MODULE 5

Case Planning Considerations for Families Affected by Parental Substance Use & Co-Occurring Disorders









National Center on Substance Abuse and Child Welfare

Contents

Introduction

The National Center on Substance Abuse and Child Welfare (NCSACW) developed the Child Welfare Training Toolkit to enhance child welfare workers knowledge and understanding about substance use and co-occurring disorders among families involved in the child welfare system. The toolkit is designed to provide foundational knowledge and skills to help advance child welfare casework practice.

The toolkit consists of ten modules—seven foundational and three special topics:

Module 1: Understanding the Multiple Needs of Families Involved with the Child Welfare System

Module 2: Understanding Substance Use Disorders, Treatment & Recovery

Module 3: Understanding Co-Occurring Disorders, Intimate Partner Violence & Trauma

Module 4: Engagement and Intervention of Co-Occurring Substance Use, Mental Disorders & Trauma

Module 5: Case Planning Considerations for Families Affected by Parental Substance Use & Co-Occurring Disorders

Module 6: Understanding the Needs of Children and Adolescents Affected by Parental Substance Use & Co-Occurring Disorders

Module 7: A Coordinated Multi-System Approach to Better Serve Children and Families Affected by Substance Use & Co-Occurring Disorders

Module 8: Special Topic: Considerations for Children and Families Affected by Methamphetamine Use

Module 9: Special Topic: Considerations for Children and Families Affected by Opioid Use

Module 10: Special Topic: Care Coordination Considerations for Children and Families Affected by Prenatal Substance Exposure

In addition, the Child Welfare Training Toolkit is designed to offer states and local jurisdictions flexibility with delivery methods—the 10 modules can be delivered as a series or as standalone in-person or virtual trainings. Note, each module is equivalent to a half day or 3-hour training which should also account for one 15-minute break for learners during instruction.

Each module contains a detailed facilitator's guide outlining identified learning objectives, a presentation slide deck, a comprehensive reference list, and supplemental resources. To better support state and local training capacity, detailed talking points for each slide's content have been included which can be used as a script or a starting point to help acclimate and support facilitator readiness. As with all training curricula, facilitators are also encouraged to infuse their own subject matter expertise, practice-level experience, and knowledge of state or local policy or practice to help reinforce the toolkit's contents and learning objectives.

Lastly and more importantly, the toolkit is designed with careful attention to adult learning theory and principles to maximize child welfare workers learning experience. Each module considers the diverse learning styles and needs including auditory, visual, kinesthetic techniques, as well as individual, small, or large group transfer of learning activities or exercises.

Note, the NCSACW provides a free online tutorial titled*, Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Child Welfare Professionals*. This self-guided online tutorial complements the contents of the Child Welfare Training Toolkit. State and local jurisdictions may encourage their workforce to take the online tutorial to further supplement their knowledge; learners who successfully complete the online tutorial will be eligible for continuing education credits.

Intended Audience

The contents of this training toolkit can be applied across the full child welfare services continuum, enriching the practice of alternative (differential) response, investigations, in-home, out-of-home, and ongoing units. State and local jurisdictions may use the toolkit to supplement their current onboarding (pre-service) or ongoing (in-service) workforce learning opportunities. Use of the training toolkit is also highly encouraged for all cross-training needs—promoting collaboration and system-level change within and between child welfare agencies, substance use and mental health treatment providers, the judicial system, and all other family-serving entities.

Facilitator Qualifications

Facilitators should be knowledgeable about substance use disorders, mental health, and child welfare practice. They should also be familiar with the laws and policies that affect child welfare agency decision-making to ensure that the information is presented in the proper context. If a facilitator does not hold knowledge in one of these identified areas, then partnering with a respective community agency is recommended to augment co-facilitation and/or subject matter expertise. All additional facilitator inquiries can be addressed to ncsacw@cffutures.org.

Language & Terminology

Discipline-specific language and terminology are used throughout this 10-module toolkit. A trainer glossary has been incorporated as part of the toolkit to better support knowledge and understanding of the purpose and intended meanings of commonly referenced terms and recommended use of person-first and non-stigmatizing language.

Materials Needed

In-Person Training Delivery

- Laptop Computer
- A/V Projector or Smart Board
- External Speakers (if needed)
- Internet or Wi-Fi Access
- Presentation Slide Deck
- Facilitator's Guide
- Flip Chart Paper
- Pens and Markers
- Training Fidgets

Virtual Training Delivery

- Laptop Computer
- Internet or Wi-Fi Access
- Virtual Meeting Platform (e.g., Zoom)
- Access to Free Online Word Cloud Generator (e.g., Mentimeter)
- Presentation Slide Deck
- Facilitator's Guide

Module 5 Description and Objectives

The goal of module 5 is to provide in-depth knowledge and understanding about case planning considerations for families affected by parental substance use and co-occurring disorders. Child welfare workers will acquire knowledge to improve their identification of safety and risk factors with enhanced assessment of indicators specific to the child, caregiver, family, and home environment; define, identify, and promote caregiver protective capacities and protective factors with knowledge of how these serve to mitigate identified safety threats; understand how safety and risk assessments inform safety planning including actionable steps to increase child safety and family unification whenever possible; identify, plan, and respond to a parent's potential return to use with knowledge of recovery management plans to support parental stabilization; understand the limitations of drug testing with knowledge of best practice considerations for use in child welfare settings; advocate for improvements to quality family time to support reunification goals and objectives; and finally, identify, plan, and determine family readiness for case closure with coordination of aftercare services and supports.

After completing this training, child welfare workers will:

- Differentiate between safety and risk factors for families affected by parental substance use
- Assess for child safety with knowledge of specific indicators related to the child, caregiver, family, and the home environment
- Define, identify, and promote caregiver protective capacities and protective factors with knowledge of how these serve to mitigate identified safety threats
- Use safety and risk assessments to inform safety planning with clear and actionable steps to increase child safety and family unification whenever possible
- Identify, plan, and respond to a parent's potential return to use with knowledge of recovery management plans to support parental stabilization
- Understand the limitations of drug testing with knowledge of best practice considerations for use in child welfare settings
- Advocate for improvements to quality family time to support reunification goals and objectives
- Identify, plan, and determine family readiness for case closure with coordination of aftercare services and supports

Presentation Slide Deck and Talking Points

This next section of the facilitator guide provides detailed information about the contents of each slide and is organized uniformly throughout the deck to help with your training preparation. These sections include:

- Facilitator Script: ready to use talking points that can be used in its current form or modified based on a facilitator's training capacity and subject matter expertise.

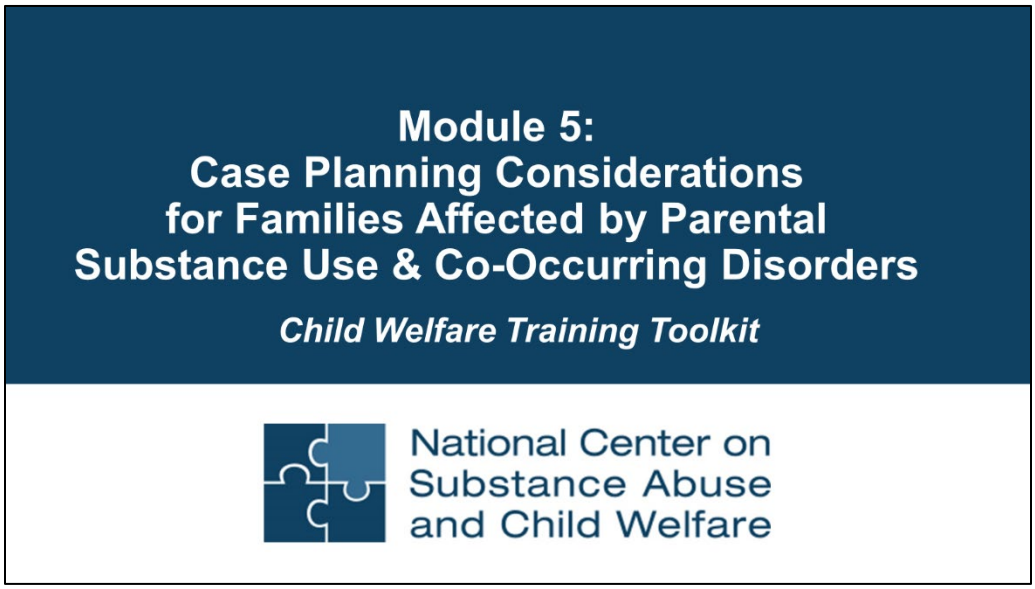
- Facilitative Prompts for Participants: content-specific inquiries developed to engage learners in further discussion and application of knowledge and skills (**bolded for easy reference**).

- Additional Facilitator Notes: contextual information to support the facilitator's knowledge and readiness, or specific mention of supplemental resources available to the learners hyperlinked within the resource section at the end of the presentation slide deck (*italicized for easy reference*).

- Underlined Content: a tool used to draw attention or emphasize specific content within the facilitator script.

Slide 1

Module 5: Case Planning Considerations for Families Affected by Parental Substance Use & Co-Occurring Disorders



Facilitator Script:

Hello and welcome! Thank you for creating time in your schedule for today's training discussion. The next three hours were carefully designed to be a robust learning experience. We encourage your active participation in the various adult learning exercises leading to a more in-depth understanding about case planning considerations for families affected by parental substance use & co-occurring disorders.

