items Time required: less than 1 minute Administered by technician No training required
Scoring	Time required: less than 1 minute Scored by technician
Clinical Utility	Screens for current problems; that is, wording is for use in the last 12 months. Some variations are alcohol related only. The TICS is more likely to be used than longer screens. For example, even a very small number of well-chosen items can detect at least a portion of individuals with alcohol and other drug problems with a minimal investment of time.
Copyright	No copyright
Cost	None
Source	Article: Brown, R. L., Leonard, T., Saunders, L. A., & Papasouliotis, O. (1997). A two-item screening test for alcohol and other drug problems. *Journal of Family Practice, 44*, 151–160.

TWEAK

The TWEAK is a five-item screen developed for detecting high-risk drinking during pregnancy. Independent researchers have evaluated the TWEAK against other screens. Although the TWEAK tends to perform relatively well, other brief screens have been found to have superior sensitivity and specificity.

Administrative Issues	Five items Orally administered Time required: 2 minutes Administered by professional or technician No training required for administration, easy to learn
Scoring	Time required: 1 to 2 minutes Scored by hand No computerized scoring or interpretation available or necessary
Clinical Utility	Research has indicated that the TWEAK performs better in identifying at-risk drinking among women including minorities than the CAGE, but its statistics suggest no better performance than other brief screens such as the RAPS4 or UNCOPE.
Copyright	For oral administration, copyright seems irrelevant.
Cost	None
Source	Article: Chan, A. W., Pristach, E. A., Welte, J. W., & Russell, M. (1993). Use of the TWEAK test in screening for alcoholism/heavy drinking in three populations. *Alcoholism: Clinical and Experimental Research, 17*(6), 1188–1192.

UNCOPE

The UNCOPE is a six-item screen designed to identify alcohol and/or drug abuse or dependence in a broad range of populations. The UNCOPE items identify indications of abuse or dependence based on part of the *DSM-IV* diagnostic criteria for substance use disorder. Two items cover abuse, and two cover *DSM-IV* abuse criteria. The instrument was originally developed to identify substance dependence in women and older individuals. This screen can be used with adults and adolescents as young as age 13.

Administrative Issues

Six items
Can be embedded in a paper-and-pencil self-administered questionnaire or orally administered by an interviewer
Time required: less than 2 minutes
No training required for administration

Scoring

Time required: less than 1 minute
Two or more positive responses indicate possible abuse or dependence and need for further assessment; three or more items are often used as the best cut-score for dependence.
Scored by interviewer
No computerized scoring or interpretation available
Norms available for clinical and correctional populations

Clinical Utility

The UNCOPE can provide reasonable indications of risk for abuse and dependence for both alcohol and other drugs. Like the other screens, the greater the number of positive responses, the greater the probability that the individual will meet criteria for dependence.

Copyright

Not copyrighted

Cost

None (attribution requested)

Source

Evince Clinical Assessment
P.O. Box 17305
Smithfield, RI 02917
Phone: 800-755-6209; 401-231-1993
E-mail: evinceassessment@aol.com
Downloadable as a .pdf file from the Web site:
www.evinceassessment.com

Assessment Tools for Substance Use Disorders

When results of screens or behavioral indicators (e.g., driving under the influence (DUI) or apparent intoxication while responsible for children) indicate there may be problems involving alcohol or drugs, the next step is to determine the diagnosis. Research has provided strong evidence that substance dependence is distinct from substance abuse and also raises the greater potential for child maltreatment because of its chronicity and severity. Of the two diagnostic categories (i.e., abuse and dependence), only dependence emerges as a chronic condition likely to involve biological predispositions. Substance dependencies tend to require service over a period of time to achieve stable recovery, which typically involves abstinence from the dependent substance. Abuse appears to be less likely to be chronic and may not require abstinence from alcohol.

A variety of assessment instruments are available, but many treatment programs rely on their own formats and procedures. Many treatment providers use an interview referred to as the "psychosocial interview." These are typically unstructured interviews during which a therapist makes the diagnostic determination. The following list of diagnostic instruments is by no means exhaustive, but is intended to provide a perspective on the variety of available instruments. The list is in alphabetical order based on the instrument acronym. Since a number of tools are designed for both mental health and substance use disorders, these are combined.

For substance use disorders, the American Society of Addiction Medicine has developed criteria for treatment planning and placement known as the American Society of Addiction Medicine Patient Placement Criteria, Second Edition-Revised (ASAM PPC-2R). These criteria are distinct for adults and adolescents, but presume that a substance use disorder has been identified for which some types of services are required. One instrument designed to summarize the current functional status of the individual and environment is provided for adults and one for adolescents. It is not anticipated that caseworkers would use such an instrument, but feedback from addiction treatment providers might be provided either by such an instrument or in a format consistent with the ASAM PPC-2R.

These assessment tools provide information to answer the question *"What is the nature and extent of the substance abuse issue?"*

COMPREHENSIVE ADDICTION AND PSYCHOLOGICAL EVALUATION (CAAPE)

The CAAPE (Comprehensive Addiction and Psychological Evaluation) is a structured interview covering seven Axis I conditions and six Axis II personality disorders in addition to substance use disorders in accordance with *DSM-IV* criteria. For some conditions such as substance use disorders, major depressive and manic episodes, and antisocial personality, the CAAPE provides a foundation for supporting a diagnostic determination. For other conditions, such as various anxiety disorders, it serves more of a detailed screening function. The CAAPE is designed so that professionals can use the information for diagnostic purposes within their areas of expertise and can make focused referrals for those areas outside of their areas of practice.

Administrative Issues	141 verbally administered questions and 4 observational items Time required: about 40 minutes Administration can be done by a technician or professional; minimal, if any, training is required; most professionals can self-train with the manual. Interpretation should be done by a properly credentialed professional.
Scoring	Time required: about 5 minutes Scoring can be done by a technician or clerk, but interpretation requires a professional.
Clinical Utility	Designed to be administered and scored within a single clinical appointment and to detect mental health conditions commonly occurring in conjunction with substance use disorders. Professionals can self-train by using the manual.
Copyright	Copyrighted
Cost	About $2.50 per administration ($62.50 per packet of 25); $15 for manual
Source	Evince Clinical Assessments P.O. Box 17305 Smithfield, RI 02917 Phone: 800-755-6299 Web site: www.evinceassessment.com

COMPOSITE INTERNATIONAL DIAGNOSTIC
INTERVIEW VERSION 1.1 (CIDI V1.1)

The CIDI V1.1 (Composite International Diagnostic Interview Version 1.1) was designed for compatibility with the *International Classification of Diseases and Related Health Problems, Revision 10 (ICD-10)*, and the *DSM-III-R* under the auspices of the World Health Organization (WHO). Items are indexed to indicate the criteria to which they apply. In addition to substance use disorders, the CIDI covers 10 psychiatric diagnoses across timeframes ranging from lifetime to the past 2 weeks. This instrument is designed for research and epidemiological use, but is available for clinical practice as well.

Administrative Issues	376 items and 14 subscales, but branching can reduce the number of items actually administered Time required: about 70 minutes Administration can be done by a technician or professional Training required
Scoring	Time required: about 20 minutes Computerized scoring available
Clinical Utility	The use of the CIDI has been reported in a number of research studies including cross-cultural investigations. An update to DSM-IV may be available, which would be necessary for many clinical applications in the United States.
Copyright	Copyrighted by WHO
Cost	About $4 for interview forms; $55 for manual
Source	American Psychiatric Press, Inc. Arlington, VA 800-368-5777 or 703-907-7322

GLOBAL APPRAISAL OF INDIVIDUAL NEEDS-INITIAL (GAIN-I)

The GAIN-I (Global Appraisal of Individual Needs-Initial) is a structured and semistructured interview designed to help clinicians gather information for diagnosis, placement, and treatment planning. It is an attempt to standardize the more informal "biopsychosocial" assessments commonly used in addiction treatment programs. There are a variety of GAIN instruments for other purposes, such as treatment satisfaction and followup.

Administrative Issues	Exact number of items difficult to determine Interview is 84 pages Time required: estimated to be over 2 hours Administration is designed for clinical staff as part of intake process.
Scoring	Items form more than 100 scales and subscales Time for scoring is not indicated, but the number of scales suggests a significant time commitment.
Clinical Utility	The GAIN instruments are designed to standardize the informal assessments often used in addiction programs.
Copyright	Copyrighted, but the instrument draws heavily on various public-domain instruments and surveys
Cost	Contact Chestnut Health Systems for information.
Source	Chestnut Health Systems 720 West Chestnut Bloomington, IL 61701 Phone: 309-827-6026 Web site: www.chestnut.org

STRUCTURED CLINICAL INTERVIEW FOR DSM (SCID)

The SCID (Structured Clinical Interview for DSM) is now a family of instruments. The SCID-I covers Axis I conditions in six self-contained modules: mood episodes; psychotic symptoms; psychotic disorders; mood disorders; substance use disorders; and a module for anxiety, adjustment, and other disorders. The SCID-II covers 10 Axis II personality disorders. Each version of the SCID has its own interviews, manuals, and reference guides. The SCID modules are arguably the most frequently used in a wide range of research studies.

Administrative Issues

Number of items will vary with module and branching

Time required: estimated at between 60 and 90 minutes for Axis I conditions

User's guides designed for professionals to administer the interview

Scoring

Scoring involves interpretation by the professional.

Clinical Utility

Uses of specific modules are likely to be the most practical for standard clinical practice. Treatment programs for substance use disorders may choose to use only that specific module unless there are indications of other conditions.

Copyright

Copyrighted

Cost

$36 for SCID-I interview booklet (88 pages); score sheets about $6.60 per interview ($33 for a packet of 5); $39.50 for user's guide; $60 for SCID-II user's guide and interview set

Source

American Psychiatric Publishing, Inc.
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209-3901
Phone: 800-368-5777
Web site: www.appi.org

The following instrument is concerned with treatment planning and placement. Such instruments are designed for intake assessments after a diagnosis has been established and provides a means for developing treatment plans.

LEVEL OF CARE INDEX-2 REVISED (LOCI-2R) FOR ADULTS

The LOCI-2R (Level of Care Index-2 Revised) is not a psychometric instrument but rather a checklist for operationalizing the ASAM PPC-2R, the criteria most widely used for determining treatment placement and for guiding treatment planning. The LOCI-2R provides a means of doing up to six summaries on a given individual during the course of treatment. This instrument can also be used for monitoring or modifying the treatment plan.

Administrative Issues

There are six dimensions to be assessed for the ASAM PPC-2R, but this assessment may involve gathering input from different professionals. The LOCI-2R is not administered as such, but can be used by professionals or treatment staff to summarize findings in a convenient way.
Training in using the criteria is required for proper use.

Scoring

There is no formal scoring, but dimensions are assessed in terms of level of care required for appropriate treatment.
Interpretation requires professionals trained in the delivery of addiction treatment services.

Clinical Utility

The instrument is used in a wide variety of clinical settings.

Copyright

Copyrighted

Cost

About $2.90 per administration ($72.50 per packet of 25)

Source

Evince Clinical Assessments
P.O. Box 17305
Smithfield, RI 02917
Phone: 800-755-6299
Web site: www.evinceassessment.com

Substance Use Disorder Assessment Instruments for Adolescents

While some might question the validity of diagnosing adolescents for substance use disorders, clinical experience and mounting scientific evidence suggest that among older adolescents, substance dependence can be diagnosed. Greater caution is called for with youth because there are developmental and subculture, or peer, influences that can result in excessive use or abuse. Like any diagnostic question, the final determination rests with an appropriately qualified and credentialed professional.

The following list is not meant to be exhaustive, but is included to provide a perspective on the types of instruments available and likely to be used by providers conducting assessments with youth. The list is in alphabetical order based on the instrument acronym.

SUBSTANCE USE DISORDER DIAGNOSTIC INTERVIEW-IV (SUDDS-IV)

The SUDDS-IV (Substance Use Disorder Diagnostic Interview-IV) is a structured interview to provide *DSM-IV*-compatible information for specific substance use disorders for both lifetime and current problems. This instrument screens for anxiety and depressive disorders. Age of onset of problems by substance group provides a means of documenting the patterns of problem development helpful for motivational enhancement. Information relevant to treatment placement is summarized on the back of the administration booklet.

Administrative Issues	64 basic questions with subparts provide data for each of the *DSM-IV* substance categories Time required: about 35 to 45 minutes Administration can be done by a trained technician or professional. Interpretation should be done by a properly credentialed professional.
Scoring	Time required: about 5 minutes Scoring can be done by a technician or a clerk, but interpretation requires a professional with appropriate credentialing.
Clinical Utility	The SUDDS-IV is designed to be administered and interpreted in a single session or appointment. It is used in a wide variety of clinical settings. A version for correctional applications is automated.
Copyright	Copyrighted
Cost	About $2.50 per administration ($62.50 for a packet of 25); $10 for administration guide; automated version about $3.60 per administration
Source	Evince Clinical Assessments P.O. Box 17305 Smithfield, RI 02917 Phone: 800-755-6299 Web site: www.evinceassessment.com

COMPREHENSIVE ADOLESCENT SEVERITY INVENTORY (CASI)

The CASI (Comprehensive Adolescent Severity Inventory) is a comprehensive, semistructured, clinical assessment and outcomes interview. A followup CASI is available for those interested in obtaining followup data on youth. The CASI is composed of 10 independent modules, each incorporating objective, concrete questions formatted to identify whether certain behaviors have ever occurred regularly, how old the adolescent was when they first occurred regularly, and whether they occurred regularly during the past year. The CASI also includes questions designed to assess the strength-base of youth.

Administrative Issues	Number of questions depends upon modules used (e.g., substance module has 45 items) Time required: 45 to 90 minutes depending on modules used Designed for use by professionals Two-day training is required.
Scoring	The CASI comprises four clinical dimensions, each composed of component subscales plus three monitoring dimensions, each composed of component subscales. SAS scoring programs are available to trained users free of charge.
Clinical Utility	The CASI is not just a diagnostic instrument but a more comprehensive intake system. The diagnostic components are part of a more general intake system, often referred to as a "psychosocial interview."
Copyright	Information on copyright unavailable
Cost	Paper version available for duplication fee; computerized version $1,299 for a 2-year site license
Source	System Measures, Inc. P.O. Box 506 Spring Mount, PA 19478

DIAGNOSTIC INTERVIEW SCHEDULE
FOR CHILDREN-VERSION IV (DISC-IV)

The DISC-IV (Diagnostic Interview Schedule for Children-Version IV) is a diagnostic interview covering more than 30 mental disorders of children and adolescents. Timeframes include the past year and the past 4 weeks. Diagnoses are based on the *DSM-IV* and *ICD-10* criteria. The DISC comes in two forms: the DISC-P for parents of children ages 6 to 17 and the DISC-Y for direct administration to children ages 9 to 17.

