

**Michigan Substance Abuse/Child Welfare Protocol for
Screening, Assessment, Engagement, and Recovery (SAER)**

Michigan

Substance Abuse/Child Welfare Protocol

For

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and Recovery (SAER)**

December 2004

Draft document – not for distribution or citation

By the
Substance Abuse/Child Welfare Collaborative
State Team
Engagement and Retention Work Group

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ACKNOWLEDGEMENTS

Numerous people contributed to this document. Significant content came from *Child Welfare/Substance Abuse Protocol Development* (September 2001) by the Michigan Family Independence Agency. Agreements developed by Baraga, Eaton, and Saginaw Counties are incorporated into this protocol, and the editors are grateful for the investment those counties have made in developing collaborations between substance abuse treatment providers, the child welfare system, and the dependency court. This protocol also borrows heavily from training conducted by the National Center on Substance Abuse and Child Welfare in February 2004, on Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR) and the Guidance document that accompanied that training.

Much of the support for development of this document came from the In-Depth Technical Assistance Project, a project of the National Center on Substance Abuse and Child Welfare (NCSACW) jointly sponsored by the Department of Human Services, Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration and the Children's Bureau of the Administration for Children and Families (ACF).

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I. Introduction

We've known for a very long time that there is a strong association between child abuse and neglect and substance abuse. Contemporary sampling shows that nationwide, as well as locally, up to 80% of the adults associated with a child welfare case have substance abuse problems that contribute to the abuse or neglect of the children.ⁱ

While alcoholism or drug addiction has no direct cause-effect link to child abuse and neglect, the abuse of alcohol and drugs is considered a serious risk-factor for child safety.ⁱⁱ Whether the substance abuse is by one or both parents, by a parent's partner, or by another adult caregiver in the home, the behaviors of adults while under the influence can have life-long impacts on children. Most states identify substance abuse as one of the top two factors in child abuse and neglect.ⁱⁱⁱ

If Michigan is to effectively impact the issue of child abuse and neglect as a result of parental substance abuse, we must develop community partnerships among the substance abuse coordinating agencies, substance abuse providers, the family court division, and the department of human services.

Practice Elements

The substance of this protocol is a set of principles, standards, and behaviors to guide daily practice. The protocol is intended to serve as a tool to improve practice and enhance collaboration between the substance abuse treatment system, the child welfare system, and the dependency court system. The sections address the interactions that the Substance Abuse/Child Welfare State team identified as most important to the provision of effective services to vulnerable children and families with substance abuse involvement. Each section of the protocol includes a table of "practice elements" with specific recommendations for the child welfare system (CWS), alcohol and drug services (ADS), and the dependency court (DC). These three systems each represent multiple entities, all of which are important pieces in the complex system that serves child welfare involved children and families with substance use issues. Readers, who wish to go straight to the practice elements, can find a table in each section consisting of three columns as follows:

Child Welfare System (CWS) means:	Alcohol and Drug Services (ADS) System means:	Dependency Court (DC) System means:
In this document "Child Welfare System" refers to child protective services, foster care services, public and private child welfare agencies and providers, and juvenile justice cases with child welfare involvement.	In this document "Alcohol and Drug Services" refers to Coordinating Agencies (CAs), assessment providers, specialty treatment programs (including treatment for women and children, pregnant women, and women of parenting age), and detoxification and treatment providers that represent your region's continuum of care.	In this document "Dependency Court" refers to judges, court administrators, legal guardians ad litem (LGALs), parents' attorneys, prosecutors, court appointed special advocates (CASAs), and court staff.

II. Developing the Collaboration

Why collaborate? When a social issue affects more than one system, effective services require the coordination, endorsement, and support of all involved agencies. The principles, standards, and behaviors of all impacted systems are important in developing interventions and services that work. Three major systems are involved with children who are abused or neglected and whose parents are affected by substance use disorders: the dependency courts, child welfare, and alcohol and drug treatment providers. It is important to engage all three of these systems in planning for systemic change. This section of the protocol provides collaboration recommendations for each system.