Slide 2

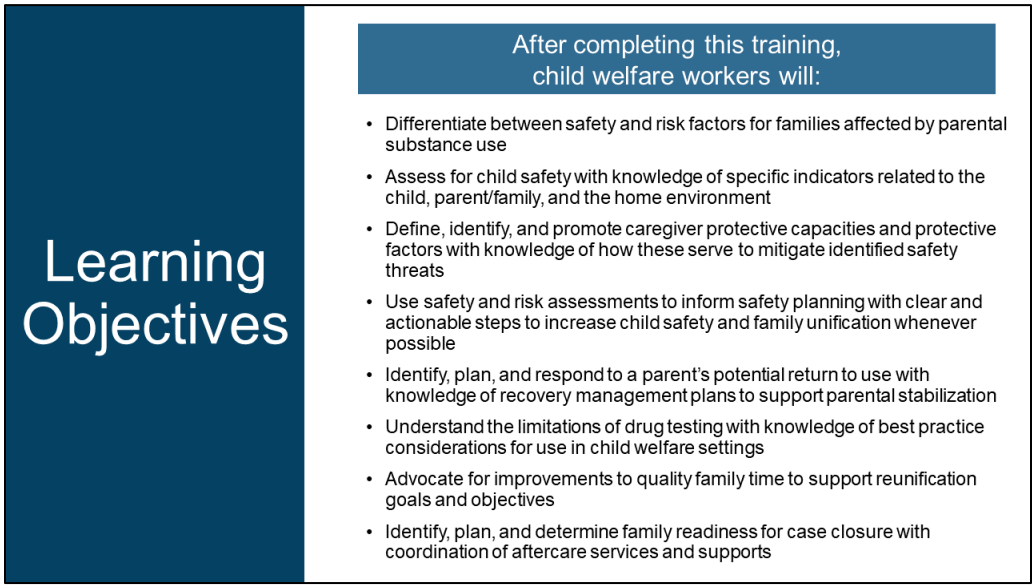
Acknowledgement

Facilitator Script:

Before we begin, I'd like to acknowledge that this training module was developed by the National Center on Substance Abuse and Child Welfare an initiative of the U.S. Department of Health and Human Services and is co-funded by the Children's Bureau, Administration for Children and Families, and the Substance Abuse and Mental Health Services Administration.

Slide 3

Learning Objectives



Facilitator Script:

The goal of module 5 is to provide in-depth knowledge and understanding about case planning considerations for families affected by parental substance use and co-occurring disorders. Child welfare workers will acquire knowledge to improve their identification of safety and risk factors with enhanced assessment skills specific to the child, parent/family, and home environment; define, identify, and promote caregiver protective capacities and protective factors with knowledge of how these serve to mitigate identified safety threats; understand how safety and risk assessments inform safety planning including actionable steps to increase child safety and family unification whenever possible; identify, plan, and respond to a parent's potential return to use with knowledge of recovery management plans to support parental stabilization; understand the limitations of drug testing with knowledge of best practice considerations for use in child welfare settings; advocate for improvements to quality family time to support reunification goals and objectives; and finally, identify, plan, and determine family readiness for case closure with coordination of aftercare services and supports.

Slide 4

Assessing for Safety, Risk & Protective Capacities

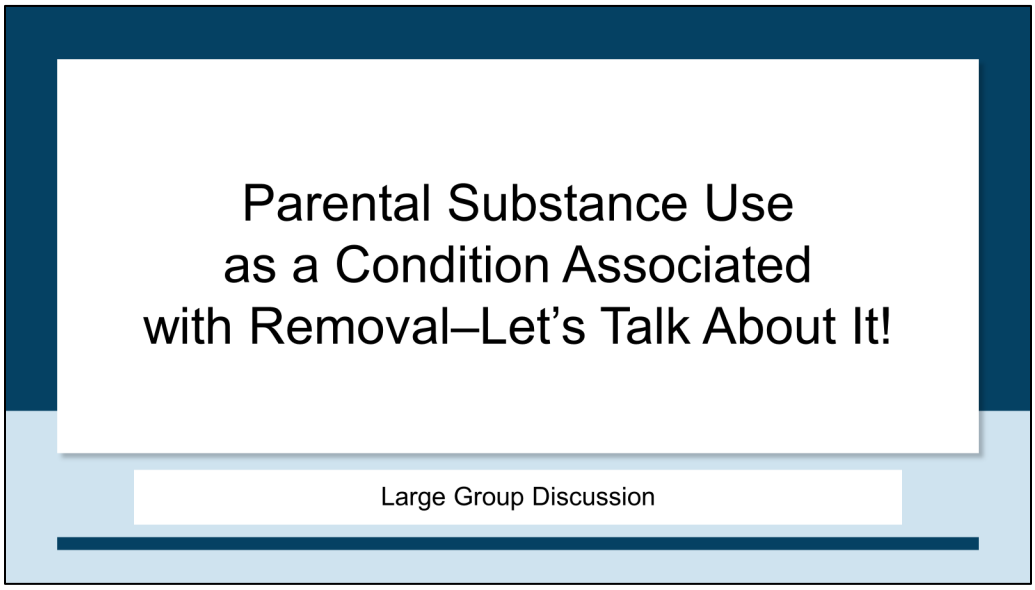
Facilitator Script:

We are going to start off today's training discussion a little differently. Did you know that nearly 9 million children live with at least one parent affected by a substance use disorder? This is equivalent to roughly 12% of all children in our country. Now of course that doesn't mean that all those families would necessarily come to the attention of child welfare agencies. As we've learned from the AFCARS data from previous modules—in 2021 alone, there were 606,187 children in out-of-home care with 236,143 with parental substance use listed as a condition associated with removal—totaling 39%.

Sources: (AFCARS Data 2000-2021, as of 03/21/23; Child Welfare Information Gateway, 2021)

Slide 5

Parental Substance Use as a Condition Associated with Removal—Let's Talk About It!



Facilitator Script:

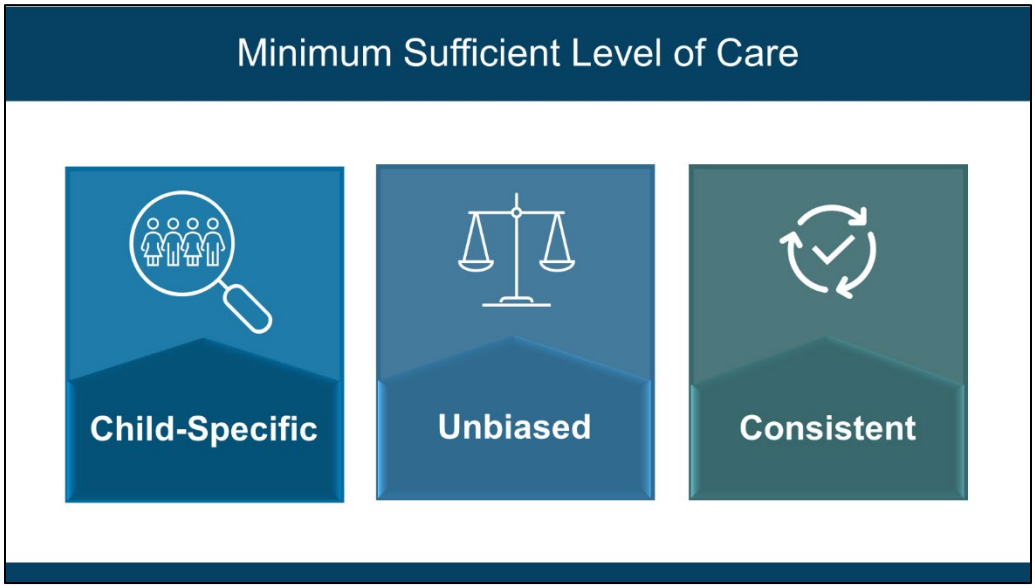
So, parental substance use as a condition associated with removal. This is such an important topic, so let's spend some more time talking about it together as a large group.

Prompts for Participants:

- **Any initial reactions to these figures? Do these figures seem high or low to you?**
- **How does this align with your state or county?**
- **Is parental substance use cause for automatic removal?**
- **What percentage of families affected by substance use disorders receive in-home preservation services compared to out-of-home re-unification services?**

Slide 6

Minimum Sufficient Level of Care



Facilitator Script:

Those condition of removal figures are an important reminder about the purpose and intent of establishing a minimum sufficient level of care (known as MSL or MSLC) the point below which a home is considered inadequate for the care of a child. It's a practice standard tied to reasonable efforts that guides child welfare casework practice and the courts in ensuring a child's safety while also not causing unnecessary separation through removal. Here are some tips to help guide your case planning practice…

MSLC should be determined on a case-by-case basis—the same standard won't apply to all families and may not be the same for each child within one family.

As a reminder, MSLC sets the standard for minimum sufficiency—it is not and should not be interpreted as the ideal standard.

Once determined, the MSLC should remain consistent throughout the life of the case; the only exception being if the child's needs have changed.

The standard for removal should not differ from the standard for reunification—this is an area of case planning and decision-making that is prone to implicit bias due to our own personal values and beliefs related to what should or shouldn't constitute MSLC for these two points of child welfare intervention.

Let's now open this one up for discussion…

- **What is your current practice of MSLC?**
- **What role does a parent's substance use or co-occurring disorder play in your assessment and standard of MSLC?**

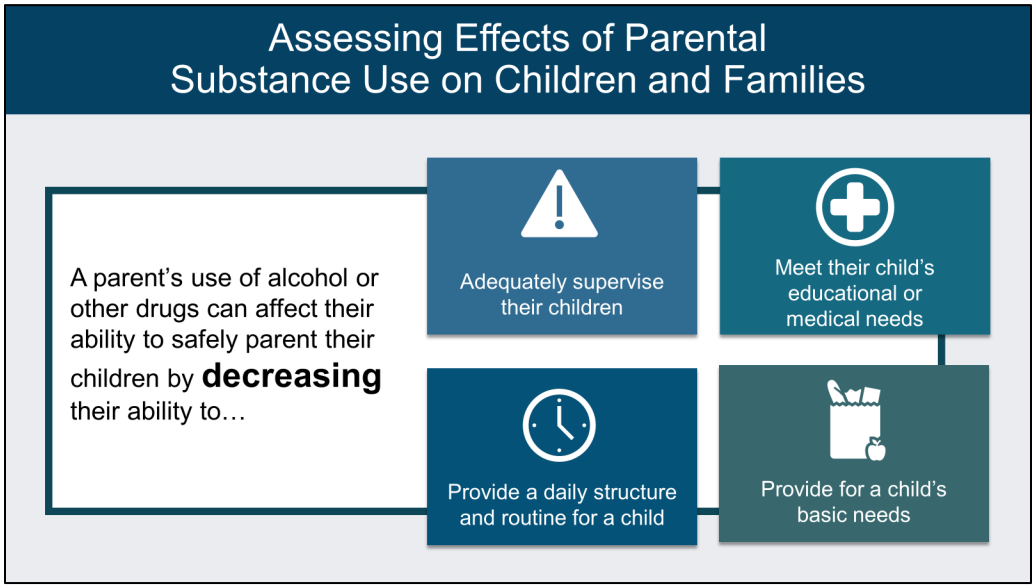
- **What would it take to allow children to safely remain with their parent during their active recovery? Or what would it take for children to be reunified with their parent while in active recovery?**

This was a great discussion and provides the perfect segue for our next discussion on assessing the effects of parental substance use.