Administrative Issues	2,930 questions for the DISC-Y and slightly more for the DISC-P, but not all are likely to be administered to a given individual 358 stem questions are likely to be used to assess most salient concerns and additional questions are asked if one of the stem questions is positive Time required: about 60 to 120 minutes Administration can be done by a technician. Interpretation should be done by a properly credentialed professional. Training of 2 to 3 days is strongly recommended for interviewers.
Scoring	Scoring and administration are typically done using a computer to display the questions and record the answers for automated scoring.
Clinical Utility	This interview, or a component of it, is among the most widely used for research purposes. The length of the total interview makes it impractical to use the entire interview in clinical practice unless the computer version is employed.
Copyright	Copyright not determined
Cost	Cost of materials not available; cost of training $300 per day at Columbia University or $1,000 per day for first 10 people plus travel expenses for offsite training
Source	Division of Child & Adolescent Psychiatry Columbia University For training: fisherp@child.cpmc.columbia.edu

GLOBAL APPRAISAL OF INDIVIDUAL NEEDS-INITIAL (GAIN-I)
FOR ADOLESCENTS

The GAIN-I (Global Appraisal of Individual Needs-Initial) for Adolescents is a structured and semistructured interview designed to help clinicians gather information for diagnosis, placement, and treatment planning. It is an attempt to standardize the more informal "biopsychosocial" assessments commonly used in addiction treatment programs. There are a variety of GAIN instruments for other purposes, such as treatment satisfaction and followup.

Administrative Issues	Exact number of items difficult to determine Interview is 84 pages Time required: estimated to be over 2 hours Administration designed for clinical staff as part of intake process
Scoring	Items form over 100 scales and subscales Time for scoring is not indicated, but the number of scales suggests a significant time commitment.
Clinical Utility	The GAIN instruments are designed to standardize the informal assessments often used in addiction programs.
Copyright	Copyrighted, but the instrument draws heavily on various public-domain instruments and surveys
Cost	Contact Chestnut Health Systems for information.
Source	Chestnut Health Systems 720 West Chestnut Bloomington, IL 61701 Phone: 309-827-6026 Web site: www.chestnut.org

GLOBAL APPRAISAL OF INDIVIDUAL NEEDS-M90 (GAIN-M90)
FOR ADOLESCENTS

The GAIN-M90 (Global Appraisal of Individual Needs-M90) for Adolescents is a followup instrument designed for use every 90 days after the GAIN-I. In addition, the GAIN-M90 has questions that allow it to be used less frequently (e.g., every 6 or 12 months) as well. The full version takes about 1 hour; however, there is a core set of items that can be administered in 25 minutes. There are several program- or project-specific variations of this instrument, including those for programs funded by CSAT and the Robert Wood Johnson Foundation (RWJF).

Administrative Issues	Exact number of items difficult to determine Interview is 68 pages Time required: estimated to 1 hour for the full version and 25 minutes for the core set of questions Materials available in hard-copy and electronic forms Can be administered by a clinician or self-administered by individuals with sufficient reading skills
Scoring	Time for scoring is not indicated, but the number of scales suggests a significant time commitment.
Clinical Utility	The GAIN instruments are designed to standardize the informal assessments often used in addiction programs.
Copyright	Copyrighted, but the instrument draws heavily on various public-domain instruments and surveys.
Cost	Contact Chestnut Health Systems for information.
Source	Chestnut Health Systems 720 West Chestnut Bloomington, IL 61701 Phone: 309-827-6026 Web site: www.chestnut.org

PRACTICAL ADOLESCENT DUAL DIAGNOSTIC INTERVIEW (PADDI)

The PADDI (Practical Adolescent Dual Diagnostic Interview) is a structured diagnostic assessment interview designed specifically for children and adolescents aged 12 to 18. It covers 11 diagnostic areas of the *DSM-IV* and substance use disorders. The interview also covers dangerousness to self or others and victimization (physical, sexual, and emotional). Professionals who may not be credentialed in both mental health and substance abuse can use the PADDI information within the scope of their specialty and for referrals to other professionals for problems outside their area of expertise.

Administrative Issues	157 questions and 7 observational items Time required: about 35 to 45 minutes Administration can be done by a technician or professional. Professionals can self-train with the manual.
Scoring	Time required: about 5 minutes when familiar with the instrument Scoring can be done by a technician or a clerk, but interpretation requires a professional.
Clinical Utility	The interview has been used within a variety of clinical and juvenile justice settings for initial assessments and for reviewing status subsequent to treatment.
Copyright	Copyrighted
Cost	About $2.70 per interview (sold in packages of 25 for $67.50); $18 for manual
Source	Evince Clinical Assessments P.O. Box 17305 Smithfield, RI 02917 Phone: 800-755-6299 Web site: www.evinceassessment.com

Planning and Monitoring Tools Regarding Substance Use Disorders

Assessment and planning may be a seamless process in which diagnostic and treatment planning information is collected in a single intake process, or the functions can be divided. In the latter case, a case manager or referral source (e.g., employee assistance professional or psychiatric social worker) may make the initial diagnosis and then refer the person to a treatment program for further evaluation and treatment planning.

The most commonly used criteria for treatment placement (as well as for determining the nature and extent of problems) is the ASAM PPC-2R criteria of the American Society of Addiction Medicine. These criteria consist of six dimensions: intoxication/withdrawal, medical conditions, mental health conditions, stage of change/motivation, recovery/relapse risks, and the recovery environment. The assessments on these dimensions are used to place people into one of nine different levels of care and five different levels of detoxification services, and they are used to change people from one level to another depending on progress or lack of it during the treatment process. The criteria also provide a framework for treatment planning regarding needs other than the level of care.

Monitoring of treatment progress typically takes the form of chart information kept by the treatment program or providers rather than formal assessment instruments designed for that purpose. Some of the assessment instruments described in the prior section of this appendix evaluate not only the current nature and extent of problems, but also provide a foundation for monitoring recovery efforts or assessing outcomes. Rather than repeat those descriptions here, other examples of instruments that can assist in the planning and monitoring functions are described.

No single instrument can be expected to fulfill all needs or provide universal utility across all possible settings and populations. The challenge for professionals is to select those instruments that best meet their needs as part of procedures designed for the setting and the population. A wise strategy is to begin by determining the knowledge, or information, required for clinical or administrative purposes and then explore which instruments are best suited to providing that information. This list is in alphabetical order based on the tool name.

Monitoring can involve several distinct objectives. One is to assess the current status of the individual or family to determine whether expected changes are occurring or whether changes need to be made to the treatment or case plan. Another distinct, but related, function is the evaluation of the program itself. Program evaluation requires similar measures, but the objectives are the documentation of change or degree of change rather than indications for clinical decisions relative to the individual case.

ADDICTION SEVERITY INDEX (ASI) and
TREATMENT SERVICE REVIEW (TSR)

The ASI (Addiction Severity Index) is one of the most widely used assessment tools in the United States. It was designed as a research instrument for program evaluation to determine the extent to which addiction treatment programs achieved improvements across seven domains: alcohol use, drug use, psychiatric status, employment status, medical status, legal status, and family/social relationships. Some of these areas have obvious financial implications (e.g., health care utilization, vocational functioning, and arrests). Although frequently used as a primary intake tool, the ASI is best suited for secondary assessment and evaluation after the diagnosis and treatment plan are developed. This instrument is best suited for secondary assessment because the ASI does not provide a basis for a diagnosis, nor does it indicate the urgency for dealing with various conditions.

The TSR (Treatment Service Review) instruments are less well known, but provide a way of monitoring what services have been received over a 14- to 30-day period. The TSRs cover not only direct clinical services with respect to substance use and mental health disorders, but also whether the individual had any assistance with other necessities such as housing, educational or vocational training, and public transportation. Although the TSR instruments do not monitor the clinical status of the individual, in conjunction with repeated measures of ASI items, they can provide a more complete profile of what services are delivered and what the current status is for monitoring.

Administrative Issues	The ASI consists of approximately 140 items across the 7 domains. Time requirement: about 1 hour Administration can be done by technicians or clinicians. Extensive training is required to ensure proper administration and scoring of the instrument. An abbreviated version, the ASI Lite, is also available.
Scoring	Scores are produced for each of the seven domains. Extensive training is required to ensure consistent scoring.
Clinical Utility	Although the ASI covers key areas of concern for both treatment planning and program evaluation, it is not adequate as an intake tool without being used in conjunction with other instruments. Its greatest utility is as a monitoring or program evaluation tool.
Copyright	The ASI, developed with Federal funds, is in the public domain.
Cost	The ASI is free; however, various companies have developed automated versions for various costs.
Source	ASI and TSR forms can be downloaded at no cost from the Treatment Research Institute at www.tresearch.org

FAMILY ASSESSMENT FORM (FAF)

The FAF (Family Assessment Form) was developed as a means of providing standardization to family assessments, but with the intention that the tool be adapted to meet the needs of specific programs and applications. It covers six areas of family functioning and is able to identify strengths as well as problems. The form consists of ratings to be completed by the worker based on observations and discussions with the family member. This instrument is not to be completed by the family member.

Administrative Issues	About 90 ratings covering 6 areas of family functioning Paper-and-pencil form is completed by a professional Time required: variable, depending upon the professional or the technician Training and supervision are required for the appropriate use of the tool.
Scoring	Time required: variable, depending upon circumstances The FAF Pro software application was designed to increase the value of the Family Assessment Form to practitioners and agencies as a tool to expedite assessment, facilitate service planning, document casework, gather and analyze data, and measure and report on program activity and client outcomes.
Clinical Utility	The FAF provides a vehicle for establishing some structure and consistency to family evaluations. Statistics indicate that with proper training and supervision, raters can achieve good reliability so that there is consistency among different workers' ratings.
Copyright	Children's Bureau of Southern California
Cost	The price list for the FAF package including software can be accessed at: http://www.familyassessmentform.com/purchase_pricelist.html.
Source	Children's Bureau of Southern California Children's Bureau Headquarters 3910 Oakwood Avenue Los Angeles, CA 90004 Phone: 323-953-7356/323-661-7306 Toll-free: 888-ALL 4 KIDS (888-255-45437) Fax: 323-661-7306 Web site: www.all4kids.org Contact person for information: Sandy Sladen fafsupport@all4kids.org

GLOBAL APPRAISAL OF INDIVIDUAL NEEDS-M90 (GAIN-M90)

The GAIN-M90 (Global Appraisal of Individual Needs-M90) is a followup instrument designed for use every 90 days after the GAIN-I. In addition, this instrument has questions that allow it to be used less frequently (e.g., every 6 or 12 months) as well. The full version takes about 1 hour; however, there is a core set of items that can be administered in 25 minutes. There are several program- or project-specific variations of this instrument, including those for programs funded by CSAT and RWJF.

Administrative Issues	Exact number of items difficult to determine
	Interview is 68 pages
	Time required: estimated to be 1 hour for the full version and 25 minutes for the core set of questions
	Materials are available in hard-copy and electronic forms.
	Can be administered by a clinician or self-administered by persons with sufficient reading and writing ability
Scoring	Time for scoring is not indicated, but the number of scales suggests a significant time commitment.
Clinical Utility	The GAIN instruments are designed to standardize the informal assessments often used in addiction programs.
Copyright	Copyrighted, but the instrument draws heavily on various public-domain instruments and surveys.
Cost	Contact Chestnut Health Systems for information.
Source	Chestnut Health Systems
	720 West Chestnut
	Bloomington, IL 61701
	Phone: 309-827-6026
	Web site: www.chestnut.org

The LOCI-2R (Level of Care Index-2 Revised) consists of two forms—one for adults and one for adolescents—that summarize and operationalize the ASAM PPC-2R placement criteria of the American Society of Addiction Medicine. Separate forms are necessary to reflect the differences between the adult and adolescent criteria. The forms are not psychometric or diagnostic instruments. The forms are, however, a means of summarizing all available information relevant to the six dimensions of the ASAM PPC-2R in accordance with the nine levels of care for adults and the eight levels of care for adolescents. The LOCI-2R forms allow clinicians or treatment teams to make up to six determinations of status for a given individual with a single form. Using one form facilitates monitoring of progress or status during treatment. Few if any other forms are designed specifically to accommodate all aspects of the ASAM PPC-2R.

Administrative Issues	Since the LOCI-2R forms are checklists summarizing all available information, there is no "administration." Time required: variable, depending upon availability of information The LOCI-2R forms are designed to be used by clinicians or treatment teams.
Scoring	There is no formal scoring. Interpretations of findings are based on the ASAM PPC-2R criteria. As many as six assessments can be made for a given individual using a single form.
Clinical Utility	The LOCI-2R forms are used by a variety of treatment programs in applying the ASAM PPC-2R criteria.
Copyright	Copyrighted
Cost	About $2.90 per patient (sold in packets of 25 forms for $72.50)
Source	Evince Clinical Assessments P.O. Box 17305 Smithfield, RI 02917 Phone: 800-755-6299 Web site: www.evinceassessment.com

RECOVERY ATTITUDE AND TREATMENT EVALUATOR (RAATE)

The RAATE (Recovery Attitude and Treatment Evaluator) actually consists of two forms: a clinician evaluation form (RAATE-CE) involving clinician ratings and a self-report questionnaire (RAATE-QI) filled out by the patient. Both forms cover five dimensions: acceptance/resistance to treatment, acceptance/resistance to continuing recovery efforts, acuity of medical conditions, acuity of psychiatric conditions, and the recovery environment. These dimensions, while related to ASAM PPC-2R dimensions, are not identical. For example, stage of change (Dimension 4) in the PPC-2R is represented on two separate scales on the RAATE forms concerning treatment and recovery as an ongoing process.