Collaboration requires judges, attorneys, child welfare professionals, and substance abuse treatment providers to rethink their roles and responsibility and to focus in different ways on the needs of children and families. Despite the differences between the three core systems – child welfare, alcohol and drug treatment providers, and the dependency court -- there is a great deal of commonality in the value base of each system and how they approach families. One of the ways counties or communities can begin the collaboration process is by developing a set of shared principles which reflect the tenets common to all three systems.

Requirements of the Adoption and Safe Families Act (ASFA) of 1997 emphasized the need for collaboration as the timeline for providing services, including reunification services, to children and families has been shortened. A permanent plan for the child must now be developed in 12 months, and if the child has been placed out of the home for 15 of the last 22 months, termination of parental rights must begin in most cases. With the parameter that reunification must occur within such a short time frame, and in order to best serve vulnerable children and families communities must establish collaborative relationships that will facilitate the achievement of permanency for the child. In many Michigan counties, Native American tribes may operate parallel child welfare, substance abuse, and tribal court systems. Protocols recognizing the sovereignty of tribes and including full faith and credit clauses are important to address child abuse and neglect in families with substance abuse issues.

While this protocol focuses primarily on collaboration between the substance abuse, child welfare and dependency court systems, to effectively provide services to vulnerable children and families, collaborative efforts must include other community partners. Domestic violence is often a factor in families with substance abuse and child abuse/neglect issues. In addition to substance abuse as a treatment issues, there are often co-occurring mental health problems. Other needs, including child care, job training, housing, and transportation represent just a few of the services that reflect the need for broad collaboration.

The State Team developed the following principles to guide the Michigan Child Welfare/Substance Abuse (CW/SA) Collaborative Project. These principles may be helpful to local counties and regions:

- | | |
|--------------------------------------|--|
| Services to Children and Families | <ul style="list-style-type: none">▪ Services to children and families must be comprehensive, family focused, delivered within legal timeframes, coordinated with school and work demands while being available and accessible to the broad community, including in rural areas.▪ The opportunity for family preservation and child safety are enhanced when communities provide services for families in which substance abuse is a concern.▪ The well being of children and families is improved when communities have knowledge of best practice models and have the capacity to use these models effectively. |
| Assessment, engagement and retention | <ul style="list-style-type: none">▪ There must be an active, family focused approach to a coordinated screening and assessment process in treatment and prevention.▪ It is the responsibility of all systems to support entry into, retention, completion and follow-through in the recovery process. |

Collaboration	<ul style="list-style-type: none"> ▪ THERE MUST BE STRONG PARTNERSHIPS ACROSS SYSTEMS (CHILD WELFARE, ALCOHOL AND DRUG SERVICES, AND THE DEPENDENCY COURT) AT BOTH THE STATE AND LOCAL LEVEL IN THE AREAS OF COLLABORATION, STAFF EDUCATION, AND CASE MANAGEMENT AND TREATMENT SERVICES. THESE PARTNERSHIPS ARE FOR THE PURPOSES OF ESTABLISHING A SET OF COMMON GOALS AND APPROACHES ACROSS DISCIPLINES. ▪ All agencies and organizations involved with at-risk children and families share responsibility to achieve the desired outcomes.
Confidentiality and exchange of information and data	<ul style="list-style-type: none"> ▪ Confidentiality issues among agencies need to be addressed so that necessary information can be shared and disclosed in a timely manner. ▪ An effective service system requires standardized and sharable data accessibility across systems. Establishing a statewide data base that integrates and provides access across systems is a priority.
Budget and PROGRAM SUSTAINABILITY	<ul style="list-style-type: none"> ▪ To sustain best policy and practice, resources across systems need to be pooled and adequate funding streams need to be identified and sustained. Maximizing resources require mutual and long-term commitments and joint planning efforts.

Family Drug Court Principles

Some Michigan communities have developed or are developing Family Drug Treatment Courts within their dependency court system. The purpose of family drug treatment courts is to better coordinate services and our systems' response to vulnerable children and families with substance use issues who are involved with the child welfare system. Whether or not a community has the capacity to develop a family drug treatment court, there are many ways in which dependency courts can facilitate collaborative partnerships. The Drug Court Planning Initiative of the U.S. Department of Justice developed the twelve principles below to encourage family drug courts to assume a proactive leadership role in their communities. The Michigan Substance Abuse/Child Welfare State Team believes most of these principles are applicable to all dependency courts and can be used to effectively facilitate a substance abuse - child welfare collaboration.