Sources: (California Social Work Education Center, 2018; National Center on Substance Abuse and Child Welfare, n.d.)

Slide 7

Assessing Effects of Parental Substance Use on Children and Families



Facilitator Script:

In our practice, we are charged with the assessment and ongoing safety of children and families involved with the child welfare system. For families affected by substance use disorders this means determining the level of effect the parent's use may be causing such as any immediate child safety concerns including considerations to past, present, and/or future risk of harm.

As we've discussed in previous modules, a substance use disorder is a complex disease that can influence a parent's actions or inactions. A parent's preoccupation with their substance use may result in their reduced capacity to safely parent their children, which may present as leaving children unsupervised or with an inappropriate caregiver during active use—often a parentified sibling. The absence of daily structure and routines may also further compound a parent's ability to meet their child's educational or medical needs—not getting their children to school, children falling behind in schoolwork due to a high number of absences or not completing homework; children missing their annual well child exams or not receiving timely medical care for emergent healthcare needs. We sometimes also observe challenges with home conditions, or difficulty maintaining employment or managing household expenses which can limit resources toward basic family needs.

As a reminder, substance use alone doesn't warrant child welfare intervention. When assessing child safety in families affected by substance use disorders, we are paying close attention to the causal relationship between the parent's substance use and their capacity to safely parent their children. For parents affected by co-occurring disorders, this also means assessing for the complex interplay between the substance use, mental disorder, and parenting capacity. Let's continue our discussion of assessment by spending some time differentiating between safety and risk factors.

Slide 8

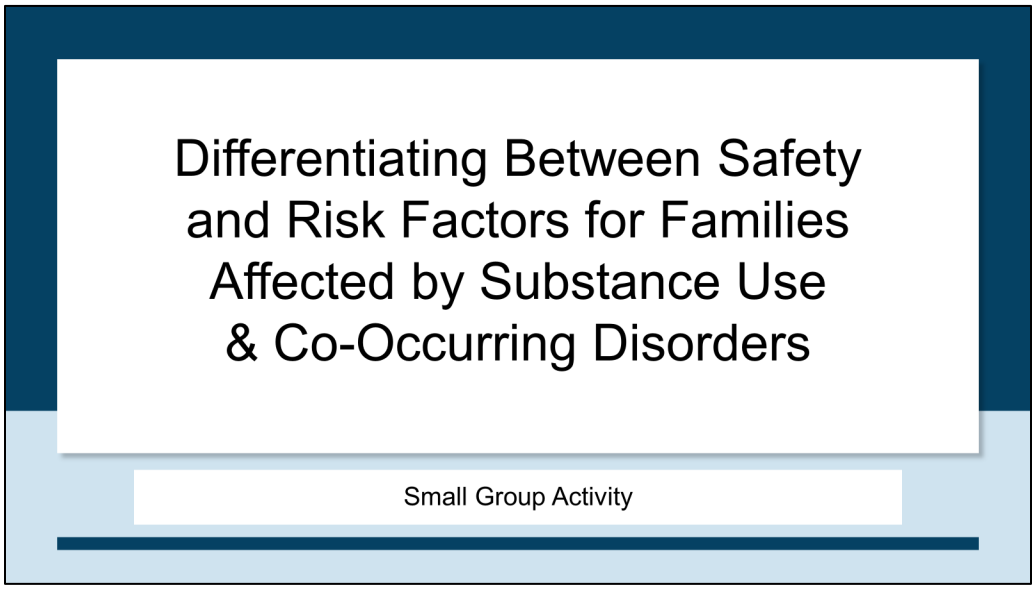
Differentiating Between Safety & Risk Factors

Facilitator Script:

While specific language and terminology will vary based on your state or local practice framework, safety factors generally refer to present or impending dangers to a child or insufficient caregiver protective capacities to ensure a child is protected from danger. Safety factors are immediate problems that need to be resolved to protect a child or prevent further harm. Whereas risk factors refer to the likelihood of a child's future maltreatment. This may include any reasonably foreseeable substantial risk of harm to a child—while these are not considered active safety threats, they can be anticipated to have severe effects on a child at any time. Often risk factors aren't observable at the onset of child welfare intervention but become clearer as we develop a partnership with the family and begin to understand the full scope of their history and needs.

Slide 9

Differentiating Between Safety and Risk Factors for Families Affected by Substance Use & Co-Occurring Disorders



Facilitator Script:

Facilitator Notes: Ask learners to convene in small groups for an activity on, 'Differentiating between safety and risk factors for families affected by substance use disorders.' Instruct learners to use the provided easel paper and markers to generate two columns titled 'Examples of Safety Factors' and 'Examples of Risk Factors.' Proceed with handing out one activity envelope to each small group containing a mixture of pre-filled post-it notes. Ask learners to work with their group members to differentiate safety versus risk factors by sorting and attaching accordingly to their easel paper. Let learners have approximately 10 minutes to discuss before bringing the small groups back together for a large group discussion.

Answer guide to support facilitation of results:

<u>Safety Factors:</u>

- Ingestion of alcohol or other drugs by a child
- Parent driving under the influence of alcohol or other substances with children in the vehicle
- Physical abuse incident while parent was under the influence of substances
- Drug paraphernalia in reach of small children
- Lack of or inappropriate supervision of children during active substance use
- Parental drug overdose with children present in the home
- Parent stopping their medication for bipolar disorder and experiencing a manic episode while caring for young children

Risk Factors:

- Parental alcohol or other drug use
- Parental history of child endangerment while under the influence of substances
- Familial history of intimate partner violence
- Children's exposure to substance use and high traffic in and out of family's home
- Absence of a supportive caregiver to provide adequate levels of child supervision
- Parental history of drug overdose and no observable recovery-oriented services or supports
- Parent's diagnosis of bipolar disorder

**Alternative Instructions for Virtual Training*

Use your virtual platform's polling feature to create the following prompts and use answer key provided above to support a discussion of poll results:

1. Parent stopping their medication for bipolar disorder and experiencing a manic episode while caring for young children

- Safety Factor
- Risk Factor

2. Parental history of drug overdose and no observable recovery-oriented services or supports: [select only one answer]

- Safety Factor
- Risk Factor

3. Lack of or inappropriate supervision of children during active substance use: [select only one answer]

- Safety Factor
- Risk Factor

4. Children's exposure to substance use and high traffic in and out of family's home: [select only one answer]

- Safety Factor
- Risk Factor

5. Parent driving under the influence of alcohol or other substances with children in the vehicle: [select only one answer]

- Safety Factor
- Risk Factor

6. Familial history of intimate partner violence: [select only one answer]

- Safety Factor
- Risk Factor

7. Parental alcohol or other drug use: [select only one answer]

- Safety Factor
- Risk Factor

8. Physical abuse incident while parent was under the influence of substances: [select only one answer]

- Safety Factor
- Risk Factor

9. Parental history of child endangerment while under the influence of substances: [select only one answer]

- Safety Factor
- Risk Factor

10. Drug paraphernalia in reach of small children: [select only one answer]

- Safety Factor
- Risk Factor

11. Parental drug overdose with children present in the home: [select only one answer]

- Safety Factor
- Risk Factor

12. Absence of a sober caregiver to provide adequate levels of child supervision: [select only one answer]

- Safety Factor
- Risk Factor

13. Ingestion of alcohol or other drugs by a child is a: [select only one answer]

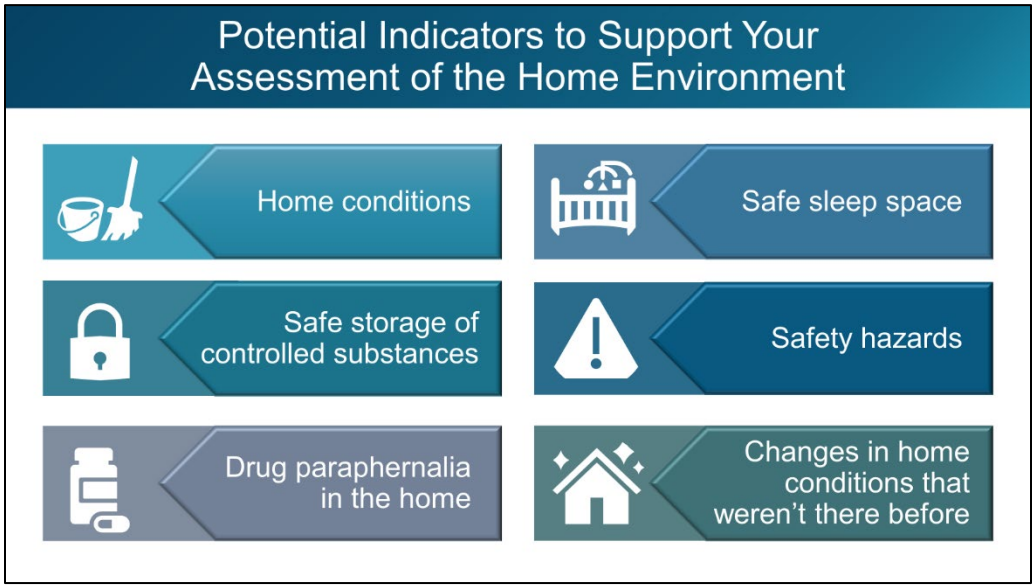
- Safety Factor
- Risk Factor

14. Parent's diagnosis of bipolar disorder

- Safety Factor
- Risk Factor

Slide 10

Potential Indicators to Support Your Assessment of the Home Environment



Facilitator Script:

Case planning for families affected by substance use and co-occurring disorders relies on us gathering accurate and comprehensive information to inform our assessment of safety and risk, as well as identifying strengths and areas of need. Previous modules of this toolkit have helped improve our awareness and understanding about substances and their effects which in turn help us better recognize potential indicators of use through our assessment of the home environment.