Administrative Issues The RAATE-CE consists of 35 ratings across the 5 dimensions, and 2 evaluations can be made on an individual with one form.
The RAATE-QI consists of 94 true–false items.
Time for interviewing a client to score the CE is approximately 30 minutes; time to compete the QI is approximately 25 minutes.
Administration of the CE requires a clinician, but a technician can administer the QI.

Scoring Scoring of the CE requires about 5 minutes by the clinician; scoring of the QI uses a template and takes about 5 minutes and can be done by a technician or a clerical person.
Interpretation of findings requires a professional.

Clinical Utility The RAATE instruments provide a means of comparing the clinician's perspective with that of the patient/client. These instruments also quantify some of the ASAM PPC-2R dimensions.

Copyright Copyrighted

Cost About $2.50 per form ($62.50 for 25 copies of either form)

Source Evince Clinical Assessments
P.O. Box 17305
Smithfield, RI 02917
Phone: 800-755-6299
Web site: www.evinceassessment.com

RISK INVENTORY FOR SUBSTANCE-AFFECTED FAMILIES

The Risk Inventory for Substance Abuse-Affected Families is one of the few instruments to explicitly assess the potential influences of substance use and substance use disorders on risks for maltreatment. It consists of eight scales, or ratings, anchored with descriptive statements for defining the level for each scale. This risk inventory assumes that substance abuse or dependence has already been identified as being an issue in the family, and the intent is to assess the risks posed to children. Topics covered include commitment to recovery, patterns of use, effects on child care and lifestyle, supports for recovery, self-efficacy and self-care of the parent, and quality of the neighborhood. Although some of the scales seem appropriate for identification of risk and others for extent of problems, some scales are definitely related to planning. This instrument has scales that could be considered appropriate for both this appendix and Appendix F, "Examples of Safety and Risk Assessments for Use by Child Welfare Staff"; therefore, it is listed in each.

Administrative Issues	Eight rating scales; scores range from 1 to either 4 or 5 with options for unknown or not applicable Ratings are completed by a professional based on observation and discussion with the family members. Time required: variable
Scoring	Time required: variable No manuals for administration or scoring available
Clinical Utility	The instrument has good face validity in terms of areas to consider in gauging the potential risks to children based on the parent's or caretaker's functioning and commitment to recovery. Lack of information on the performance of the tool and apparent lack of research on the instrument may require initial care in interpretation of findings.
Copyright	Copyrighted by Children's Friend and Service
Cost	$10 per instrument copy
Source	Children's Friend and Service 153 Summer Street Providence, RI 02903 Phone: 401-331-2900 Fax: 401-331-3285

STRUCTURED DECISION MAKING (SDM)
FAMILY AND CHILD STRENGTHS AND NEEDS ASSESSMENT

The SDM (Structured Decision Making) model, as described by the Children's Research Center (CRC) of the National Council on Crime and Delinquency (NCCD), is a procedure for improved practice by child welfare services. CRC states that at the heart of the model is a series of tools to assess families and structure the agency's response. One of the tools is the standardized Family and Child Strengths and Needs Assessment, which guides service planning.

The CRC publication, *The Improvement of Child Protective Services with Structured Decision Making: The CRC Model*, provides an example developed in one State—The Wisconsin Urban Caucus Family Strengths and Needs Assessment.

Administrative Issues	Unknown
Scoring	Time required: unknown
Clinical Utility	The general information obtainable on the procedure suggests that the concept and practices have merit. A number of States are listed as having implemented the procedure. Data supplied indicate that the risk levels as assessed are related to subsequent referrals, placements, and substantiations. Utility for individual casework cannot be determined from the materials reviewed.
Copyright	Unknown
Cost	Unknown
Source	Children's Research Center 426 South Yellowstone Drive, Suite 250 Madison, WI 53719 Phone: 608-831-8882 Fax: 608-831-6446

Examples of Instruments Used by States and Treatment Providers

The following pages include samples of the alcohol and drug assessment, planning, and monitoring instruments used in Sacramento County, California; the "Stages of Change Form" developed by Prototypes, in Los Angeles; the "Family Services Progress Matrix" of indicators for progress in the substance abuse recovery process developed by the State of Illinois; and the Specialized Treatment and Recovery Services (STARS) progress report developed by Bridges, Inc.

The **Sacramento County Alcohol and Other Drug (AOD) Preliminary Assessment** is completed during a personal interview with a family by a child welfare worker who has received specialized training in the area of alcohol and drug abuse. The worker uses the results of this preliminary assessment to make an expedited referral into treatment. The treatment provider conducts a more indepth assessment as part of an initial psychosocial evaluation.

The **Prototypes Stages of Change Form** is completed by family members when they first enter the Prototypes treatment program and again 21 days after they enter treatment. This form allows family members and substance abuse counselors to explore a family member's readiness to change and to develop appropriate treatment strategies.

The **Illinois Department of Children and Family Services Progress Matrix** is used by workers to help them assess how well families are progressing.

The **Specialized Treatment and Recovery Services (STARS) Twice-Monthly Progress Report** is completed by Recovery Specialists who are assigned to each parent with a substance use disorder in the Sacramento County Court system. The form reports on objective indicators of the progress of parents in treatment. This report is completed two times per month and is systematically delivered to the case-carrying social worker, the parent's attorney, and the court.

SACRAMENTO COUNTY
ALCOHOL AND OTHER DRUG (AOD) PRELIMINARY ASSESSMENT

This assessment is necessary for clients using publicly funded AOD treatment. It is to be completed during a face-to-face contact between staff and client. Staff, who have participated in Level I and II of AODTI training, have the option of completing this assessment to expedite treatment placement/authorization by the Alcohol and Drug Bureau.

Client Name: (last) _____ (first) _____ Date: _____

☐ Male ☐ Female DOB: _____ Race/Ethnicity _____ SSN: _____-____-_____

Address: _____ Zip _____ Phone:_____

Area of Residence:　☐ South　☐ Broadway/Oak Park　☐ Midtown　☐ Central

(e.g. Arden)

　☐ East (e.g. Rancho Cordova)　☐ Northwest (e.g. Del Paso)　☐ Northeast (e.g. Citrus Heights)

Staff Name: _____ Code: _____ Phone: _____ FAX:_____

Department/Division: _____ Program: _____ Mail code:_____

Referral Source (if other than staff above):

_____CalWOR

Ks ☐ Yes ☐ No

Prior Assessments with approximate date:_____

_____

Part I – Presenting Needs　_____

Part II – Immediate Need Triage

Yes	No		
☐	☐	A.	Client has history of life-threatening withdrawal symptoms
☐	☐	B.	Client has current, life-threatening withdrawal symptoms
☐	☐	C.	Client has current, severe and untreated physical health problems
☐	☐	D.	Client is in imminent danger of hurting self or others
☐	☐	E.	Client has current, acute psychotic symptoms (e.g. hallucinations)

Part III – AOD Use Information

Substances most frequently used *(check all that apply and indicate age of **1st** and date of **last** use)*

	Age of 1st use	Date of last use		Age of 1st use	Date of last use
☐ methamphetamine	_____	_____	☐ PCP	_____	_____
☐ cocaine/crack	_____	_____	☐ hallucinogens	_____	_____
☐ other stimulants	_____	_____	☐ marijuana	_____	_____
☐ opiates	_____	_____	☐ tobacco	_____	_____
☐ alcohol *(check one below)*	_____	_____	☐ prescription	_____	_____
☐ associated with violence history			☐ non-prescription	_____	_____
☐ **not** associated with violence history			☐ other (specify)	_____	_____

Part IV – Level of Functioning in Relation to AOD Use

A. Check low, moderate or high level of functioning for each area. Definitions are as follows:

　Low Functioning – severe difficulty or impairment with serious and persistent signs and symptoms

　Moderate Functioning – moderate difficulty or impairment with moderate to serious signs and symptoms

　High Functioning – minimal difficulty or impairment with no or minimal signs and symptoms

	Low*	Moderate	High	Special Needs and/or Strengths
1. Health status				
2. Emotional stability				
3. Family relations				
4. Social supports				
5. Legal problems				
6. Job/Education				
7. Housing				

*Requires statement in "Special Needs and/or Strengths" Section explaining difficulty.

B. Staff assessment of 1 through 7 determines overall biopsychosocial functioning as:

☐ low   ☐ moderate   ☐ high

The Sacramento Preliminary Assessment is included as a separate Excel file.

CADDs ID: _____

Date: _____

Stages of Change Form

1. Each rung on the ladder below represents where various individuals are in their thinking about entering drug treatment. Darken the circle that indicates where you are now in terms of entering drug treatment to get help with reducing or stopping substance use.

2. Each rung on the ladder below represents where various individuals are in their thinking about getting counseling for emotional problems. Darken the circle that indicates where you are now in terms of getting counseling for emotional problems.

3. Each rung on the ladder below represents where various individuals are in their thinking about changing their sexual behaviors to reduce the risk of getting HIV. Darken the circle that indicates where you are now in terms of changing sexual behaviors to reduce the risk of getting HIV.

4. Each rung on the ladder below represents where various individuals are in their thinking about making life changes to decrease chances of being physically harmed. Darken the circle that indicates where you are now in terms of making changes to decrease your chances of being physically harmed.

5. Each rung on the ladder below represents where various individuals are in their thinking about getting a job, going to school, or getting training. Darken the circle that indicates where you are now in terms of getting a job, going to school, or getting training.

Ladder 1
- 10, 9 → I have been receiving treatment for substance use for more than 6 months or I have completed a drug treatment program and still consider myself to be in recovery
- 8, 7 → I have been receiving treatment for substance use for more than 6 months (or less)
- 6
- 5, 4 → I am thinking about entering drug treatment within the next 30 days
- 3
- 2, 1 → I am thinking about entering drug treatment within the next 6 months
- 0 → I am not thinking about entering drug treatment within the next 6 months

Ladder 2
- 10 → I have been receiving counseling for emotional problems for more than 6 months
- 9
- 8, 7 → I have been receiving counseling for emotional problems for 6 months (or less)
- 6
- 5, 4 → I am thinking about getting counseling for emotional problems within the next 30 days
- 3
- 2, 1 → I am thinking about getting counseling for emotional problems within the next 6 months
- 0 → I am not thinking about getting counseling for emotional problems within the next 6 months

Ladder 3
- 10, 9 → For more than 6 months, I have changed my sexual behaviors to reduce the risk of getting HIV
- 8, 7 → In the last few months, I have changed my sexual behaviors to reduce the risk of getting HIV
- 6
- 5, 4 → I am thinking about changing my sexual behaviors within the next 30 days to reduce the risk of getting HIV
- 3
- 2, 1 → I am thinking about changing my sexual behaviors within the next 6 months to reduce the risk of getting HIV
- 0 → I am not thinking about changing my sexual behaviors within the next 6 months to reduce the risk of getting HIV

Ladder 4
- 10, 9 → For more than 6 months, I have taken steps to decrease my chances of being physically harmed
- 8, 7 → In the last few months, I have taken steps to decrease my chances of being physically harmed
- 6
- 5, 4 → During the next 30 days, I plan to take steps to decrease my chances of being physically harmed
- 3
- 2, 1 → During the next 6 months, I plan to take steps to decrease my chances of being physically harmed
- 0 → I do not plan to take steps in the next 6 months to decrease my chances of being physically harmed

Ladder 5
- 10, 9 → For more than 6 months, I have taken steps to get a job, go to school, or get training
- 8, 7 → In the last few months, I have taken steps to get a job, go to school, or get training
- 6
- 5, 4 → During the next 30 days, I plan to take steps to get a job, go to school, or get training
- 3
- 2, 1 → During the next 6 months, I plan to take steps to get a job, go to school, or get training
- 0 → I am not thinking about getting a job, going to school, or getting training within the next 6 months

ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES PROGRESS MATRIX

INDICATORS FOR PROGRESS IN THE SUBSTANCE ABUSE RECOVERY PROCESS: ZERO TO THREE MONTHS				
0-3 Months	**Poor Progress**	**Some Progress**	**Moderate Progress**	**Substantial Progress**
Substance Abuse Treatment	Parent remains in denial of substance abuse/addiction and has not completed substance abuse screen.	Reduction of initial resistance and defensiveness. ↓ Completed Adult Substance Abuse Screen. ↓ Parent has completed substance abuse assessment and has accepted treatment referral. ↓ Parent has entered substance abuse treatment. ↓ Sporadic attendance in substance abuse treatment.	Attendance in substance abuse treatment becomes more consistent. Improvements in personal hygiene.	Regular attendance in substance abuse treatment. ↓ Parent has accepted the negative consequences of substance abuse. ↓ Parent is thinking more clearly and is able to verbalize consequences of continued substance abuse. ↓ If applicable, parent has participated in collaborative service planning meeting with child welfare worker and substance abuse treatment worker. If parent is ready for discharge: Parent has developed relapse prevention plan. Parent has developed aftercare plans. If parent has been discharged: Parent is attending after care services at a treatment facility and or attending self-help or community support groups.
Substance Abuse Education	Parent remains in denial of substance abuse and has not entered treatment/ substance abuse education classes.	Parent has recently entered substance abuse treatment and substance abuse education classes.	Attending substance abuse education classes on addiction and recovery. Acknowledges need for insight into personal addiction.	Parent is receiving or has completed substance abuse education classes. Has gained insight into personal addiction. Parent is able to discuss the impact of substance abuse on parenting behaviors.
Participation in Recovery Support Systems	No current participation in recovery support groups.	Has received education on 12 Step/recovery support group meetings.	Has mapped out 12 Step (AA/CA/NA) or community recovery support group.	Has attended a 12 Step/ support group at the treatment program. ◆*All clients are not ready to participate in 12 Step/support groups during the early months of treatment/recovery.*

| Abstinence | Actively abusing drugs. | Parent has decreased substance abuse.