1. Place the safety and welfare of abused and neglected children above the needs of the parent(s).
2. Facilitate early intervention and treatment.
3. Family drug courts are based on the adult drug court model.
4. Take a comprehensive approach to strengthening family function.
5. Build customized case plans based on comprehensive assessments of the treatment, developmental, mental and physical health needs of the parents and their children.
6. Operate in a non-adversarial, team-oriented environment in which practitioners in all relevant specialties actively participate in case planning and monitoring.
7. Place parents in structured treatment programs that include mandatory, regularly scheduled court appearances, substance abuse treatment, drug testing, as well as training, education and counseling as required to meet their developmental needs.
8. Hold regularly scheduled staffings in conjunction with the court session, in which each client's progress, obstacles, and options are discussed individually, and case plans are updated as needed.
9. Hold parents accountable through the use of standardized sanctions and incentives.
10. Strive to maintain or reunify families according to the Adoption and Safe Families Act of 1997.
11. In cases where family reunification is not possible within ASFA timelines, conduct proceedings required to terminate parental rights and free children for permanent placement in a safe home.
12. Family drug court judges perform a leadership role in the family drug court team.

Practice Elements

Below are practice elements for collaboration for the three systems. The three systems -- child welfare, alcohol and drug services, and the dependency court -- should evaluate the effectiveness of their current communication and partnership and take steps with their community partners to address areas which need to be strengthened.

Child Welfare System (CWS) should:	Alcohol and Drug Services (ADS) System should:	Dependency Court (DC) System should:
1. Our CWS partners include public and private child welfare providers, as well as, representatives from alcohol and drug services and dependency court.	1. Our ADS partners include Coordinating Agencies, assessment providers, specialty treatment programs (including treatment for women and children) and providers that represent a continuum of care, as well as, representatives from child welfare services and dependency court.	1. Our DC partners include judges, referees, court administrators, legal guardians ad litem (LGALs), parents' attorneys, prosecutors, court appointed special advocates (CASAs), as well as, representatives from the child welfare system and alcohol and drug services.
2. Our region has used a formal values assessment process with the child welfare system, alcohol and drug services, and dependency court to determine how much consensus or disagreement we have about issues related to alcohol and drug use, parenting, and child safety. (One available tool is the Collaborative Values Inventory in Appendix I.)	2. Our region has used a formal values assessment process with the child welfare system, alcohol and drug services, and dependency court to determine how much consensus or disagreement we have about issues related to alcohol and drug use, parenting, and child safety. (One available tool is the Collaborative Values Inventory in Appendix I.)	2. Our region has used a formal values assessment process with the child welfare system, alcohol and drug services, and dependency court to determine how much consensus or disagreement we have about issues related to alcohol and drug use, parenting, and child safety. (One available tool is the Collaborative Values Inventory in Appendix I.)
3. The child welfare system, alcohol and drug services, and the dependency court have negotiated shared principles or goal statements that reflect a consensus on issues related to families with alcohol and other drug-related problems in the child welfare system and dependency court.	3. The child welfare system, alcohol and drug services, and the dependency court have negotiated shared principles or goal statements that reflect a consensus on issues related to families with alcohol and other drug-related problems in the child welfare system and dependency court.	3. The child welfare system, alcohol and drug services, and the dependency court have negotiated shared principles or goal statements that reflect a consensus on issues related to families with alcohol and other drug-related problems in the child welfare system and dependency court.
4. Our region has prioritized parents in the child welfare system for receipt of alcohol and other drug treatment services.	4. Our region has prioritized parents in the child welfare system for receipt of alcohol and other drug treatment services.	4. Our region has prioritized parents in the child welfare system for receipt of alcohol and other drug treatment services.
5. Our region has discussed and developed an agreement on "communication" – what, how, who, when – in order to effectively share information between systems. Policies, procedures, and specific content have been shared with all workers to facilitate communication bridges. (One tool to assist communication is Appendix II: Pathways to Communication)	5. Our region has discussed and developed an agreement on "communication" – what, how, who, when – in order to effectively share information between systems. Policies, procedures, and specific content have been shared with all workers to facilitate communication bridges. (One tool to assist communication is Appendix II: Pathways to Communication.)	5. Our region has discussed and developed an agreement on "communication" – what, how, who, when – in order to effectively share information between systems. Policies, procedures, and specific content have been shared with all workers to facilitate communication bridges. (One tool to assist communication is Appendix II: Pathways to Communication.)
6. Public and private child welfare system leaders participate regularly in collaboration meetings with alcohol and drug services and dependency court partners.	6. Alcohol and drug services assessment and treatment directors and Coordinating Agency leadership participate regularly in collaboration meetings with child welfare system and dependency court partners.	6. The judge, attorneys, and court administrators participate regularly in collaboration meetings with child welfare system and alcohol and drug services partners.