During your assessment of the home environment, you may discover conditions that are either unkept, disorganized, or lacking essentials like food, water, gas or electricity. There may be the addition of safety hazards due to makeshift manufacturing which could include the presence of hazardous chemicals and supplies, or unusual smells or odors. Similarly, your assessment may discover the presence of drug paraphernalia in the home– residuals of controlled substances, other contraband, or sharp objects. For parents with prescriptions for medicinal marijuana (including states with legalized marijuana) or opioid pain medication we would also be assessing for safe storage of these controlled substances to ensure they are kept out of reach of children and adolescents. We would also be inquiring about safe sleep practice for parents and their infants. This is especially important for parents with known or potential substance use histories as it provides an opportunity for awareness around the increased risks and dangers associated with co-sleeping and/or sudden infant death syndrome. One final note on our assessment of home environments is just a reminder to stay mindful of any changes you may observe over time; our work as child welfare workers involves initial assessments but also just as importantly ongoing, continual assessment. Is the condition of the home destabilizing? Are previous safety measures no longer in place? What can this tell us about the child, parent, and family?

Facilitator Note: The National Center on Substance Abuse and Child Welfare's webinar: Planning for Safety in Cases When Parental Substance Use Disorder is Present is available as an additional resource.

Slide 11

Considerations for Assessing Child Safety

Facilitator Script:

When you are concerned about a parent's substance use or co-occurring disorder and assessing a child's safety, consider the following factors related to the child…

Younger children are more dependent on their parent to meet their basic needs. For infants and very young children, there is total reliance on their parents, as young children have no capacity to protect themselves. Older children have more of an ability to keep themselves safe AND communicate with others and get help if needed. However, each developmental stage presents a challenge related to parental substance use and co-occurring disorders and should be considered.

Children that are visible in the community through attending school, childcare, or other community activities have more exposure which can enhance their safety. Relationships formed in these settings allow children to open up and talk about what might be going on at home to a caring or trusting adult while also providing an opportunity for caring or trusting adults to watch for potential risks factors or threats of harm.

Children with special needs may be at higher risk due to the complexities of their daily caretaking, higher levels of familial stress, and subsequent impact on the parent's recovery and stability. This reinforces the need for thorough developmental screening and assessments, including our own awareness and understanding of the unique challenges of special needs children and families to inform objective decision-making as it relates to safety, risk, strengths and needs.

Finally, we should observe the parent-child interaction as part of an ongoing assessment process. Is the parent responsive to their child? Does the child go to the parent for comfort or guidance? Staying attune with the parent-child relationship can help us identify more subtle threats of harm, and eventually can be part of safety planning and improving caregiver protective capacities and protective factors for the family. More on these in just a moment.

Source: (National Center on Substance Abuse and Child Welfare, 2022a)

Slide 12

Additional Considerations for Assessing Child Safety

Facilitator Script:

When assessing for child safety, we also want to consider factors specific to the parent(s) and family.

Is the parent asking for help, or in treatment now? Do they recognize they need treatment? Do they have a history of reaching out for help in the past? Do they have any past recovery time? Does the parent understand how their substance use or mental disorder affects their child(ren)? All these indicators help us better understand how the parent has responded in the past (through their actions or inactions) and gives indication on how they might engage in services and treatment in the future.

In addition, one of the most concrete forms of protection for children affected by parental substance use or co-occurring disorders is their family's access to natural support systems. Our assessment should explore the extent of the parent(s) relationships with extended family, friends, faith-based and/or recovery-oriented communities. This includes the presence or potential for an identified supportive caregiver to allow children to safely remain at home; as these along with other family strengths or protective capacities help mitigate identified safety and risk factors. Let's spend some more time amplifying the message about these…

Source: (National Center on Substance Abuse and Child Welfare, 2021c)

Slide 13

What Are Caregiver Protective Capacities?

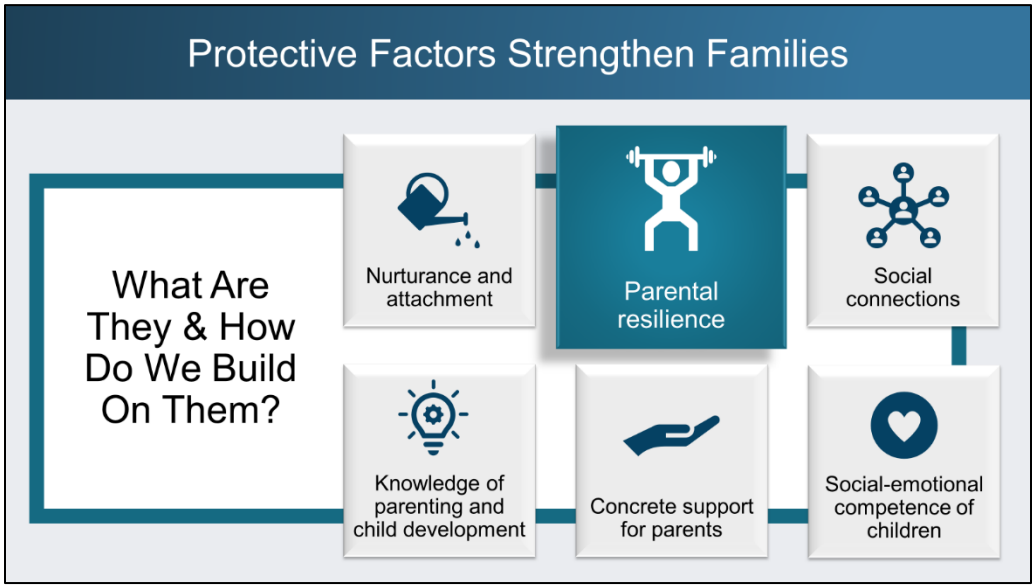
Facilitator Script:

Caregiver protective capacities (or parental strengths) refer to behavioral, cognitive, and emotional characteristics that can specifically and directly be associated with a person being protective of his/her/their child. They are specific qualities that can be observed, understood, and demonstrated as a part of the way a parent thinks, feels, and acts. Protective capacities speak to the ability to act on behalf of a child to ensure their immediate and ongoing safety. Specifically, behavioral protective capacities represent the ability to control impulses, act on behalf or adapt to needs of the child, including setting the child's needs before one's own; whereas cognitive protective capacities represent the ability to recognize and understand potential threats of harm and the need for child safety, including one's own role in ensuring a child's protection; and finally, emotional protective capacities represents the ability to meet one's own emotional needs, demonstrate resiliency while also expressing unconditional love and empathy toward your child(ren). In summary, caregiver protective capacities serve as the framework for our continuous assessment of child safety and risk.

Sources: (Capacity Building Center for States, 2016; Center for the Study of Social Policy, n.d.)

Slide 14

Protective Factors Strengthen Families



Facilitator Script:

Now separate from caregiver protective capacities at the individual level, we also have a protective factors framework that extends beyond the parent or caregiver to include strengths and attributes of families, communities, and larger societies that reduce risk and promote the overall health and well-being of children, parents, and families. While our initial and ongoing assessment are heavily focused on identifying safety and risk factors, protective factors should be viewed just as equally important for families involved in the child welfare system. Protective factors represent positive attributes that speak to a family's inherent strengths despite the initial safety event that brought them to the attention of the department—these will look different for each family but generally include knowledge, skills, strengths, supports, or connections that serve to protect against threats of harm and are associated with a greater likelihood of positive family outcomes.

Here we are highlighting six core protective factors to support your work with families. Now, while it can be difficult to identify family strengths within the complex interplay of child maltreatment, this serves as a good reminder that all families have inherent strengths, and it is our role to identify and foster their development during the child welfare intervention period to help move families toward greater stability. Let's now spend some time with each of these…

Nurturance and Attachment: While parental acts of nurturance and attachment will look differently based on children's age and various stages of development, all will be underscored by a common pattern of positive parent-child interactions. For parents with infants, it is important to look for indicators such as verbal and non-verbal cues—does the parent talk to their baby, exchange facial or vocal expressions; what are other ways that the parent physically interacts with their baby such as holding, rocking, or other soothing techniques? For parents with preschoolers, indicators of nurturance and attachment can be found in how play is encouraged and approached—do parents plan activities for their littles ones; does the parent join in on activities or create routines to allow for parent-child bonding such as daily walks, trips to the park, or bedtime stories? For parents with school-aged children, indicators of nurturance and attachment can be found in how parents

engage with and structure their time outside of the school day—what is the family's morning routine; do parents make breakfast and/or sit with their children; who's helping children get ready for school; do parent's spend time talking to their children about their days– is this over dinner or during family time before everyone gets ready for bed?

Parental Resilience: Parental resilience by nature is more difficult to measure and requires more intentional efforts to understand and identify for child welfare-involved families. For starters, resilience represents how we manage and respond to stress, adversities or challenges. For parents, this involves our understanding of the full extent of their stressors while paying careful attention to both direct and subtle forms of coping—how do parents cope with a stressful day? Are they demonstrating self-regulation and other problem-solving skills in response to their reported stressors? Are you observing signs of them reaching out for support during these high stress periods or incidents? With parental resilience the emphasis is less on the stressor itself and more about how a parent taps into their inner strengths and capacities to come back from and thrive despite their adverse circumstances.

Social Connections: Parenting can be an extremely rewarding yet challenging experience for many. Social connections can very much become a lifeline for emotional support and guidance during this stage of life—positive relationships or friendships to lean into, learn from, and grow your families with. Ways to explore indicators of healthy social connections is to explore a parent's meaningful relationships—who do they identify when you ask about their support network? Are these people who can offer sound parenting advice? Or are they people who they can call and know that they will be there to listen with empathy and compassion? Are there others who can offer more concrete types of support such as transportation or childcare?

Knowledge of Parenting and Child Development: Knowledge of parenting and child development is both inherent and learned—we take experiences from our own upbringing and pair it with new knowledge, resources, and tools as we navigate how best to support our child's growth and development. Observable indicators may look like a parent's general understanding of developmental milestones; or a parent having age-appropriate expectations of their child; parents who are able to recognize and respond to their child's needs; and demonstrate healthy and effective forms of parenting and behavior management.