Parent is able to self report relapse. | Fewer episodes of relapse and is able to discuss triggers. | Parent has developed a specific relapse prevention plan. Parent *may* have achieved abstinence. |
|---|---|---|---|---|
| **Other Service Plan Provision Compliance** | Parent is non-compliant with service plan:
• Visiting with workers
• Other assessments | Parent is inconsistent in meeting service plan conditions. | Parent is consistently working on service plan conditions. | Parent is currently in compliance with service plan conditions. |
| **Visiting** | Parent does not visit child(ren). | Parent inconsistently visits child(ren). | Parent consistently visits child(ren). | Parent consistently visits child(ren). |
| **Parental Skills/ Parental Functioning** | A parent who retains custody of the child must follow a child safety plan but may not acknowledge the impact of substance abuse on parenting. | | | Parent may begin to identify the impact of substance abuse on parenting. |

INDICATORS FOR PROGRESS IN THE SUBSTANCE ABUSE RECOVERY PROCESS: THREE TO SIX MONTHS				
3-6 Months	**Poor Progress**	**Some Progress**	**Moderate Progress**	**Substantial Progress**
Substance Abuse Treatment	No current participation in substance abuse treatment.

Parent may have initially engaged in treatment but left against staff advice. | Parent is inconsistent in attending substance abuse treatment.
↓
Within this time frame the parent could become more consistent.

Improvements in personal hygiene. | Parent's continued progress is demonstrated in:
• Consistent attendance
• Ability to identify triggers
• Self report of drug free time, meeting attendance, and certificates of achievements
• Improvement in personal hygiene and self esteem
• Greater insight into substance abuse / addiction
• Developed a specific relapse prevention plan | Parent's attendance in substance abuse treatment is consistent and has demonstrated compliance with treatment plan and is preparing for discharge. Developing and discussing aftercare plans with treatment provider (may occur at this time due to extended length of stay or residential treatment).

If parent has been discharged: Parent is consistently participating in after care services and working with a specific relapse prevention plan. |
| **Participation in Recovery Support Systems** | No current participation in recovery support groups. | Attends initial recovery support meeting (AA/CA/NA) or initial community support group. | Increased attendance in AA/CA/NA meetings or support group meetings. Working on Steps 1 and 2 of the 12 Steps of AA/NA; parent is able to discuss the process of recovery.

Parent is letting go of relationships with substance abusers and developing sober friendships. | Regular attendance in self help meetings.
↓
Developing relationships with recovering role models/mentors.
↓
Parent has chosen 12 Step Sponsor or community support person.
↓
Increasing involvement in drug free activities, recovery support systems, sober relationships, and/or community activities. |

Abstinence	Parent is currently abusing drugs.	Parent is able to self report relapse. Fewer episodes of relapse and the parent is able to discuss triggers.	Parent has recently achieved abstinence. (At least 30 days)	Parent has achieved a sustained period of abstinence.
Service Plan Compliance	Parent is non-compliant with service plan: • Visiting with worker • Other assessments	Parent is inconsistent in meeting service plan conditions.	Parent is consistently working on service plan conditions.	Parent is currently in compliance with service plan conditions.
Visiting	Parent inconsistently visits with child(ren).	Parent is consistent in visits with child(ren).	Parent demonstrates increased parenting responsibility during visits.	Parent demonstrates increased parenting responsibility during visits.
Parenting Skills/ Parental Functioning	Parent is unwilling or unable to acknowledge impact of drug use on parenting.	Parent begins to acknowledge the impact of drug use on parenting.	Parent acknowledges impact of drug use on parenting and identifying parenting deficits.	Parent is able to identify parenting deficits and strengths. Parent is developing parenting goals.

INDICATORS FOR PROGRESS IN THE SUBSTANCE ABUSE RECOVERY PROCESS: SIX TO NINE MONTHS				
6-9 Months	**Poor Progress**	**Some Progress**	**Moderate Progress**	**Substantial Progress**
Substance Abuse Treatment	Currently not participating in substance abuse treatment (parent left treatment).	Parent is more consistent in attendance. Parent is able to identify triggers. Self report of drug free time, meeting attendance, and certificates of achievements. Continued improvement in personal hygiene and self-esteem. Parent has gained greater insight into substance abuse/ addiction.	Consistent attendance in substance abuse treatment; has demonstrated compliance with treatment plan. Verbalizes a greater awareness of intense emotions and triggers. Uses new coping skills learned in substance abuse treatment or 12 Step support groups. Has developed a specific relapse prevention plan. Developing/discussing aftercare plans with treatment provider (may occur at this time due to extended length of stay or residential treatment).	Regular attendance in formal substance abuse treatment. Parent has entered after care services. Parent consistent in follow through with after care services. Parent is consistently working on relapse prevention plans.
Participation in Recovery Support Systems	No current participation in recovery support groups.	Attends 12 Step recovery support meeting or community support groups. ↓ Has increased participation in self help meetings or community recovery support groups. ↓ Has chosen sponsor.	Consistently working on the 12 Steps program with sponsor /consistently attending community support. Actively working on relapse prevention with after care provider, sponsor or recovery support person.	Parent is consistently working 12 Step program, attending self help meetings, and maintaining contact with sponsor. ↓ Parent is applying Steps 1-3 in daily life (AA/CA/NA). ↓ Parent is discussing long term goals and setting time frames with support persons.

Abstinence	Parent is currently abusing drugs.	Parent has decreased substance abuse and self reports relapse. Has fewer episodes of relapse and has developed a specific relapse prevention plan.	Parent has recently achieved abstinence. Parent has sustained periods of abstinence.	Parent continues to maintain abstinence.
Service Plan Compliance	Parent is non-compliant with service plan.	Is inconsistent in meeting service plan conditions.	Is consistently working on service plan conditions.	Parent is currently in compliance with service plan conditions.
Visiting	Parent inconsistently visits child(ren).	Parent consistent in visits with child(ren).	Consistently visiting child(ren) and demonstrating increased parenting responsibility during visits (if applies).	Parent consistently visiting child and demonstrating increased parenting responsibility during visits (if applicable).
Parenting Skills/ Parental Functioning	Parent is unwilling or unable to acknowledge impact of drug use on parenting.	Parent begins to acknowledge the impact of drug use on parenting. ↓ Acknowledges impact of drug use on parenting.	Parent identifies parenting deficits and strengths and sets parenting goals Parent is working on parenting goals.	Parent is working on parenting goals. ↓ Parent is achieving one or more parenting goal.

INDICATORS FOR PROGRESS IN THE SUBSTANCE ABUSE RECOVERY PROCESS: NINE TO TWELVE MONTHS			
9-12 Months	**Poor Progress**	**Some to Moderate Progress**	**Substantial Progress**
Participation in Recovery Support Systems	Parent does not currently participate in mutual help/ recovery support groups. Parent is not actively engaged with a sponsor.	Parent has increased participation in mutual help/ recovery support groups. ↓ Has chosen sponsor. ↓ Has made more consistent contact with sponsor. ↓ Works on the 12 Steps program with sponsor. ↓ Actively works on relapse prevention with after care provider, sponsor or recovery support person.	Parent consistently participates in mutual help meetings/ recovery support groups. ↓ Consistently working on the 12 Step program with sponsor or with a community support person. ↓ Parent is engaged in sober relationships and activities. ↓ Has accepted the maintenance phase of recovery is a lifelong responsibility.
Abstinence	Parent is currently abusing drugs.	Fewer episodes of relapse and the parent has developed a specific relapse plan. ↓ Parent has recently achieved abstinence.	Parent has sustained periods of abstinence. ↓ Parent continues to maintain abstinence.
Service Plan Compliance	Parent is non-compliant with service plan.	Parent is inconsistent in meeting service plan conditions. (i.e. Attending parent training, counseling, keeping assessment appointments.)	Parent is consistently working on service plan conditions.
Visiting	Parent inconsistently visits child(ren).	Parent consistently visits child.	Parent demonstrates increased parenting responsibility during visits (if applicable).

Parenting Skills/ Parental Functioning	Parent is unwilling or unable to acknowledge impact of drug use on parenting. Parent beginning to acknowledge the impact of drug use on parenting.	Parent acknowledges impact of drug use on parenting. ↓ Parent identifies parenting deficits and strengths and sets parenting goals. ↓ Parent is working on parenting goals. ↓ Parent is demonstrating improved parental functioning.	Parent maintains improved parenting functioning and continuing to work on parenting goals.
Interpersonal Relationships	No attempts to address interpersonal conflicts with family members.	Minimal attempts to address interpersonal conflicts with family members.	Parent is actively addressing interpersonal conflicts with family members.
Skill Building	No participation in skill building training.	Parent has entered skill building training.	Parent consistently participates in skill building training.

S.T.A.R.S

Specialized Treatment and Recovery Services

a program of Bridges, Inc.

STARS

Twice-Monthly Progress Report

Report Period   From: To:

CLIENT NAME:

Case Names:

Petition #:

Start Date: Level: File #:

Social Worker: Worker Code: Phone:

Program Compliance:	
Compliant	Incarcerated
	Wherabouts Unknown
Non-Compliant	Other

Alcohol/Drug Test Results	**Treatment**	**Stars Contacts**
Total tests requested	Program:	# Required
Negative test	Outpatient	Face to Face
Positive tests	Residential	Missed
Pending tests	TX sessions req'd	Phone
Failures to test	TX sessions attnd	
(unable or refusal)	Absences	**12 Step/Support Groups**
No shows	Excused	Required
Excused tests	Unexcused	attended

Progress Notes/Comments:

STARS Worker: **Phone**   **Date:**

Appendix E

Substance Use, Abuse, Dependence Continuum, and Principles of Effective Treatment

Appendix E:
Substance Use, Abuse, Dependence Continuum, and
Principles of Effective Treatment

Alcohol and drug use occurs along a continuum, and not everyone who uses substances abuses or is dependent on them. Levels of use are generally identified as use, abuse, and dependence.

The table on the next page summarizes the differences between substance use, abuse, and dependence, and it highlights implications for risk to children based on a parent's use, abuse, or dependence on alcohol or other drugs. The information regarding clinical criteria included on the table is from the American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (American Psychiatric Association, 1994).

Additional information regarding the types of risks to children based on parental substance abuse disorders can be found in *Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers* available on line at www.ncsacw.samhsa.gov (Beshears, Yeh, & Young, 2004).

The box shown after this chart provides the National Institute on Drug Abuse (NIDA) researched-based basic principles of substance use disorder treatment process (NIDA, 1999). Child welfare and court staff should incorporate these principles into training curricula.

Alcohol and Drug Use Continuum	Implications for Child Welfare/ Examples of Risk to Children
Use of alcohol or other drugs to socialize and feel effects. Use may not appear abusive and may not lead to dependence, however the circumstances under which a parent uses can put children at risk of harm.	• Driving with children in the car while under the influence. • Use during pregnancy can harm the fetus.
Abuse of alcohol or drugs includes at least one of these factors in the last 12 months: • Recurrent substance use resulting in failure to fulfill obligations at work, home or school. • Recurrent substance use in situations that are physically hazardous. • Recurrent substance-related legal problems. • Continued substance use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the substance.	• Children may be left in unsafe care—with an inappropriate caretaker or unattended—while parent is partying. • Parent may neglect or sporadically address the children's needs for regular meals, clothing, and cleanliness. • Even when the parent is in the home, the parent's use may leave children unsupervised. • Behavior toward children may be inconsistent, such as a pattern of violence then remorse.
Dependence, also known as addiction, is a pattern of use that results in three or more of the following symptoms in a 12 month period: • Tolerance—needing more of the drug or alcohol to get "high". • Withdrawal—physical symptoms when alcohol or other drugs are not used, such as tremors, nausea, sweating, and shakiness. • Substance is taken in larger amounts and over a longer period than intended. • Persistent desire or unsuccessful efforts to cut down or control substance use. • A great deal of time is spent in activities related to obtaining the substance, use of the substance or recovering from its effects. • Important social, occupational, or recreational activities are given up or reduced because of substance use. • Substance use is continued despite knowledge of persistent or recurrent physical or psychological problems caused or exacerbated by the substance.	• Despite a clear danger to children, the parent may engage in addiction-related behaviors, such as leaving children unattended while seeking drugs. • Funds are used to buy alcohol or other drugs, while other necessities, such as buying food, are neglected. • A parent may not be able to think logically or make rational decisions regarding children's needs or care.

NIDA's Principles of Effective Drug Treatment

1. No single treatment is appropriate for all individuals.

2. Treatment needs to be readily available.

3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.

4. 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.

5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness.

6. Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.

7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.

8. Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.

9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.

10. Treatment does not need to be voluntary to be effective.

11. Possible drug use during treatment must be monitored continuously.

12. 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.

13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.).Washington, DC: Author.

Beshears, E., Yeh, S., & Young, N. K. (2005). *Understanding substance abuse and facilitating recovery: A guide for child welfare workers*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

National Institute on Drug Abuse (1999). *Principles of drug addiction treatment:A research based guide*. Accessed September 18, 2006, at http://www.nida.nih.gov/PODAT/PODAT1.html

Appendix F

Examples of Safety and Risk Assessments for Use by Child Welfare Staff

Examples of Safety and Risk Assessments for Use by Child Welfare Staff

This appendix provides information about and samples of screening and assessment tools for child maltreatment and child development. In the description of each tool, the definition follows the tool acronym.

These tools should be used to support ongoing processes that involve regular communication among staff and between staff and families. Tools by themselves do not provide answers to complicated issues such as substance use disorders and child maltreatment. Tools can, however, contribute to decisions about whether problems exist, the nature and extent of those problems, and what actions all three systems—child welfare, alcohol and drug, and court—should take to address problems.

Although there are broad ranges of documentation procedures describing ways to assess child safety, there are few commercially available safety assessment tools other than those distributed as part of consultation services. That is, a number of organizations provide consulting and training in this area and have instruments that are used in the process, but the instruments tend not to be sold apart from the training. Many jurisdictions have established their own safety assessment and documentation procedures and forms, but do not distribute them as defined tools.

Screening Tools for Child Safety

The following list, alphabetized by tool name, provides information to answer the questions *"Is there a child maltreatment issue? What is the immediacy of the issue?"*

CHILD ABUSE POTENTIAL INVENTORY (CAPI)

The CAPI (Child Abuse Potential Inventory) appears to be one of the more widely researched instruments in terms of the volume of publications on the tool, due in large part to the prolific work of its author. The instrument covers areas such as problems with family, children, and others; rigidity; stress; and general unhappiness, but does not provide any screening for influences of substance use or specific mental health problems.