Your local collaborative may decide to develop a formal memorandum of understanding (MOU). Examples of MOUs developed by Michigan counties are included in Appendix III. The following tenets

adapted from the Sobriety Treatment and Recovery Teams (START) Project in Ohio may be useful in guiding the goals and content of your MOU:

- Child abuse and neglect is frequently associated with substance abuse and addiction. To reduce the potential loss of custody and possible termination of parental rights, it is critical to provide treatment services for the parent.
- Safety, permanency, and well being of children must always be maintained.
- In relation to substance abuse, the focus of services to the parent must be assessment and treatment of the addiction. Other behaviors and needs may be rooted within substance dependency.
- A sober, supportive living environment is critical to successful recovery.
- Addiction, as a disease, requires abstinence. We acknowledge that relapse may occur which will require modified and/or intensified services.
- No single agency or system contains all the resources and expertise to fully respond to the needs of the addicted parent who has abused and/or neglected his or her child.
- We will modify policies and procedures that impede the family's cooperation with all service providers.
- We will adopt creative approaches to building family support systems, improving parenting skills, meeting childcare needs, and filling gaps in service that are identified along the way.
- Our goal is reunification of the family as quickly as the child's safety can be assured. A child deserves a safe and permanent home. If a parent is unable to achieve sobriety, an alternative permanent home may be needed for the child's safety.

III. Screening: Presence and Immediacy

Historically, systems screen for their own categories of problems – the child welfare system screens for child abuse and neglect, alcohol and drug services screens for alcohol and other drug abuse or dependence, and the courts focus on statutory compliance. However, to enhance the capacity of parents to care for their children, child welfare agencies must screen their families for substance use and refer them for assessment and treatment when appropriate, and alcohol and drug services providers must be aware of the safety status of clients' children and make a report to child protective services when appropriate. Information obtained needs to be shared, in accordance with laws and policies of confidentiality, across these two systems and with the dependency court in court involved cases.

Nationally, child welfare directors have reported that alcohol or other drug use is one of the top two factors in child abuse and neglect. As a consequence, it is critical that child welfare workers recognize that the use of alcohol or drugs is a contributor to child abuse or neglect. The child protective services or child welfare worker should screen for substance use through:

- ✧ Observations of environment and behavior, and
- ✧ By asking screening questions.

Observing the environment includes examining the home for indications that alcohol or other substance abuse may be an issue. For example, is there a hash pipe on the table, or does the refrigerator have beer but lack food? An important part of screening and assessment is what you as the worker sees that may indicate that alcohol or drugs may be an issue in the home. Questions should seek information to facilitate the family assessment of needs and strengths

Screening for alcohol or other drug involvement should always be part of the safety assessment conducted in response to the report of abuse or neglect. If screening indicates alcohol or other drug involvement, a referral for a formal alcohol and drug services assessment must be made. Without a formal assessment for alcohol/drug involvement, the severity of the use and its impact on the parent's functioning and family may be underrated. Often, other serious issues of abuse or neglect are related to the alcohol or other drug use, and unless the needed substance abuse treatment is provided, services to address the other issues have little chance of long-term success. In summary, attempts to work on other behaviors may fail if the substance use is not addressed.