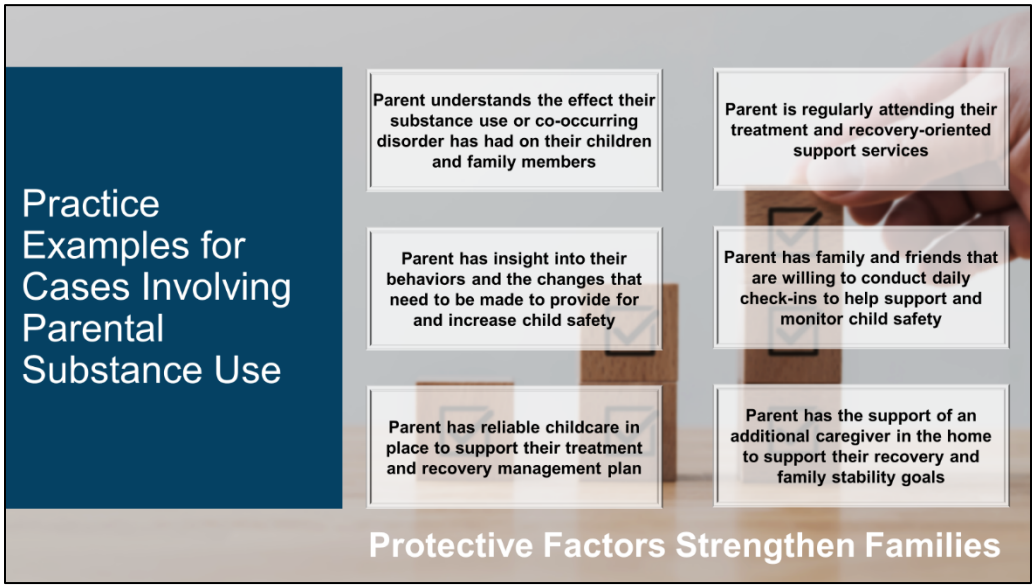
Concrete Support in Times of Need: Families that come to the attention of child welfare services often face a high level of economic uncertainty—as we covered in previous modules this might look like employment instability, housing or food insecurities, and other psychosocial stressors. Indicators of this protective capacity may look like a parent seeking out knowledge of community resources and supports to meet their family's needs. Another similar indicator would be whether a parent follows through with accessing needed services and supports; or their ability to advocate for their family's needs when faced with barriers or challenges.

Social-Emotional Competence of Children: Social-emotional competence is developed through positive parent-child interactions whereby children learn healthy patterns of communication, self-regulation, and interpersonal relationships. Parents model this for children and may include indicators such as openly talking about feelings—both the positive and the negative; owning or acknowledging when a situation could have been handled differently; or using techniques or strategies to self-regulate such as taking deep breaths or expressing a need for a break or quiet time.

Sources: (Capacity Building Center for States, 2016; Center for the Study of Social Policy, n.d.)

Slide 15

Practice Examples for Cases Involving Parental Substance Use



Facilitator Script:

So, what do protective capacities for parents affected by substance use disorders look like in practice? Here, we have some concrete examples for you:

- Parent understands the effect their substance use has had on their children and family members
- Parent has insight into their behaviors and changes that need to be made to provide for and increase child safety
- Parent has reliable childcare in place to support their treatment and recovery management plan
- Parent is regularly attending their treatment and recovery-oriented support meetings
- Parent has family and friends that are willing to conduct daily check-ins to help support and monitor child safety
- Parent has the support of an additional caregiver in the home to support their recovery and family stability goals

Each of these protective capacities helps to mitigate the safety and risk associated with a parent's substance use disorder allowing for further assessment and decision-making about in-home versus out-of-home service provision.

Slide 16

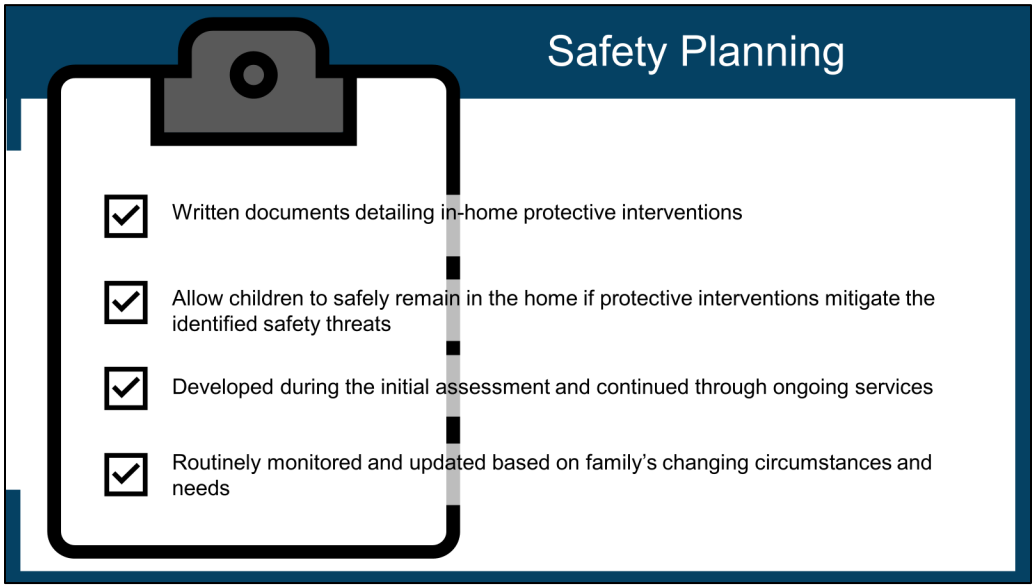
Safety Planning for Families Affected by Substance Use Disorders

Facilitator Script:

Let's now take what we've learned about assessment of safety, risk, and protective capacities and discuss how it informs safety planning for families affected by substance use disorders…

Slide 17

Safety Planning

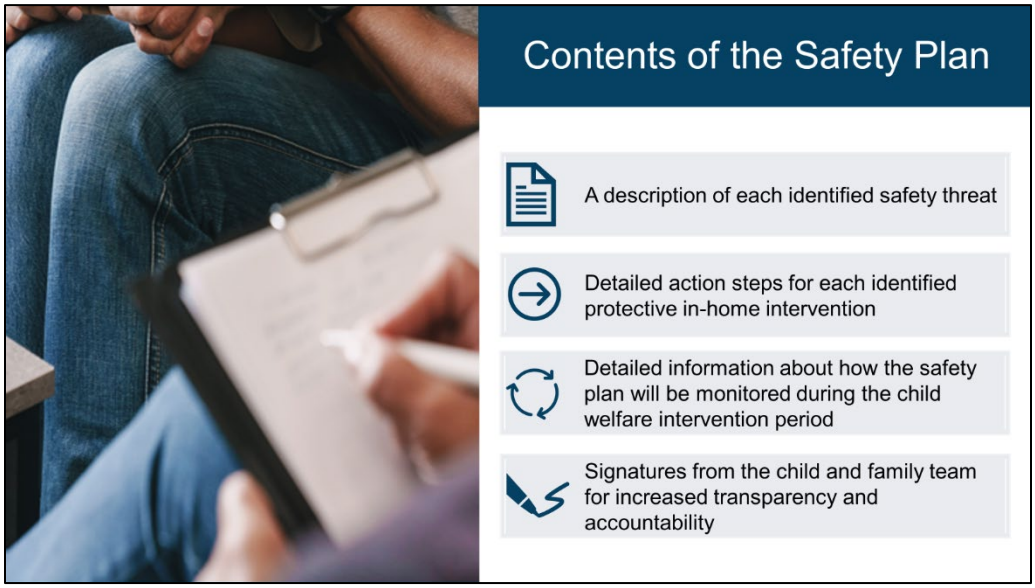


Facilitator Script:

Safety planning with families begins with the onset of child welfare intervention. We take the information obtained from our initial safety and risk assessments (imminent threats of harm and likelihood of future maltreatment) and determine the level of protective intervention that is needed to ensure a child's safety—for some families, the level of safety threats identified will require removal and placement into out-of-home care with the goal of family reunification; however, for other families the level of safety threats can be mitigated by the use of a safety plan detailing in-home protective interventions, thus allowing families to remain intact during the child welfare intervention period (often referred to as in-home family preservation or family maintenance services). As safety plans are informed by our initial and ongoing safety and risk assessments, they by nature require routine monitoring and updating to reflect point in time protective interventions—such as changes in family circumstances and/or modifications to the identified protective interventions.

Slide 18

Contents of the Safety Plan



Facilitator Script:

States and local jurisdictions will document safety plans on their own specific template or forms guided by policies, procedures, or practice models; however, contents of the safety plan generally include a detailed description of each identified safety threat—or factors placing the child at imminent risk of harm. As a reminder, safety plans are designed to be a collaborative practice tool and therefore should always be written in a way that helps parents and families fully understand the reason for the protective intervention. This is reinforced with detailed action steps that clearly outline what needs to happen to ensure a child's safety—information like how the safety threat will be mitigated; steps that the parent(s) will take to protect their child; steps others will take to support the parent in keeping the child safe in the home environment. Similarly, detailed information about how the plan will be monitored during the child welfare intervention period should also be included—information specific to identified participants, their role and responsibilities, and the specific timeframe for each identified protective intervention. Safety plans should be formalized with signatures from all participating parties allowing for increased transparency and accountability from all members of the child and family team.

Source: (Evident Change, n.d.)

Slide 19

Additional Safety Planning Considerations for Families Affected by Substance Use & Co-Occurring Disorders

Facilitator Script:

For families affected by substance use or co-occurring disorders, safety planning considerations often include…

Identifying family support caregivers—natural supports who are available and willing to help monitor child safety during the parent's early recovery process. All identified family support caregivers should be assessed for their suitability and capacity to carry out identified action steps within the safety plan.

Exploring alternative living arrangements—supporting families affected by substance use disorders may require us to get creative with in-home protective interventions. This may look like avoiding removal and separation altogether by considering potential alternatives that allow the parent and child to remain intact; instead of placing the child with a relative, would the relative be open to taking in the parent and child and serve as an in-home supportive caregiver? If residential treatment is indicated for the parent, are there family-centered treatment programs that allow children to live on-site with their parent during the duration of their programming?

Creating achievable and realistic action steps—as we know, the early recovery process will take time. Safety plans are only as good as they are realistic and achievable for families. An action step for a parent that says, "parents will stop using substances" may not carry the same effect as an action step that says, "parents will not use substances in the presence of their children as noted by calling on [identified caregiver] for child supervision during periods of active use."

These are just a few examples of safety planning considerations for families affected by substance use disorders—but let's also hear from you and your casework practice. What are some other considerations or examples specific to safety planning?

Slide 20

Case Planning for Potential Return to Use

Facilitator Script:

As we've learned in previous modules of this toolkit, behavior change is a difficult and often non-linear process—especially when it involves recovery from a substance use or co-occurring disorder. Child welfare-involved parents may have periods of time where they are not actively engaged in treatment and supportive services, making limited progress toward their case plan goals, or at times completely disengaged with no form of contact with their caseworkers. Our work to normalize the ambivalence parents experience during the change process also means not giving up on these families and having realistic expectations about the potential for return to use during the family's child welfare intervention period. Let's spend some more time discussing return to use including strategies to identify, plan, and respond for improved family recovery outcomes.