Administrative Issues	160 items, of which 77 form a physical child abuse scale; 6 factor subscales are contained in the abuse scale; and 3 validity scales Pencil-and-paper self-administered or interview Time required: unspecified, but may be expected to require 40 to 60 minutes A manual, an interpretive manual, and scoring templates are available commercially, but computerized scoring programs are no longer available.
Scoring	Time required: undetermined Scored by hand No computerized scoring or interpretation available
Clinical Utility	The CAP Inventory taps areas that are logically related to maltreatment risks, and the research on the tool seems extensive. The reported concurrent validity of the instrument seems good, especially for identifying nonabusive cases, but the predictive validity is not as clear.
Copyright	Copyrighted by Joel S. Milner
Cost	Data sheets are $2 for a set of 10; manuals and scoring templates are priced between $20 and $50
Source	Psytec, Inc. P.O. Box 564 DeKalb, IL 60115 Phone: 815-758-1415 Fax: 815-758-1725

RISK INVENTORY
FOR SUBSTANCE ABUSE-AFFECTED FAMILIES

The Risk Inventory for Substance Abuse-Affected Families is one of the few instruments to explicitly assess the potential influences of substance use and substance use disorders on risks for maltreatment. It consists of eight scales, or ratings, anchored with descriptive statements for defining the level for each scale. This risk inventory assumes that substance abuse or dependence has already been identified as being an issue in the family, and the intent is to assess the risks posed to children. Topics covered include commitment to recovery, patterns of use, effects on child care and lifestyle, supports for recovery, self-efficacy and self-care of the parent, and quality of the neighborhood. Several of the scales cover areas that could provide indications for immediate action. This instrument has scales that could be considered appropriate for this appendix and Appendix D, "Examples of Screening and Assessment Tools for Substance Use Disorders"; therefore, it is listed in each.

Administrative Issues

Eight rating scales; scores range from 1 to either 4 or 5 with options for unknown or not applicable
Ratings are completed by professionals based on observations and discussions with the family members.
Time required: variable

Scoring

Time required: variable
No manuals for administration or scoring available

Clinical Utility

The instrument has good face validity in terms of areas to consider in gauging the potential risks to children based on the parent's or caretaker's functioning and commitment to recovery. Lack of information on the performance of the tool and apparent lack of research on the instrument may require initial care in interpretation of findings.

Copyright

Copyrighted by Children's Friend and Service

Cost

$10 to receive a copy of the instrument

Source

Children's Friend and Service
153 Summer Street
Providence, RI 02903
Phone: 401-331-2900
Fax: 401-331-3285

STRUCTURED DECISION MAKING (SDM)
SAFETY ASSESSMENT

The SDM (Structured Decision Making) model, as described by the Children's Research Center (CRC) of the National Council on Crime and Delinquency (NCCD), is a procedure for improved practice by child welfare services. CRC states that at the heart of the model is a series of tools to assess families and structure the agency's response. One tool is the Safety Assessment, used to determine the threat of immediate harm and to identify steps needed to protect children.

The CRC publication, *The Improvement of Child Protective Services with Structured Decision Making: The CRC Model*, provides an example of an SDM Safety Assessment tool developed in one State—The Georgia Safety Assessment and Plan.

Administrative Issues	Unknown
Scoring	Time required: unknown
Clinical Utility	The general information obtainable on the procedure suggests that the concept and practices have merit. A number of States are listed as having implemented the procedure. Data supplied indicate that the risk levels as assessed are related to subsequent referrals, placements, and substantiations. Utility for individual casework cannot be determined from the materials reviewed.
Copyright	Unknown
Cost	Unknown
Source	Children's Research Center 426 South Yellowstone Drive, Suite 250 Madison, WI 53719 Phone: 608-831-8882 Fax: 608-831-6446

Assessment Instruments for Child Welfare

The following list of instruments provides information on tools to assess parents and families for factors related to child maltreatment and child and family well-being. Items in these tools that relate to substance use disorders tend to confuse disorders with substance use that is not necessarily problematic. In addition, the items frequently do not reflect the level to which substances may impair functioning or directly increase risks for maltreatment. Much of the assessment research has focused on the impacts of maltreatment on the victim rather than on risk indicators to identify risk from a potential perpetrator. A potential positive element of risk assessment instruments is that they have not been used to replace professional judgment. In some areas of screening, screens have been misused because their findings have been taken at face value in making decisions, without integrating the screen results with other information. Such integration of information appears more the norm with respect to risk assessments for maltreatment.

The maltreatment instruments listed in the following section could also be considered as tools to assist in monitoring and modifying case planning.

The "Child Abuse Potential Inventory," the "Parenting Stress Index," the "Risk Inventory for Substance Abuse-Affected Families" and the "Structured Decision-Making Risk Assessment" describe risk assessment instruments and appear in this order. The "Family Assessment Form," the "Risk Inventory for Substance Abuse-Affected Families," and the "Structured Decision Making Family Strengths and Needs describe child and family well-being assessment instruments and appear in this order.

These tools provide information to answer the questions: *"What is the nature and extent of the child maltreatment issue?"*

CHILD ABUSE POTENTIAL INVENTORY

The CAP (Child Abuse Potential Inventory) appears to be one of the more widely researched instruments in terms of the volume of publications on the too, due in large part to the prolific work of its author. The instrument covers areas such as problems with family, children, and others; rigidity; stress; and general unhappiness, but does not provide any screening for influences of substance use or specific mental health problems.

Administrative Issues	160 items, of which 77 form a physical child abuse scale; 6 factor subscales are contained in the abuse scale; and 3 validity scales Pencil-and-paper self-administered or interview Time required: unspecified, but may be expected to require 40 to 60 min. A manual, an interpretive manual, and scoring templates are available commercially, but computerized scoring programs are no longer available.
Scoring	Time required: undetermined Scored by hand No computerized scoring or interpretation available
Clinical Utility	The CAP Inventory taps areas that are logically related to maltreatment risks, and the research on the tool seems extensive. The reported concurrent validity of the instrument seems good, especially for identifying nonabusive cases, but the predictive validity is not as clear.
Copyright	Copyrighted by Joel S. Milner
Cost	Data sheets cost $2 for a set of 10; manuals and scoring templates are priced between $20 and $50
Source	Psytec, Inc. P.O. Box 564 DeKalb, IL 60115 Phone: 815-758-1415 Fax: 815-758-1725

PARENTING STRESS INDEX (PSI)

The PSI (Parenting Stress Index) is designed to identify potentially dysfunctional parent–child systems, focuses intervention on high-stress areas, and predicts future psychosocial adjustment of the child. The PSI was developed for use with parents of children ages 3 months to 10 years. The instrument has been available since the early 1980s; there has been a great deal of research and study around the PSI including translation in multiple languages and studies with many cultural and ethnic groups.

Administrative Issues	Standard Form: 101 items; and optional 19-item Life Events Stress Scale is also provided. Short Form: 36 items (The standard form is recommended over the short form, because the 10 to 15 minutes saved does not appear to outweigh the loss of information.) Parent self-report Amount of time required for administering, scoring, and profiling is not indicated. A computer scoring and report writing program, which allows for the comparison of individual parent profiles to 47 researched clinical profiles, is available,
Scoring	Time required: undetermined 74-page manual Computerized scoring available
Clinical Utility	There is reported discriminant validity examining PSI scores of mothers of children who are "normal" and mothers of children who have special needs, and discriminating between mothers who are physically abusive and nonabusive, amount of husband support, and single and married mothers. Spanish version available
Copyright	Copyrighted presumably by Pediatric Psychology Press
Cost	Unknown
Source	Pediatric Psychology Press 320 Terrell Road West Charlottesville, VA 22901

RISK INVENTORY FOR
SUBSTANCE-AFFECTED FAMILIES

The Risk Inventory for Substance Abuse-Affected Families is one of the few instruments to explicitly assess the potential influences of substance use and substance use disorders on risks for maltreatment. It consists of eight scales, or ratings, anchored with descriptive statements for defining the level for each scale. This risk inventory assumes that substance abuse or dependence has already been identified as being an issue in the family, and the intent is to assess the risks posed to children. Topics covered include commitment to recovery, patterns of use, effects on child care and lifestyle, supports for recovery, self-efficacy and self-care of the parent, and quality of the neighborhood.

Administrative Issues

Eight rating scales; scores range from 1 to either 4 or 5 with options for unknown or not applicable
Ratings are completed by professionals based on observations and discussions with the family members.
Time required: variable

Scoring

Time required: variable
No manuals for administration or scoring available

Clinical Utility

The instrument has good face validity in terms of areas to consider in gauging the potential risks to children based on the parent's or caretaker's functioning and commitment to recovery. Some of these factors also address the nature and extent of problems. Lack of information on the performance of the tool and apparent lack of research on the instrument may require initial care in interpretation of findings.

Copyright

Copyright by Children's Friend and Service

Cost

$10 to receive a copy of the instrument

Source

Children's Friend and Service
153 Summer Street
Providence, RI 02903
Phone: 401-331-2900
Fax: 401-331-3285

STRUCTURED DECISION MAKING (SDM)
RISK ASSESSMENT

The SDM (Structured Decision Making) model, as described by the Children's Research Center (CRC) of the National Council on Crime and Delinquency (NCCD), is a model for improved practice by child welfare services. CRC states that at the heart of the model is a series of tools to assess families and structure the agency's response. One tool is the Risk Assessment, which is a research-based tool to estimate the likelihood of future abuse/neglect.

The CRC publication, *The Improvement of Child Protective Services with Structured Decision Making: The CRC Model*, provides an example of an SDM Risk Assessment tool developed in one State—The California Family Risk Assessment.

Administrative Issues   Unknown

Scoring   Time required: unknown

Clinical Utility   The general information obtainable on the procedure suggests that the concept and practices have merit. A number of States are listed as having implemented the procedure. Data supplied indicate that the risk levels as assessed are related to subsequent referrals, placements, and substantiations. Utility for individual casework cannot be determined from the materials reviewed.

Copyright   Copyrighted

Cost   Unknown

Source   Children's Research Center
426 South Yellowstone Drive, Suite 250
Madison, WI 53719
Phone: 608-831-8882
Fax: 608-831-6446

FAMILY ASSESSMENT FORM (FAF)

The FAF (Family Assessment Form) was developed as a means of providing standardization to family assessments, but with the intention that the tool be adapted to meet the needs of specific programs and applications. It covers six areas of family functioning and is able to identify strengths as well as problems. The form consists of ratings to be completed by the worker as based on observations and discussions with the family member. This instrument is not to be completed by the family member.

Administrative Issues	Approximately 90 ratings covering 6 areas of family functioning Paper-and-pencil form is completed by the professional. Time required: variable, depending upon the professional or technician Training and supervision are required for the appropriate use of the tool.
Scoring	Time required: variable, depending upon circumstances No computerized scoring or interpretation available
Clinical Utility	The FAF provides a vehicle for establishing some structure and consistency to family evaluations. Statistics indicate that with proper training and supervision, raters can achieve good reliability so that there is consistency among different workers' ratings.
Copyright	Children's Bureau of Southern California
Cost	Contact source.
Source	Children's Bureau of Southern California Children's Bureau Headquarters 3910 Oakwood Avenue Los Angeles, CA 90004 Phone: 323-953-7356/323-661-7306 Toll-free: 888-ALL 4 KIDS (888-255-45437) Fax: 323-661-7306 Web site: www.all4kids.org Contact person for information: Sandy Sladen fafsupport@all4kids.org

RISK INVENTORY FOR
SUBSTANCE-AFFECTED FAMILIES

The Risk Inventory for Substance Abuse-Affected Families is one of the few instruments to explicitly assess the potential influences of substance use and substance use disorders on risks for maltreatment. It consists of eight scales, or ratings, anchored with descriptive statements for defining the level for each scale. This risk inventory assumes that substance abuse or dependence has already been identified as being an issue in the family, and the intent is to assess the risks posed to children. Topics covered include commitment to recovery, patterns of use, effects on child care and lifestyle, supports for recovery, self-efficacy and self-care of the parent, and quality of the neighborhood.

Administrative Issues	Eight rating scales; scores range from 1 to either 4 or 5 with options for unknown or not applicable Ratings are completed by professionals based on observations and discussions with the family members. Time required: variable
Scoring	Time required: variable No manuals for administration or scoring available
Clinical Utility	The instrument has good face validity in terms of areas to consider in gauging the potential risks to children based on the parent's or caretaker's functioning and commitment to recovery. Some of these factors also address the nature and extent of problems. The lack of information on the performance of the tool and apparent lack of research on the instrument may require initial care in interpretation of findings.
Copyright	Copyrighted by Children's Friend and Service
Cost	$10 to receive a copy of the instrument
Source	Children's Friend and Service 153 Summer Street Providence, RI 02903 Phone: 401-331-2900 Fax: 401-331-3285

STRUCTURED DECISION MAKING (SDM)
FAMILY AND CHILD STRENGTHS AND NEEDS ASSESSMENT

The Structured Decision Making (SDM) model, as described by the Children's Research Center (CRC) of the National Council on Crime and Delinquency (NCCD), is a model for improved practice by child welfare services. CRC states that at the heart of the model is a series of tools to assess families and structure the agency's response. One tool is the standardized Family and Child Strengths and Needs Assessment, which guides service planning.

The CRC publication, *The Improvement of Child Protective Services with Structured Decision Making: The CRC Model*, provides an example of an SDM Family Strengths and Needs Assessment tool developed in one State—The Wisconsin Urban Caucus Family Strengths and Needs Assessment.

Administrative Issues	Unknown
Scoring	Time required: unknown
Clinical Utility	The general information obtainable on the procedure suggests that the concept and practices have merit. A number of States are listed as having implemented the procedure. Data supplied indicate that the risk levels as assessed are related to subsequent referrals, placements, and substantiations. Utility for individual casework cannot be determined from the materials reviewed.
Copyright	Unknown
Cost	Unknown
Source	Children's Research Center 426 South Yellowstone Drive, Suite 250 Madison, WI 53719 Phone: 608-831-8882 Fax: 608-831-6446

The following three instruments are examples of the types of screening instruments available for use with children and youth. These and other instruments help staff determine whether children are experiencing developmental delays and gather information from teachers, parents, and youth themselves. This list is in alphabetical order based on the instrument acronym.