Slide 21

Understanding the Nature of Return to Use

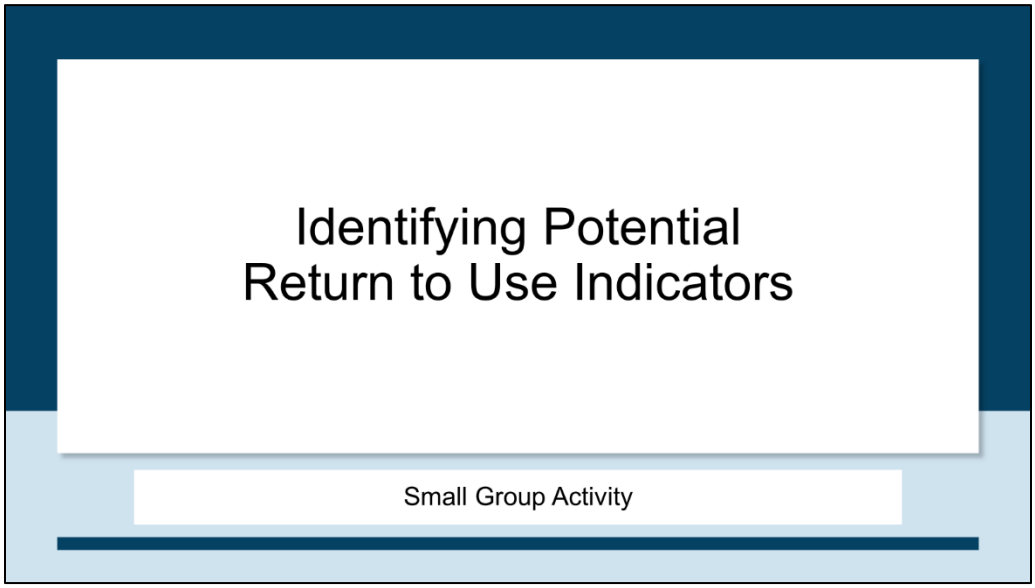
Facilitator Script:

Substance use disorders are known as chronic, life-long conditions which for some will mean a return to use will be part of their recovery process. This may look like a single episode of return to use after an attempt to stop or multiple episodes spanning years of long-term recovery. Regardless of the nature and frequency, return to use rates for persons with substance use disorders are really no different from rates for other chronic medical illnesses. The National Institute on Drug Abuse (NIDA) emphasized these similarities by demonstrating how relapse rates for substance use disorders were between 40-60% whereas rates for hypertension and asthma were 50-70%, respectively. While this data from NIDA is a little older, it still resonates present day through their message that return to use is not a sign of failure—rather an indicator for modified, enhanced, or new forms of treatment and recovery planning.

Source: (National Institute on Drug Abuse, 2023)

Slide 22

Identifying Potential Return to Use Indicators



Facilitator Script:

Facilitator Notes: Ask learners to reconvene in their small groups for an activity on, 'Identifying Potential Return to Use Indicators.' Instruct learners to use the provided easel paper and markers to generate a list of potential indicators with consideration to three categories: 1) Personal appearance 2) Behavioral signs and 3) Physical home environment. Bring small groups back together for a large group report out– encouraging each small group to share their full or partial list (depending on time allotted).

Sample Answer Key/Guidance to Help Facilitate Activity:

Potential Indicators for Return to Use (Alcohol Disorder)

Personal Appearance: Slurred speech, Poor coordination

Behavioral Signs: Mood swings (highs and lows), Impaired judgment

Physical Home Environment: Empty bottles of liquor or beer; strong alcohol odors

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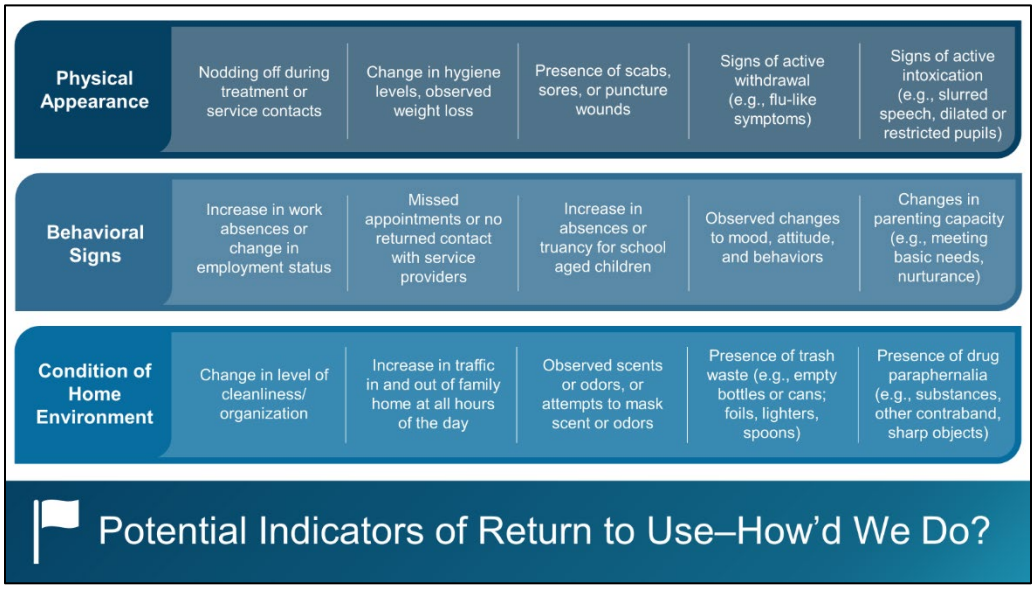
**Alternative Instructions for Virtual Training*

Prepare a link for a word cloud generator through www.mentimeter.com. Ask participants to identify potential return to use indicators for any of the three following categories: personal appearance, behavioral signs, and/or physical home environment. Then display the completed word cloud for the learners in real-time to create a similar effect as the in-person exercise.

Slide 23

Potential Indicators of Return to Use—How'd We Do?



Facilitator Script:

Facilitator Notes: Review the compiled list of potential indicators of return to use as a follow-up to the small group activity. Opportunity to reinforce what the learners identified as well as fill in any potential gaps.

As presented here, there are many potential indicators of a return to use—some indicative of a parent's progressive destabilization prior to a return to use as well as signs of active return to use. As child welfare workers, it's important that we discuss with the child and family team the slightest shifts in our observations of the parent's physical and behavioral presentation as well as any observable impacts on the family and home environment as these all provide important insight into how best to re-engage, modify, or enhance treatment and supports necessary for optimal family stability and recovery outcomes.

Source: (National Center on Substance Abuse and Child Welfare, 2022c)

Slide 24

Child Safety & Return to Use

Facilitator Script:

So, by now we've covered identifying potential return to use indicators, but we also need a clear plan and response. These next steps require open communication among all members of the child and family team—this includes parents, peer recovery specialists, child welfare workers, substance use treatment providers, and any other child and family service providers. It is important for everyone to understand that 1) return to use is a common part of an individual's recovery process, and 2) return to use does not have to automatically result in removing a child from their parent's care. The latter is made possible through helping parents plan for their child's safety in the event that a return to use occurs—often referred to as recovery management or contingency plans.

We all share a collective responsibility in these planning efforts; for example, treatment providers work with parents on increasing their awareness of and ability to identify activators or triggers for their cravings or use, including corresponding thoughts or behaviors so that they can interrupt past patterns of decision-making. This level of behavioral change is reinforced by identified recovery supports and services that serve as alternative adaptive options in place of the preferred substance or steps to immediately engage in should a return to use transpire. These plans often include the following types of information:

- Personal sensitivities for return to use
- Red flags or potential indicators of an impending return to use
- People/places/things to avoid (activators or triggers)
- Supports to call if or when struggling with maintaining active recovery (e.g., recovery sponsor, recovery-oriented network, treatment provider)
- Self-help meetings or other recovery-oriented activities to attend for increased support

- Specific steps to carry out to protect and ensure child safety (e.g., enlist support of identified sober caregiver; call to child welfare worker and/or peer recovery specialist)
- Immediate and subsequent increase in parent and family contacts for crisis stabilization
- Time sensitive family team meeting (or shared decision-making meeting) to revisit the child safety plan/recovery management plan
- Signatures of child and family team members for increased transparency and accountability

Source: (National Center on Substance Abuse and Child Welfare, 2022b)

Slide 25

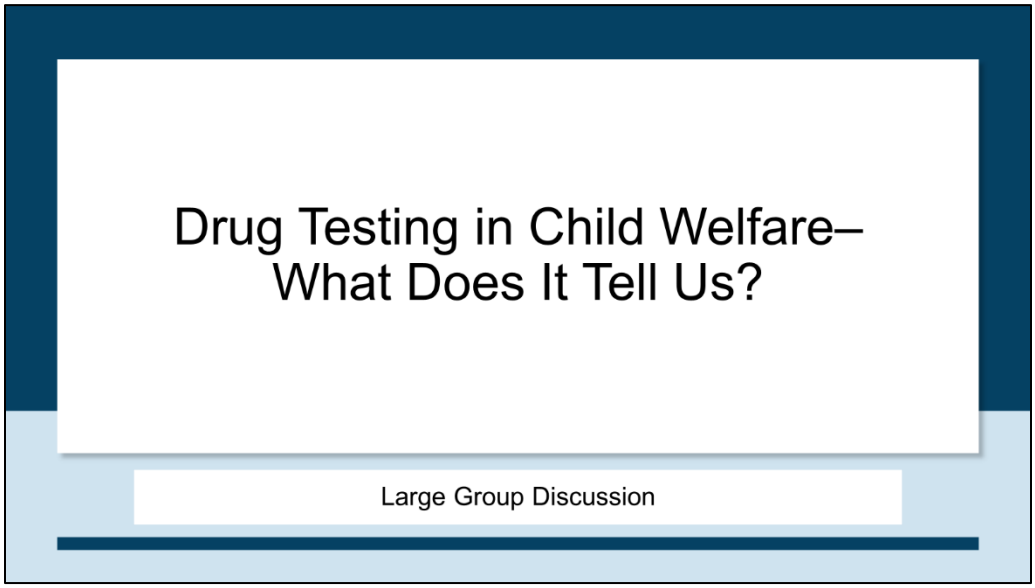
Considerations for Drug Testing & Child Welfare Case Planning

Facilitator Script:

Let's now take what we've learned from our discussion on child safety and return to use and fold in important considerations specific to drug testing and case planning.