AGES AND STAGES QUESTIONNAIRES (ASQ)

The ASQ (Ages and Stages Questionnaires) is a parent-completed, child-monitoring system that provides a way to screen infants and young children for developmental delays during the crucial first 5 years of life. Parents/caregivers complete simple, illustrated questionnaires at designated intervals, assessing children in their natural environment. Questionnaires cover five key developmental areas: communication, gross motor, fine motor, problem solving, and personal–social.

Administrative Issues	19 30-item questionnaires for use with young children at 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, and 60 months of age Parents/caregivers complete questionnaires. Professionals convert parents'/caregivers' responses.
Scoring	Each questionnaire can be completed in 10 to 15 minutes. Time for conversion of parents'/caregivers' responses by professionals is approximately 2 to 3 minutes. The *ASQ User's Guide* offers clear guidelines for determining whether children are at high or low risk in various domains.
Clinical Utility	Questionnaires are available in English, Spanish, French, and Korean.
Copyright	Copyrighted presumably by Diane Bricker, Ph.D., and Jane Squires, Ph.D.
Cost	Ranges from $190 for the complete set of questionnaires to $165 for the questionnaires only; ASQ CD-ROM available for $165; Home video available for $44
Source	Available online at Brookes Store http://www.pbrookes.com/store/books/bricker-asq/

AGES AND STAGES QUESTIONNAIRES (ASQ)

The ASQ:SE (Ages and Stages Questionnaire: Social Emotional) was developed in response to feedback on the ASQ. It provides an easy-to-use tool focusing on children's social and emotional behavior. It allows professionals to quickly recognize young children at risk for social or emotional difficulties, identify behaviors of concern for caregivers, and identify any young children needing further assessment. Used with children from 6 to 60 months, the ASQ:SE screens in the areas of self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people.

Administrative Issues	Eight color-coded questionnaires for use with young children at 6, 12, 18, 24, 30, 36, 48, and 60 months of age Parents/caregivers complete the questionnaires. Professionals score the questionnaires.
Scoring	Eight corresponding score sheets come in the *ASQ:SE User's Guide*. Each questionnaire takes 10 to 15 minutes to complete. Professionals can score parents'/caregivers' responses in 2 to 3 minutes.
Clinical Utility	The ASQ:SE has been investigated with more than 3,000 children across the age intervals and their families. Reliability is 94%; validity is between 75% and 89%. The *ASQ:SE User's Guide* includes instructions on setting up and running the ASQ:SE, validity data, tips on cultural sensitivity, case studies, and activities. Available in English and Spanish
Copyright	Copyrighted presumably by Diane Bricker, Ph.D., and Jane Squires, Ph.D.
Cost	Ranges from $125 for the complete set of questionnaires to $100 for the questionnaires only
Source	Available online at Brookes Store http://www.pbrookes.com/store/books/squires-asqse/

CHILD BEHAVIOR CHECKLIST/6-18 (CBCL/6-18), TEACHER REPORT FORM/6-18 (TRF/6-18), YOUTH SELF-REPORT/11-18 (YSR/11-18), CHILD BEHAVIOR CHECKLIST/1 ½-5 (CBCL/1 ½-5), AND CAREGIVER-TEACHER REPORT FORM (C-TRF)

The CBCL/6-18 (Child Behavior Checklist/6-18, TRF/6-18 (Teacher's Report Form/6-18), and the YSR/11-18 (Youth Self-Report Form/11-18) use national norms from problem, competence, and adaptive scales. They feature DSM-oriented scales in addition to empirically based scales.

CBCL/6-18 obtains parents' reports of children's competencies and problems. Profiles for scoring the CBCL/6-18 include six DSM-oriented scales, 3 competence scales, total competence, eight cross-informant syndromes, internalizing, externalizing, and total problems.

TRF/6-18 obtains teachers' ratings of most CBCL/6-18 problem items, plus other items appropriate for teachers, including scales for academic performance and adaptive functioning

YSR/11-18 can be completed by youth having fifth-grade reading skills, or administered orally. It has many of the CBCL/6-18 items, but 14 CBCL problem items are replaced with socially desirable items endorsed by most youth.

The CBCL/1½-5 (Child Behavior Checklist/1 ½-5) and the C-TRF (Caregiver-Teacher Report Form) measure for six cross-informant syndromes and five DSM-oriented scales, and include a Language Development Survey.

CBCL/1 ½-5 obtains parent ratings on 99 problem items and describes problems, disabilities, parents' key concerns, and what parents believe to be the best things about their children. The Language Development Survey obtains parents' reports of children's expressive vocabularies and word combinations, plus risk factors for language delays.

C-TRF obtains ratings from daycare providers and teachers and describes problems, disabilities, key concerns, and best things about the child.

Administrative Issues	Can be self-administered or administered by an interviewer
Scoring	Time required: unknown Can be hand scored; computerized scoring available
Clinical Utility	Reliability and validity tests have been conducted on the CBCL instruments; importantly, demographic variables for race and socioeconomic status accounted for a relatively small proportion of score variance; normative data exist on all the instruments. Spanish versions are available in the CBCL/6-18, YSR/11-18 and CBCL/1 ½-5.

Copyright	Copyrighted by Achenbach System of Empirically Based Assessment
Cost	Each tool and the corresponding hand-scoring forms can be purchased at $25 for 50 copies; reusable templates for hand-scoring can be purchased for $7; starter kits for hand scoring and computer scoring can be purchased in a range from $150 to $325.
Source	Achenbach System of Empirically Based Assessment 1 South Prospect Street Burlington, VT 05401-3456 Phone: 802-264-6432; 802-264-6433 Fax: 802-652-2602 E-mail: mail@ASEBA.org Web site: www.aseba.org

Appendix G

Sharing Confidential Information

Sharing Confidential Information

Understanding other systems is a necessary but not sufficient condition for collaboration. Collaboration requires communication, and knowledge and understanding create a framework within which formal structures for communication can be established, but by themselves do not assure that communication in fact occurs. One test of whether such communication structures exist is whether child welfare workers and alcohol or substance abuse treatment counselors regularly communicate about the status of both parents and children involved with the child welfare and alcohol and drug systems.

One task of the Steering Committee will be to establish uniform policies that allow workers from the child welfare, alcohol and drug, and court systems to share important information about families (information generally subject to Federal confidentiality rules) and information required to monitor families' progress. The Steering Committee is well-positioned to develop communication protocols that are effective and understood by staff because it provides a mechanism for senior officials in all three systems to communicate among themselves, arrive at consensus on what policies should be instituted, issue those policies to local jurisdictions and offices, and monitor how well the policies are working.

It is particularly critical that the Steering Committee establish policies and protocols that allow staff to share information they learn through screening and assessing families because these terms mean different things to staff from different systems. For example, alcohol and substance abuse treatment staff use screening and assessment to make decisions regarding the most appropriate form of treatment for parents. In contrast, child welfare staff conduct screenings for substance use disorders to make decisions regarding whether children are safe or can remain in their homes.

Developing administrative policies and protocols to enhance cross-system communication is particularly critical when the information to be shared is considered confidential by one or more of the systems. The next section of this guidebook describes roles and responsibilities that are inherent to working collaboratively, but in order for staff to carry out those roles and responsibilities, they have to be working within shared and clear protocols for sharing information with each other. Without standard policies and protocols, workers from each system are left on their own to decide they are permitted to share, and confidentiality concerns are often raised by alcohol and drug, child welfare, and court staff as a reason why they cannot communicate with each other.

In fact, confidentiality is a serous concern. All three systems operate within strict Federal, State, and jurisdictional guidelines regarding how information about families may be shared, and families have a legal and ethical right to trust that information about them will be kept confidential. At the same time, it is possible to develop policies that allow sharing of information in ways that do not violate legal or ethical standards.

The Steering Committee can take the lead in developing standards for sharing sensitive information that complies with all regulations and also gives staff and families both the certainty they need to allow appropriate information to be disclosed and to exchange information in writing and orally. Members of the Steering Committee and others should have basic knowledge of—

- The basic Federal confidentiality rules for treatment providers and the reasons for these rules;
- Additional State law restrictions governing confidentiality (State laws may be more restrictive than Federal requirements); and
- The basic Federal, State, and local laws governing confidentiality in the child welfare and court systems.

A consent form signed by the parent is probably the most common strategy for facilitating cross-system communication. Jurisdictions can develop a common consent form for use by all collaborating parties. Or, jurisdictions can use Federally approved consent forms. Typical consent forms include the following:

- Name or general description of programs making disclosure;
- Name or title of individual or organization that will receive disclosure;
- Name of the person who is the subject of disclosure;
- Purpose or need for disclosure;
- How much and what kind of information will be disclosed;
- Statement that the person giving consent may revoke (take back) consent at any time, except to the extent that the program has already acted on it;
- Date, event, or condition upon which consent will expire, if not previously revoked;
- Signature (and, in some States, that of his or her parent); and
- Date on which consent is signed.

It is important to note that when disclosure of information is made with the person's written consent, the system making the disclosure must include with the information conveyed a notice that "redisclosure" is prohibited without authorization. For example, if someone authorizes an alcohol or other drug treatment provider to share certain information with a child welfare worker, that worker is not allowed to share this information with someone else who is not identified on the consent form (i.e., the definition of "redisclosure").

The Center for Substance Abuse Treatment (CSAT) publication *Welfare Reform and Substance Abuse Treatment Confidentiality: General Guidance for Reconciling Need to Know and Privacy* provides additional guidance in how to address issues of confidentiality. Although the publication was created specifically for use with welfare recipients, the guidance offers practical strategies and Federally approved confidentiality forms for protecting family and individual rights, promoting interagency collaboration, and supporting case planning. (The report is free and can be ordered by calling 800-729-6686 and requesting TAP#24.)

The Privacy Rule included in the Federal Health Insurance Portability and Accountability Act (HIPAA) establishes other standards for safeguarding information.   For more information on HIPAA and the Privacy Rule, as well as on confidentiality rules, please refer to the CSAT publication *The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPPA Privacy Rule: Implications for Alcohol and Substance Abuse Programs*. This document is available at www.samhsa.gov or by calling 800-729-6686. Agencies within the alcohol and drug system may or may not fall under this Privacy Rule and should consult with legal counsel regarding how and whether the HIPAA regulations apply to them. However, agencies within the alcohol and drug system that are already in compliance with 42 CFR Part 2 (Federal confidentiality regulations governing treatment agencies) should not find it difficult to comply with the HIPAA regulations.

Appendix H

Glossary of Terms

Glossary of Terms

Following is a glossary providing definitions of terms and concepts used in this guidebook or in the fields of alcohol and drug treatment, child welfare services, and dependency courts.

Active efforts – the Indian Child Welfare Act (ICWA) requires, among other things, that States provide "active efforts" to prevent the break up of an Indian family. Active effort means not just an identification of the problems or solutions, but efforts showing an active attempt to assist in *bridging the gap*.

Adjudication hearing – in child welfare proceedings, the trial stage at which the court determines whether allegations of dependency, abuse, or neglect concerning a child are sustained by the evidence and, if so, are legally sufficient to support State intervention on behalf of the child and provides the basis for State intervention into a family, as opposed to the disposition hearing that concerns the nature of such intervention. In some States, adjudication hearings are referred to as "jurisdictional" or "fact-finding" hearings.

Adoption and Safe Families Act of 1997 (P.L. 105-96) – on November 19, 1997, the President signed into law the Adoption and Safe Families Act of 1997 (ASFA) which amended Titles VI-B and IV-E of the Social Security Act to clarify certain provisions of P.L. 96-272. ASFA made changes in a wide range of policies established under the Adoption Assistance and Child Welfare Act to improve the safety of children, to promote adoption and other permanent homes for children, and to support families.

Aftercare or continuing care – the immediate period after an intensive period of substance abuse treatment designed to support an individual's recovery through provision of formal supports such as relapse prevention services. These supports are combined with informal community-based recovery supports, such as participation in 12-Step programs, church, or other activities that support the recovery process.

Alcohol and drug services (ADS) – includes the broad continuum of programs and strategies designed to prevent and treat substance abuse and dependence and to ameliorate adverse consequences associated with substance use.

Alcohol and drug services staff (ADS staff) – counselors and other personnel with specialized knowledge and skills to provide services that prevent, intervene, and treat substance use disorders.

Alcoholism – an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead to intoxification if drinking is begun, by chronicity, by progression, and by tendency towards relapse. (This is a definition of the American Medical Association.)

Assessment in child welfare – broadly refers to gathering information that affects a child's immediate safety, potential risk of future harm, and a family's level of functioning and well- being based on its strengths and needs. The types of assessment in child welfare follow:

> *Safety Assessment* – evaluates immediate threats to the life or well-being of a child.

> *Risk Assessment* – evaluates potential future threats to the life or well-being of a child in the context of existing protective factors.

Family Assessment – evaluates how well a family is functioning in several domains that affect child and family well-being, including needs and strengths of the family.

Case plan – an individualized plan of action based on a comprehensive assessment, with measurable goals and outcomes developed by a family and child welfare services worker to ameliorate risk to children and ensure their safety, permanency, and well-being.

Child abuse – to hurt or injure a child by maltreatment. As defined by statutes in the majority of States, the term is generally limited to maltreatment that causes or threatens to cause lasting harm to a child.

Child neglect – to fail to give proper attention to a child; to deprive a child; to allow a lapse in care and supervision that causes or threatens to cause lasting harm to a child; to fail to perform or discharge a duty to a child, such as medical neglect or educational neglect.

Child protective services (CPS) – the division within child welfare services that is responsible for maintaining a child abuse and neglect referral system and for determining whether a child is in need of protection.

Child welfare services (CWS) – includes the broad continuum of programs and strategies designed to protect children from child abuse and neglect and to strengthen families.

Child welfare services staff (CWS staff) – social workers and other personnel with specialized knowledge and skills who provide services to prevent and intervene with families at risk of and involved with child abuse and neglect.

Community-based recovery support – informal support available to an individual that helps that individual to maintain recovery from a substance use disorder. This support frequently involves participation in 12 Step programs, but may also include supportive friends, family, church, sports activities, hobbies, or other activities that reinforce the individual's recovery either directly or indirectly.

Dependency court – the court system that adjudicates cases of child abuse and neglect. In some States, these courts may be known as juvenile courts or family courts.