Slide 26

Drug Testing in Child Welfare—What Does It Tell Us?



Facilitator Script:

Before we jump into the slides on drug testing in child welfare, let's start by hearing a little more about your local policy and practice…

- **First, has your child welfare agency implemented drug testing policies and procedures?**
- **How are parent's drug test results used to support case planning practice?**
- **What happens if a parent does not show up for a scheduled drug test? Is this considered a "positive" drug test and are there any negative consequences attached to missed or positive results?**

Slide 27

Important Considerations for Drug Testing in Child Welfare Settings

Facilitator Script:

The National Center on Substance Abuse and Child Welfare (NCSACW) suggests three important considerations for drug testing in child welfare settings. These include,

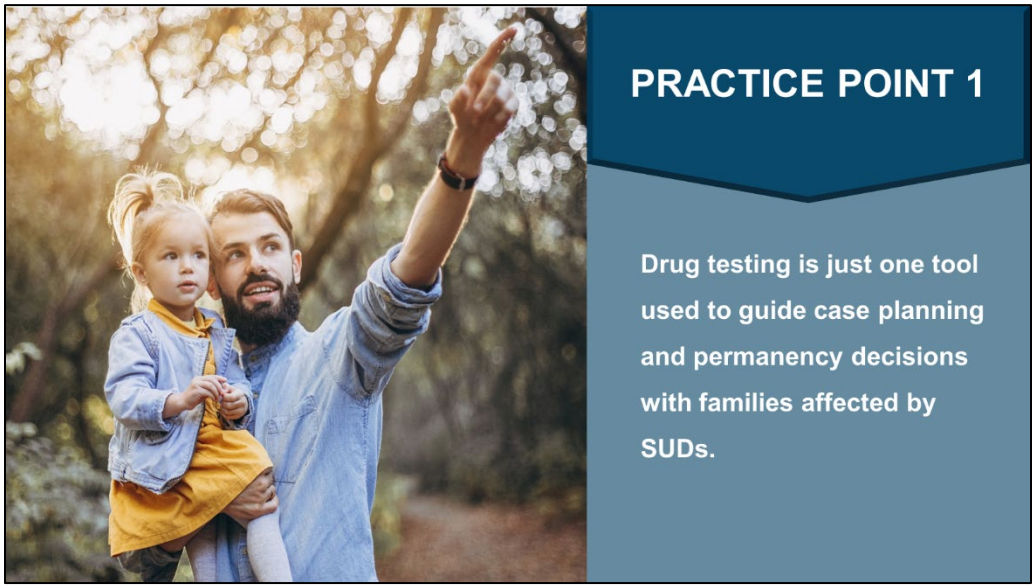
- Awareness that drug testing is costly and limited in terms of determining child risk and safety—as a drug test alone cannot determine the existence or absence of a substance use disorder; or the level of severity; whether or not a child is safe; or any information related to the parent's strengths or protective capacities—including how these may serve to mitigate safety and risk.
- Child welfare agencies also risk relying too much on drug test results to inform decisions on child removal, parent-child family time, reunification, and termination of parental rights. Using drug test results in the absence of greater context and comprehensive assessment of the family's safety, risk, and protective capacities—can result in lasting and irreparable harm to families.
- We witness this level of harm when drug testing is administered inappropriately—in the absence of clear policies and procedures (for example, clear purpose and guidelines on who to test and when) as well as when administered inconsistently—such as when drug test results are used punitively (such as reason to cancel scheduled quality family time or visits, sanctions in family treatment court models, or justification to remove, deny reunification, or move toward termination of parental rights). While these examples speak to consequences at the individual level, the harm from inappropriate or inconsistent drug testing policies have and will continue to perpetuate stigma and reinforce bias based on race, ethnicity, or socioeconomic status—contributing to ongoing disparities for child welfare-involved families from diverse racial and ethnic backgrounds.

This is not to say that there is not a place or need for drug testing in child welfare—rather more emphasis on developing a cross-system collaborative approach with clearly defined policies and practices that are designed to promote parental recovery and family well-being. Let's now review some practice tips.

Sources: (National Center on Substance Abuse and Child Welfare, 2021a; National Center on Substance Abuse and Child Welfare, 2021b)

Slide 28

Practice Point 1



Facilitator Script:

Drug testing should be one of many tools to help inform and guide collaborative case planning and decision-making for families affected by substance use disorders. Again, drug testing alone only provides us with a biological sample to help determine whether a parent has used a particular substance within a specific timeframe.

As we covered in previous modules in this toolkit, screening tools provide a brief set of standardized questions to help determine if a substance use is a presenting concern followed by steps to take to refer a parent for a clinical assessment by a qualified substance use disorder treatment provider.

We are also now well versed in our understanding of substance use disorders including their effects on the parent and family with the ability to identify potential indicators of use through our observation of a parent's physical appearance, behavioral signs, and the condition of the home environment—all significant to informing a comprehensive and objective assessment of each family's individual needs.

Our toolbox also consists of standardized safety and risk assessment tools that allow for systematic collection of information to help determine the presence of any immediate safety threats to children while also identifying any potential risks for future harm.

When used collectively, all four tools help to advance timely and equitable casework practice for families affected by substance use disorders.

Source: (National Center on Substance Abuse and Child Welfare, 2021a)

Slide 29

Practice Point 2

Facilitator Script:

Results from drug tests provide an opportunity for us to engage parents and families in the treatment and recovery process. Discussing the results in a timely and supportive manner—one that is free of bias and stigma helps to eliminate the personal shame internalized by the parent. Strategies such as using strength-based and person-first language is a good example of this—it can look like replacing old stigmatizing language such as "clean versus dirty" with more neutral terms such as "negative versus positive" or "substance not detected versus substance detected" terminology—small actionable steps that go a long way in building and restoring trust with parents.

Results also provide an opportunity to reinforce, modify, or enhance substance use disorder treatment and recovery support services. For negative results, this can provide an opportunity to talk about what is working well about the current treatment and service plan and provide positive reinforcement through recognizing the actionable steps the parent has taken on their path to early recovery. For positive results, this too presents an opportunity to talk about what isn't working well and making necessary modifications or enhancements to support or re-engage the parent into substance use disorder treatment and recovery support services. Is the parent de-stabilizing and needing more intensive services and supports? Would the parent benefit from peer recovery supports or increased recovery-oriented activities such as attending recovery support groups and/or obtaining a recovery sponsor?

Source: (National Center on Substance Abuse and Child Welfare, 2021a)

Slide 30

Practice Point 3

Facilitator Script:

When used appropriately, drug testing can be a therapeutic tool to help engage and retain parents in substance use disorder treatment and recovery support services—ideally resulting in families meeting their case plan goals and objectives. For this to happen though, drug testing needs to be implemented within a strength-based motivational approach. This includes our understanding of the complexities of early recovery and the time needed to fully heal and integrate new ways of coping with everyday life stressors. As we covered in detail in previous modules of this toolkit, motivational interviewing offers us specific techniques and strategies to engage parents and promote their intrinsic desire for behavior change—in this case, parents who are experiencing ambivalence about their level of substance use and/or their engagement in treatment services. This strength-based motivational approach with parents will help them come to their own realization about how their actions or behaviors are either moving them closer to or farther away from their desired recovery goals.

Source: (National Center on Substance Abuse and Child Welfare, 2021a)

Slide 31

Considerations for Quality Family Time for Families Affected by Substance Use Disorders

Facilitator Script:

In addition to drug testing, we should also be discussing considerations for quality family time for families affected by substance use disorders…

Slide 32

Visitation or Family Time—What's the Difference?

Facilitator Script:

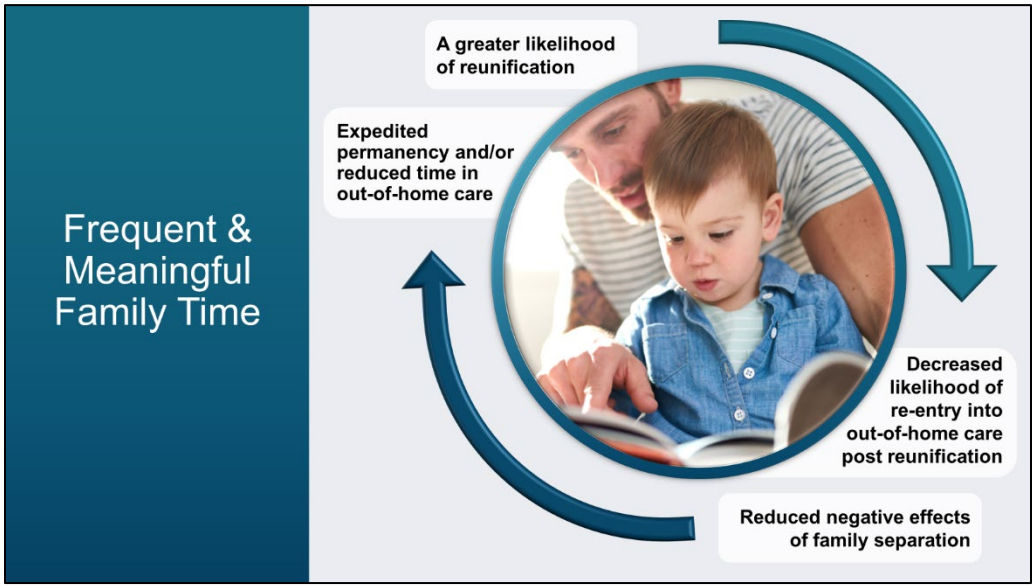
What the field most often regards as visitation or visitation plans seldom fulfills the needs that parent and children have for meaningful and nurturing time together. Use of this language often implies standard visitation schedules whereby all parents receive a predetermined amount of supervised time with their children often without consideration to their own unique set of circumstances or protective capacities. Also common is the view or belief that visitation is something that is earned—something to be incentivized—longer, more frequent, or unsupervised time with children being tied to 'good' behavior which also can in turn be taken away or reduced for 'bad' behavior—for example parental substance use. We'll speak more on this in the next slide.

Alternatively, viewing child and family contacts during out-of-home care less as visits and more as family time highlights the critical importance of the length and quality of time that children get to spend with their parents, siblings (when separated), and other important relative or non-relative extended family members. This shift in language reinforces the view and belief that family time is a right of parents and children and our role as child welfare workers is to ensure these rights are being met in the most natural and family-friendly settings.

Source: (Children's Bureau, 2020)

Slide 33

Frequent & Meaningful Family Time



Facilitator Script:

Family time for parents and children affected by substance use or co-occurring disorders is incredibly important to their safety, permanency, well-being, and recovery outcomes. We know that frequent and meaningful family time is associated with:

- A greater likelihood of reunification
- Expedited permanency and/or reduced time in out-of-home care
- Decreased likelihood of re-entry into out-of-home care post reunification
- Reduced negative effects of family separation

We also know that the road to early recovery can be a very stressful and uncertain time for parents which may require additional support from both treatment and child welfare providers in relation to meting their case plan goals and family time expectations. Here are some practice tips for you to consider…

A parent's substance use disorder treatment program may not align with the schedule for family time visits. For example, if a parent is participating in residential treatment, they may need your support in coordinating with their treatment provider to arrange visits at their treatment location or obtain approval to leave their residential location for purposes of attending the family time visit.

Treatment providers and child welfare workers should also be in agreement that drug testing should never be used punitively in relation to family time—for example, canceling a visit in response to a positive test—the only exception being if there are immediate safety threats that cannot be mitigated by any other means.

Family time is critical for maintaining the parent-child relationship, the child's well-being, and the parent's motivation to participate and remain in treatment. It's also important that we not automatically assume the worst when a parent cannot attend a scheduled visit—assumptions

such as lack of interest in reunifying with their child or a return to use. The best way to support parents through these challenges is to talk openly and explore what contributed to the missed visit and strategize on how best to reduce challenges or barriers moving forward.

Source: (Children's Bureau, 2020)

Slide 34

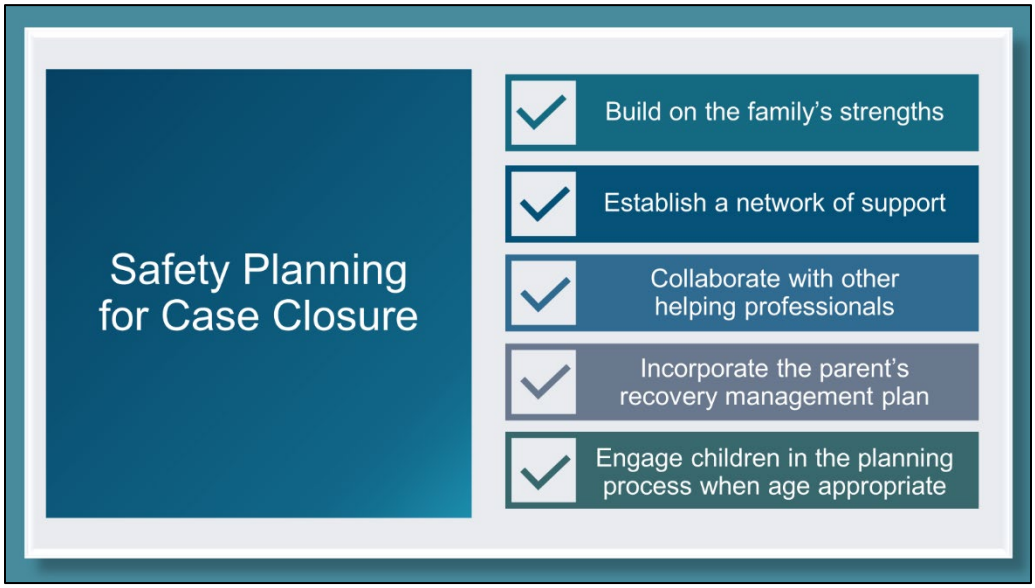
Moving Toward Family Recovery & Child Welfare Case Closure

Facilitator Script:

Let's now transition our discussion to steps we can take in our role as child welfare workers to support families as they move toward their long-term recovery and family stability goals.

Slide 35

Safety Planning for Case Closure



Facilitator Script:

Sustaining safety and protective capacities for families beyond the formal child welfare intervention period is a critical final step in the case planning process and includes:

- Building on the family's strengths—help parents articulate what they have learned and define their strengths.
- Identify other supportive family members or friends who agree to be part of the process. These supportive family members or friends should go to a meeting to talk about what kind of support they can offer the family. Can they watch the children if the parent needs a break? Can they provide transportation? Will they check in on the family—how often? Can the children's parent call them if they need help?
- Determine what helping professionals will stay involved with the family. What will their role be? Are they able to monitor ongoing safety for the family? What signs will they look for to know whether the parent or family is starting to struggle? How do they feel about calling child welfare if they have concerns in the future?
- Determine whether or not the parent has a recovery management plan. If not, work with treatment providers to establish one. Has the parent had to implement their plan? If so, what worked well? And were there any worries or concerns related to the plan that need to be improved for the future?
- Include the children if age appropriate. If they have a concern about their parent, who is a safe person they would reach out to? Do they have a way to connect with this person? What are examples of when they would reach out? It is key to work through a plan with children to make sure they know what to do and who they will reach out to. The plan must be realistic for the child's age and developmental level.

Source: (National Center on Substance Abuse and Child Welfare, 2023)

Slide 36

Determining Family Readiness for Case Closure

Facilitator Script:

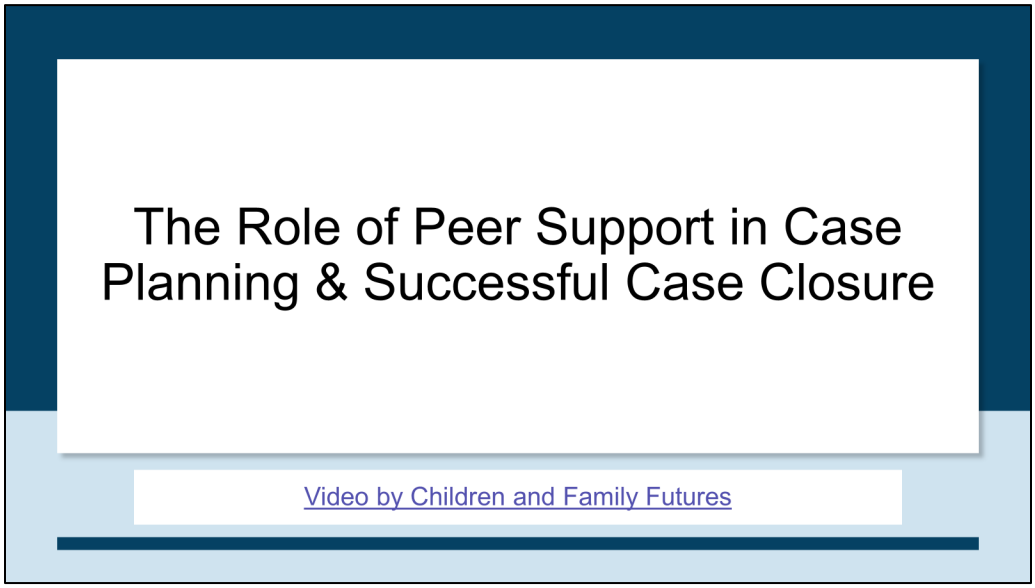
Determining when a family is ready for case closure is a critical final step in the case planning process. It's a decision that balances both the family strengths and progress achieved with any remaining concerns regarding child safety. Here are some 'green flags' to support your decision-making in your work with children, parents, and families affected by substance use and co-occurring disorders:

- The reason for child welfare involvement has been rectified
- Parents are engaged and making progress in treatment and are in active recovery
- Parents are actively participating in community-based recovery supports
- Observable, increased parental capacities and protective factors
- Parent can identify how they will seek help if they need it
- Healthy informal supports are present and active in the family's life
- Stable in concrete needs (housing, income, etc.)
- Concurrent planning is in place in case something goes wrong

Source: (National Center on Substance Abuse and Child Welfare, 2023)

Slide 37

The Role of Peer Support in Case Planning & Successful Case Closure



Facilitator Script:

Internet or Wi-Fi permitting, follow the hyperlink for a 9-minute digital story about the role of peer recovery in engaging families in case planning and promoting successful case closure. Proceed with facilitating a large group discussion using the following prompts:

Prompts for Participants:

- **Any initial reactions to the peer recovery video?**
- **Which parts of Angela's experience or role resonated with you the most?**
- **Any key takeaways about the importance and value of peer recovery support as seen through Angela's experience?**

Video Source: Children and Family Futures

Slide 38

Contact the NCSACW TTA Program

Facilitator Script:

Well, this wraps up the instructional content for module five. If you have any follow up questions from today's training, feel free to reach out to the National Center on Substance Abuse and Child Welfare at ncsacw@cffutures.org or toll free at 1-866-493-2758. Thank you all for our rich discussion today and for your continued work on behalf of children, parents, and families affected by parental substance use and co-occurring disorders. Have a nice day, everyone!

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Resources

- Child Welfare Information Gateway: *Protective Factors Approaches in Child Welfare* (2020)
- National Center on Substance Abuse and Child Welfare: *Brief 2: Drug Testing for Parents Involved in Child Welfare: Three Key Practice Points* (2021)
- National Center on Substance Abuse and Child Welfare: *Child Welfare & Planning for Safety: A Collaborative Approach for Families with Parental Substance Use Disorders and Child Welfare Involvement* (2022)
- National Center on Substance Abuse and Child Welfare: *Engagement and Safety Decision-Making in Substance Use Disorder Cases* (2023)
- National Center on Substance Abuse and Child Welfare: *Frontline Collaborative Efforts: Establishing Comprehensive Assessment Procedures and Promoting Family Engagement into Services. National Center on Substance Abuse and Child Welfare* (2021)
- National Center on Substance Abuse and Child Welfare: *Identifying Safety and Protective Capacities for Families with Parental Substance Use Disorders and Child Welfare Involvement* (2022)
- National Center on Substance Abuse and Child Welfare: *Mitigating Safety & Risk for Children Affected by Parental Substance Use Disorders* (2023)
- National Center on Substance Abuse and Child Welfare: *Planning for Safety in Cases When Parental Substance Use Disorder is Present* (2023)