Dependency cases – cases that go before a juvenile court in which allegations of child abuse or neglect are heard. The specific definition of a dependency case and a dependent child varies by State statute.

Dependent child – a young person subject to the jurisdiction of the court because of child abuse or neglect, or lack of proper care through no fault of the parent.

Diagnosis of a substance use disorder – using criteria established by the American Psychological Association, *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)*, to determine whether a person is classified as a substance user, substance abuser, or is substance dependent.

Disposition hearing – the stage of the juvenile court process in which, after finding that a child is within jurisdiction of the court, the court determines who shall have custody and control of a child and elicits judicial decision on whether to continue out-of-home placement or to remove a child from home. Service plans, treatment plans, and conditions of placement are discussed and determined.

Identification of a child who is potentially a victim of abuse or neglect, or both – an awareness of behaviors, signs, or symptoms indicating that there is reasonable suspicion that a child has been the victim of abuse or neglect, or both. Some health, social service, and educational professionals are required by law to report such suspicions to child protective services.

Identification of a person with a potential substance use disorder – observations or knowledge that a person's substance use is associated with adverse consequences in areas of life functioning including interpersonal relationships, family responsibilities, employment, criminality, or emotional well-being, or any combination of these.

Immediate need triage – observations and questions leading to a determination that an individual is at immediate risk of biomedical or psychiatric complications associated with substance use that could be life threatening (e.g., overdose or withdrawal complications); or because of a lack of readiness to change, relapse, or continued use potential or recovery environment problems, there is a strong probability that certain behaviors will occur (e.g., continued alcohol or drug use or relapse or noncompliance with psychiatric medications) that will present a significant risk of serious adverse consequences to the individual or others, or both, and that such adverse events will occur in the very near future.

Permanency planning hearing – a special type of postdispositional proceeding designed to reach a decision concerning the permanent placement of a child. ASFA established a permanency planning hearing within 12 months of a child's placement, rather than within 18 months as in current law. At the hearing, there must be a determination whether and when a child will be returned home, placed for adoption and a termination of parental rights petition will be filed, or referred for legal guardianship or, when other options are not appropriate, will have another planned permanent living arrangement. For children for whom a court determines reasonable efforts to reunify are not required, a permanency planning hearing must be held within 30 days of such determination.

Preliminary protective hearing – the first court hearing in a juvenile abuse or neglect case, referred to in some jurisdictions as a "shelter care hearing," "detention hearing," "emergency removal hearing," or "temporary custody hearing"; occurs either immediately before or immediately after the child is removed from home on an emergency basis; may be preceded by an ex parte order directing placement of the child; in extreme emergency cases may constitute the first judicial review of a child placed without prior court approval.

Reasonable efforts – the reasonable efforts requirement of the Federal law is designed to ensure that families are provided with services to prevent their disruption and to respond to the problems of unnecessary disruption of families and foster care drift. Public Law 96-272, the Adoption Assistance and Child Welfare Act of 1980, required that "reasonable efforts" be made to prevent or eliminate the need for removal of a dependent, neglected, or abused child from the child's home and to reunify the family if the child is removed. To enforce this provision, the juvenile court must determine, in each case where Federal reimbursement is sought, whether the agency has made the required reasonable efforts. (42 U.S.C. 671(a)(15), 672(a)(1).) ASFA expanded reasonable efforts provisions by requiring that when a court determines that reasonable efforts to reunify are not required, a permanency planning hearing must be held within 30 days of such determination. Reasonable efforts also must be made to place the child in a timely manner in accordance with the permanency plan and to complete whatever steps are necessary to finalize the plan.

Recovery – the process by which an individual has learned to develop and maintain a lifestyle that is free from substance use which enables individuals with substance abuse and dependency problems to return to full functioning.

Relapse – to fall back into a previous problem behavior pattern; a return of a disease or illness after partial recovery from it.

Reliability – the consistency of test scores over different test administrations, multiple raters, and different test questions. Reliability usually refers to one of two types of reliability—*test-retest reliability and internal consistency reliability*. The two are often confused even though they represent very different concepts:

> *Test-Retest Reliability* – whether one gets the same results with different administrations of the same screen. It is usually expressed as a correlation between scores from the first and second administrations of the same screen. The higher the score (between zero and 1), the greater the correlations from the two test periods. Considerations of test-retest reliability of an instrument should be looking for scores over 0.85.

> *Internal Consistency Reliability* –how strongly the items of a screen correlate with each other. If the items are designed to measure a single characteristic (e.g., depression) or risk (e.g., probability of having a substance use disorder), then the questions or items in the instrument should be highly correlated with the concept being measured and with each other. It is expressed as a statistic in which the average correlation of half of the items is compared to the average correlation of the other half. Again, the statistic can vary from zero (no reliability) to 1.0 (perfect reliability).

Review hearing – court proceedings that take place after disposition in which the court comprehensively reviews the status of a case, examines progress made by the parties since the conclusion of the disposition hearing, provides for correction and revision of the case plan, and makes sure that cases progress and children spend as short a time as possible in temporary placement.

Screening for child abuse or neglect, or both – observations and questions leading to a determination that a child may have been the victim of abuse or neglect, or both. These observations or questions are centered on issues of physical or sexual abuse, deprivation, and neglect of child's basic needs or well-being.

Screening for substance use disorders – a set of routinely administered observations and questions leading to a determination that a person has a potential substance use disorder. Screening is conducted by child welfare service staff as well as community-based providers, hospital staff, other health or social services agency staff, or may be a specialized service conducted by an alcohol or drug counselor.

Sensitivity of a tool or instrument – how sensitive the screen is to detecting a given condition is expressed in a percentage. Sensitivity is the proportion or percentage of cases detected by the screening tool out of all individuals with the condition. In the case of screening for substance use disorders, sensitivity is expressed as the proportion of people who are properly identified as being at risk.

Specificity of a tool or instrument – how specific the tool is to detecting only the condition being screened for. It is expressed in a percentage and the higher the number, the fewer false positive mistakes. Among those without the condition, specificity is the proportion or percentage of cases correctly

identified as not being at risk. Specificity of a screen concerns the ability to correctly identify negative cases as negative.

Substance use disorders (SUDs) – include the spectrums of substance abuse and dependence as defined by the diagnostic criteria of the American Psychological Association, *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)*:

> **Substance use** – the consumption of legal or illegal, or both, psychoactive substances.

> **Substance abuse** – 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/social problems.

> **Substance dependence** – a pattern of use resulting in at least three of seven dependence criteria as specified in the *DSM-IV*: (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/psychological problems related to use.

Termination of parental rights (TPR) hearing – a hearing or trial in which severance of all legal ties between child and parents is sought, and in which the burden of proof must be by clear and convincing evidence; also referred to in some States as a "severance," "guardianship with the power to consent to adoption," "permanent commitment," "permanent neglect," or "modification" hearing. ASFA requires that a termination of parental rights petition be filed, except in certain cases, when a child of any age is under the responsibility of the State for 15 months out of the most recent 22 months. (The clock starts to run on the date of the first judicial finding of abuse or neglect or 60 days after the child is removed from the home, whichever is earlier.). ASFA also requires that a termination petition be filed when a court has determined a child to be an abandoned infant, or for cases in which a parent has committed murder or voluntary manslaughter of another child of the parent or a felony assault that has resulted in serious bodily injury to the child or another child. ASFA lists some exceptions that can be made to these requirements.

Treatment plan – an individualized plan of action based on a comprehensive assessment, with measurable goals and outcomes developed by a participant and substance abuse specialist to reduce or eliminate substance use and related adverse consequences.

Validity – the degree in which a test or other measuring device is truly measuring what it is intended to measure. There are four basic subtypes of validity: *concurrent, construct* (or criterion), *face* (or content), and *predictive*:

> **Concurrent validity** – means that two or more screens arrive at the same or similar answer. It does not mean that either screen is accurate with respect to some criteria; it simply means that they agree.

> **Construct, or criterion, validity** – is the extent to which a screen agrees with a definitive criterion or definitely measures a given construct (e.g., depression or presence of a substance use disorder). To establish this type of validity, we must have a definitive determination of what we are trying to identify. For example, in oncology, the biopsy is the definitive determination of whether a growth is malignant or not. All types of cancer screens are judged against the biopsy results to assess their accuracy. For this case in which the criterion for a test involves a categorical distinction, criterion validity may also be called discriminant validity—the test should discriminate between a positive or negative biopsy.

Face, or content, validity – means that the screen asks obvious questions related to the issue in question. In other words, if we are interested in substance use disorders, the items (or questions) of the screen ask about problems with the use of substances. If we are interested in depressive disorders, face valid questions would ask, for example, about feeling depressed or about having trouble sleeping. This type of validity typically is not represented by a statistic, but rather subjectively.

Predictive validity – determines whether the tool predicts what will happen? For example, various tests are employed to determine whether a given individual will be successful in college. Determining this type of validity requires monitoring future events (college success) and to verify whether the instrument correctly predicted what happened.

Appendix I

A Guide to Compliance With the Indian Child Welfare Act

A Guide to Compliance With the Indian Child Welfare Act

Following is a guide to Indian Child Welfare Act (ICWA) compliance. This information, including the flow chart on page 12, is from the National Indian Child Welfare Association's curriculum, "Cross Cultural Skills in Indian Child Welfare: Guide for the Non-Indian" (1987), with information derived from Oregon Children's Services Division's "A Guide and Checklist to ICWA Compliance," developed by Maria Tenorio, ICWA Specialist, Salem, Oregon, 1986.
State rules and regulations may vary from this guide; therefore, workers should make sure they know what their agency requires. Also, many States supply sample letters and/or checklists for compliance. Following this guide will ensure compliance with the Act, but not necessarily State rules.

WHEN THE ACT APPLIES

Tribal–State Agreements

The first precaution in applying ICWA is to make sure there is no tribal State agreement that has specific procedures to follow. Several tribes now have agreements with State agencies on child welfare matters.

Not Covered

Juvenile delinquency proceedings (violations of criminal law) are not covered with two exceptions:

- Juvenile delinquency proceedings where parental rights may be terminated; and
- Status offenses (juvenile delinquency proceedings which involve an offense that would not be a crime if committed by an adult, e.g., drinking, being a runaway, and being a truant)

Divorce proceedings when one parent is granted custody

Voluntary placement if the parent may regain custody "upon demand" (placement preferences still apply)

Covered

- Foster care placements
- Termination of parental rights
- Preadoptive placements

Adoptive placements (include conversion from foster care to adoptive placement)

- Both voluntary and involuntary placements if parents can't regain custody of child "upon demand"
- Divorce proceedings in which neither parent will get custody
- Juvenile delinquency proceedings where parental rights may be terminated
- Status offenses (juvenile delinquency proceedings which involve an offense that would not be a crime if committed by an adult, e.g., drinking, being a runaway, and being a truant)

Initial Determination

Oral Inquiry

At intake, and in every change or potential change in custody, the worker orally requests racial/ethnic data by reading aloud the racial/ethnic categories for the client's self-identification and asks: "Which of the following do you consider yourself a member: Asian, Black, Hispanic, Indian, White?"

If the family member responds that he or she is Indian or believes there is Indian ancestry, the worker fills out a family tree chart with the help of client family or other form provided by the agency.

Indian Tribe Verified

If the Indian tribal name and/or address is given, proceed to next section.

Indian Heritage Uncertain

If the parents are unavailable or unable to provide a reliable answer regarding the Indian heritage of their children—

- Make a thorough review of all documentation in the case record;
- Contact the previous caseworker, if any; and
- Make a close observation of the physical characteristics of the child, parents, siblings, and relatives.

Indian Tribe Unknown

If, in following the above steps, you have reason to believe the child is Indian, you will need to identify the Indian tribe by—

- Consulting with other relatives or extended family members; and
- Contacting, as appropriate, the suspected tribe, an Indian social services organization, or the Bureau of Indian Affairs.

Inquiry to Indian Tribe

- The worker checks with the child's tribe to determine whether the child is a member or is eligible for membership. If several tribes are suspected, the worker should send the inquiry letter to all of them.
- The worker can also telephone tribe(s), since this inquiry does not constitute the required official notice to a tribe. Any phone conversation should be documented in the case record with a letter to the effect, "As we discussed by phone today, you believe (stated)... etc."

Tribe Does Not Respond

If the tribe does not respond, call the tribal enrollment officer and follow up with a letter documenting the conversation.

Child Eligible for Membership

- If the tribe responds that the child is eligible for membership, request (or assist the family in filling out) application forms. Proceed to next section.

- If necessary, counsel parents hesitant to enroll a child by emphasizing the positive benefits of tribal membership.

Child Eligible for Membership

Once a tribe has determined that a child is not a member and not eligible for membership, the response must be documented in the case record, including date and source of documentation:

- Document all steps taken to determine the child's Indian or tribal ancestry; and
- File in the case record the tribe's written statement declaring the child ineligible for membership.

Incorporate in any court hearing the tribe's written statement declaring the child ineligible for membership.

Cultural Heritage Protection

For cases in which ICWA does not apply, but the child is biologically an Indian, and considered Indian by the Indian community, follow the Act in your case planning. Respect the child's right to participate in the culture of origin, particularly if such child is identifiably Indian by physical features and/or social relationships declaring the child to be Indian.

THE STATE MAY HAVE NO JURISDICTION

Exclusive Jurisdiction

Some tribes have exclusive jurisdiction over child welfare matters. If the child is a member of such a tribe, the child must be released to his or her parents unless this is an emergency (protective services) removal. You may wish to make a referral to the tribe's social services department to notify them of the family's difficulties.

Nationwide tribes with exclusive jurisdiction as of 1987 are Yakima, Spokane, Colville, and Muckleshoot (Washington); Omaha (Nebraska); Penobscot (Maine); Lac Courte Oreilles and Ho-Chunk Nation (formerly known as the Wisconsin Winnebago) (Wisconsin); Passamaquoddy (Maine); White Earth (Minnesota); and Warm Springs and Burns Paiute (Oregon).

Tribal Court Ward

A tribe has exclusive jurisdiction over tribal court wards, regardless of the child's residence or domicile.

If there is reason to believe that the child has resided or is domiciled on the reservation, phone the tribal court clerk to ask whether the child is a ward of the tribal court.

If yes, the child must be released to parents or custodians unless this is an emergency (protective services) removal. You may wish to make a referral to the tribe's social services department at the same time.

If not, be sure to document this fact in the case record.

NOTICE

Timelines

No requests for a court proceeding (with the exception of emergency removals) can be made until—

- At least 10 days after receipt of notice by parents or custodian, OR after 30 days if 20 days is requested by the parents or custodian to prepare for the proceeding; OR

- At least 10 days after receipt of notice by the tribe, OR after 30 days if the tribe requests an additional 20 days to prepare for the proceeding; OR

- No fewer than 15 days after receipt of notice by the BIA. (See below.)

Who Receives Notice

- Parents, always
- Custodian, if one is involved
- Tribe, always
- If child is affiliated with or eligible for membership in more than one tribe, all tribes should receive notice
- The BIA only if the identity/location of parents or custodians cannot be determined

Service of Notice

Notice should be served in person whenever possible; otherwise, notice should be served by registered mail, return receipt requested. File a copy of this notice with the court, along with any returned receipts or other proof of service.

Tribe Does Not Respond

Even if a tribe does not respond to an official notice sent, or if the tribe replies that it does not wish to intervene in the proceeding, continue to send the tribe notices of every proceeding. It is important to keep the tribe informed because the tribe can intervene at any point in the proceeding to assert its interest and the tribe has the right to notice of all hearings, motions, and other actions related to the case.

Translation of Notice

If there is reason to believe that the parent or Indian custodian will not understand the notice because of possible limited English proficiency, a copy of the notice shall be sent to the BIA Area Office nearest to the residence of that person. BIA staff should be requested to arrange to have the notice explained in the language that the person best understands. The BIA, by Federal regulation, is required to assist in identifying interpreters.

Transfer to Tribal Court

Section 191 L(b) of ICWA allows the parent or custodian or Indian tribe to transfer the proceeding to tribal court. The State court must transfer the proceeding unless the tribal court declines jurisdiction,

either parent objects to such transfer, or if the court determines that good cause exists to deny the transfer.

If the tribe requests orally, or in writing, a transfer of the proceeding to its tribal court—

- Inform the parents or custodians of their right to object to the transfer.

If any party believes that good cause exists not to transfer the proceeding:

- They should state in writing their reasons for such belief; and
- Their written statement must be distributed to all parties so that everybody has the opportunity to provide the court with their views.

Services To Prevent Out of Home Placement

Active efforts must be undertaken to provide remedial services subsequent to an investigation and before a decision is made to place the child out of the home. Proceed by—

- Contacting the tribal social services program for involvement at the earliest possible point; and
- Using other community services specifically designed for Indian families:
  - Extended family;
  - Urban Indian program, when appropriate; and
  - Individual Indian caregivers, such as medicine men.

Definition of Active Efforts

Active effort means not just an identification of the problems or solutions, but efforts showing an active attempt to assist in both arranging for the best-fitting services and helping families to engage in those services. *These can be demonstrated by—*

- Making an evaluation of the family's circumstances that takes into account the prevailing social and cultural conditions and the way of life of the child's tribe and/or Indian community.

- Intervening only when supported by relevant, prevailing Indian social and cultural standards regarding intervention in familial relationships by people who are not members of the family:
  - Develop a case plan with assistance of the parent/custodian that involves use of tribal Indian community resources;
  - Encourage maintenance of the child in his or her own family except where physical or emotional harm may result; and
  - Involve the child, if old enough, in the design and implementation of the case plan.

- Providing time and resources to prevent family breakup in at least equal measure to time and resources provided to other families.
- Assisting parents or custodian and child in maintaining an ongoing familial relationship.

Documentation

All remedial services offered to the family need to be recorded to demonstrate that, prior to petitioning for removal, active efforts were made to alleviate the need to remove the child. The case record cannot simply state that such efforts were unsuccessful, but efforts must *be shown* to be unsuccessful.

Before court proceedings to remove a child are initiated, case records should document that:

- Conduct or condition of the parent will result in serious physical or emotional harm to the child; and
- Efforts were made to counsel and change the parent's behavior, but did not work.

Documentation in the case record should relate indications of the likelihood of serious emotional or physical damage to particular conditions in the home, showing a causal relationship between the conditions and the serious damage that is likely to result to the child. (For example, it is not adequate to show that the parent abuses alcohol. It is necessary to show how, because of alcohol abuse, the parent may cause emotional or physical damage to the child.)

BURDEN OF PROOF

Through ICWA, Congress has declared that an Indian child may not be removed simply because there is someone else willing to raise the child who is likely to do a better job or that it would be "in the best interests of the child" for him or her to live with someone else. Nor can a placement or termination of parental rights be ordered simply based on a determination that the parents or custodians are "unfit parents." It must be shown that it is dangerous for the child to remain in his or her present conditions.

Foster Care Placement: Clear and Convincing Evidence

ICWA states that a court may not issue an order effecting a foster care placement of an Indian child in the absence of a determination, supported by clear and convincing evidence, including the testimony of one or more qualified expert witnesses, that the child's continued custody with the child's parents or Indian custodian is likely to result in serious emotional or physical damage to the child.

Termination of Parental Rights: Evidence Beyond a Reasonable Doubt

In order to ask the court to terminate parental rights, the agency as petitioner must show the court by evidence beyond a reasonable doubt, including the testimony of one or more qualified expert witnesses, that continued custody of the child by the parent or Indian custodian is likely to result in serious emotional or physical damage to the child.

Clear and Convincing

This is a high level of proof, though not as high as proof beyond a reasonable doubt. It means that in order to be successful, the side favoring foster placement must present evidence that is not just slightly more persuasive than the evidence against it, but clearly more persuasive.

This means that the side favoring termination must not only put on a more convincing case than the opposition, but must be so convincing that it eliminates all reasonable doubts in the mind of the person deciding the case. If the court fails to do so, the court is obligated by the Act to deny termination.

Qualified Expert Witnesses

Persons with the following characteristics are considered most likely to qualify as experts:

- A member of the Indian child's tribe who is recognized by the tribal community as knowledgeable in tribal customs as they pertain to family organization and child rearing practices;
- A layperson having substantial education and experience in the area of his or her specialty along with substantial knowledge of prevailing social and cultural standards and child rearing practices within the Indian child's tribe; or
- A professional person having substantial education and experience in the area of his or her specialty along with substantial knowledge of prevailing social and cultural standards and child rearing practices within the Indian community.

This list is not meant to be exhaustive or limited in any manner. Enlist the assistance of the Indian child's tribe in locating persons qualified to serve as expert witnesses. The BIA is also required to provide this assistance.

PLACEMENT OF INDIAN CHILDREN

A diligent search to follow the Act's placement preferences shall include, at a minimum—

- Contact with the tribe's social services program;
- Search of State and county lists of Indian homes; and
- Contact with other tribes and Indian organizations with available placement resources.

Foster Care/Preadoptive

Contact the tribe to ask whether it has a different placement preference from the following:

1. Member of child's extended family;
2. Foster home licensed, approved, or specified by the Indian child's tribe;
3. Indian foster home licensed or approved by an authorized non Indian; or
4. Institution for children approved by an authorized non-Indian licensing authority.

Change of Placement: Notify Parents

If the child is to be moved from one placement to another, or if the foster family plans to move, the child's parents or custodians must be notified in writing. Follow placement preferences outlined above, unless the child is returned to parents or custodians.

Adoptive Placements

Contact the tribe to ask whether it has a different placement preference from the following:

1. Child's extended family;
2. Other members of the child's tribe; or
3. Other Indian families.

Disrupted Adoptive Placements

If an adoption is vacated or set aside, or adoptive parents voluntarily consent to termination of parental rights, the Indian parents or custodians must be notified:

- Notice of their right for a return of their child must include a statement that such petition will be granted unless the court rules it is not in the child's best interest.
- Where parental rights have been terminated, it is up to the agency to decide whether or not to notify parents or custodians of their right to petition for a return of their child.

Documentation

Written records are to be maintained on each child, separate from the court record, of all placements and efforts to comply with required placement records. This record shall contain the following:

- The petition or complaint;
- All substantive orders entered; and
- Complete record of placement determination.

Where required placement preferences have not been followed, efforts to find suitable placements within those priorities shall be documented in detail.

Voluntary Placements

Consent cannot be accepted unless—

- The child is older than 10 days old;
- The consent is in writing and recorded before a judge; and
- The consent is accompanied by the judge's certificate ensuring that terms and consequences of the consent were—
  - ★ Fully explained in detail and fully understood by the Indian parents or custodians; and
  - ★ Fully explained in English or interpreted into a language understood by the parents or custodians.

Consent signed by Indian parents or custodians should contain the following:

- Name and birth date of child;
- Name of child's tribe;
- Child's enrollment number or other indication of membership in the tribe;
- Name and address of consenting parents or custodians;
- Name and address of prospective parents, if known, for substitute care placements; and
- Name and address of person or agency through which placement is being arranged, if any, for adoptive placements.

EMERGENCY REMOVALS

Unless circumstances do not permit such inquiry, the racial/ethnic status of the child shall be immediately determined by asking:

Of which of the following do you consider yourself a member?

Asian   Black   Hispanic   Indian   White

Indian: Name of tribe and/or band:

Emergency protective custody of any Indian child can be taken only if—

- the child is not located on the reservations of tribes that have jurisdiction over child custody proceedings; and
- the child is in danger of imminent physical damage or harm.

Placement

If the child is believed to be Indian, efforts shall be made to place the child during emergency care in a setting that follows the placement priorities established by either the tribe or ICWA:

1. A member of the child's extended family;
2. A foster home licensed, approved, or specified by the Indian child's tribe;
3. An Indian foster home licensed or approved by an authorized non Indian licensing authority; or
4. An institution for children approved by an Indian tribe or operated by an Indian organization that has a program suitable to meet the child's needs.

Termination of Placement

Emergency custody must be terminated when removal is no longer necessary to prevent imminent physical damage or harm to the child, or the appropriate tribe exercises jurisdiction over the case.

Continuation of Custody

If termination of an emergency removal is not possible, a court order should be obtained authorizing continued protective custody. The petition filed in such a proceeding should include the following in addition to that information required by State law:

- The name, age, tribal affiliation, and last known address of the Indian child;
- The name and address of the child's tribe and parents and/or Indian custodian, if any. If unknown, the agency shall provide a detailed description of efforts made to locate them;
- If known, whether the residence or domicile of the parent, Indian custodian, or child is on or near a reservation, and which reservation;
- A specific and detailed account of the circumstances that led to the conclusion that the child would suffer imminent physical damage or harm; and
- A specific plan of action to restore the child to his or her parents or Indian custodian, or to transfer the child to the jurisdiction of the appropriate Indian tribe.

Will ICWA Apply?
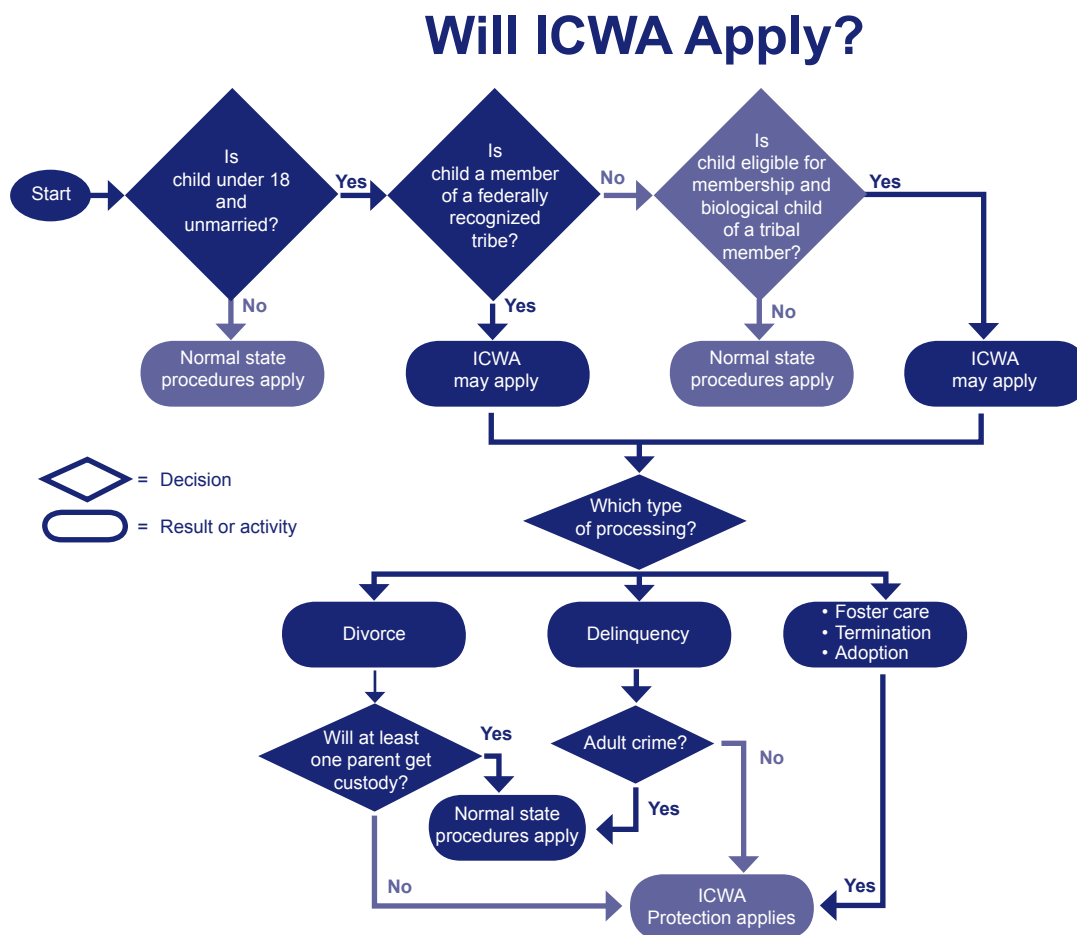
Source: National Indian Child Welfare Association. (2002). *Online ICWA course*. Accessed September 18, 2006, at http://www.nicwa.org/services/icwa/index.asp

Appendix J

Acknowledgments of Contributors and Reviewers

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