Most alcohol and drug services providers have not routinely incorporated questions about child safety, permanency, and well-being. Alcohol and drug services providers do obtain other relevant family information as part of their client's social history, and it is important that they begin to specifically screen for potential child abuse and neglect. If the client is currently involved with the child welfare system, the information should be shared with the child's caseworker. If there is no child welfare system involvement in the case, yet the potential of abuse or neglect is indicated, the alcohol and drug services professional should make a report to the child protective services agency. Child protective services will determine whether or not an investigation for abuse or neglect is warranted and whether or not the child can safely remain in the home or must be temporarily placed with relatives, in foster care, or some other temporary living arrangement. Michigan law does not require knowledge of child abuse or neglect, rather mandated reporters are required to make a report if the individual "has reasonable cause to suspect child abuse or neglect" (MCL 722.623, Section 1 a).

In both the child welfare and alcohol and drug service systems the initial screen provides front end data to move into the next appropriate phase within that system. However, once co-occurring issues are identified, including substance use disorders or child abuse or neglect, the initial system can no longer adequately address the needs and the other system should become involved. The two systems must collaborate for the family to receive appropriate assessment and services.

The dependency court is encouraged to take a proactive role to ensure that the probable involvement of alcohol or drug abuse has been addressed, that appropriate screening occurred, and that the case moved into the assessment phase if indicated. In addition, the court can provide leadership to ensure that linkages between systems and services occur.

Practice Elements

Practice elements for screening to determine presence and immediacy are included in the table below:

Child Welfare System (CWS) should:	Alcohol and Drug Services (ADS) System should:	Dependency Court (DC) System should:
<p>1. Always screen for alcohol or drug use as a factor in abuse or neglect using the Family Assessment of Needs and Strengths (FANS) (Examples of substance use screening questions can be found in Appendix IV.) Directly refer all individuals with a positive screen or other indication of substance abuse for assessment. Obtain the parent's consent to receive findings from the alcohol and drug assessment. Share your environmental and behavioral observations with the alcohol and drug assessment provider when the referral is made.</p>	<p>1. Ascertain whether or not children are in the home of treatment clients. Depending on status of client (not actively using, relapse, active use) and children, file a report with Child Protective Services if you suspect that children are at risk of neglect or abuse. (See screening tool in Appendix IV.)</p>	<p>1. Ask if a substance abuse screen has been conducted in every case and require that a screen be conducted with parents and other adult caregivers to rule out substance abuse as a factor in cases where no screen occurred (including relatives who serve as placement or potential placement for children).</p> <ul style="list-style-type: none"> ▪ Ensure that a positive screen has resulted in referral for a formal substance abuse assessment. ▪ Review screen results when determining imminent risk and making decisions about removal of children and a finding of reasonable effort.
<p>2. Ensure that all children are screened using the Child Assessment of Needs and Strengths to determine needs and make referrals or provide services. It is important to determine the impact of parental substance use and to screen older children for their own substance use.</p>	<p>2. Develop a plan of intervention to address children's needs, as well as treatment issues, using qualified experts.</p>	<p>2. Require that children be assessed to determine impact of parental substance use and that appropriate services for the child are obtained.</p> <ul style="list-style-type: none"> ▪ For older children (8+ years old, or younger if indicated) ensure that children are screened for substance use themselves
<p>3. Partner with alcohol and drug services agencies to ensure that services for Children of Substance Abusers (COSAs) are available and that children are linked to the support services that they need.</p>	<p>3. Link children of clients to supportive services to improve well-being of children.</p>	<p>3. Ensure that children are provided timely and appropriate services, consistent with identified needs that resulted from parental substance abuse</p>
<p>4. Consistently monitor cases for indications of substance use and impact of caregivers' use on children</p>	<p>4. Consistently monitor, communicate, and refer cases for clinical implications for children.</p>	<p>4. Require that a substance abuse assessment be conducted in all cases where a screen has shown a potential substance use disorder. Review services provided and participation of caregivers and children at all court hearings</p>
<p>5. Routinely share with alcohol and drug services and dependency court information collected regarding children and potential caregiver substance use disorders.</p>	<p>5. Routinely share with child welfare system and dependency court the information collected regarding children and parents or other adult caregivers.</p>	<p>5. Use authority and leadership to assure linkages among systems.</p>
<p>6. Consistently collect data on results of screens and use for monitoring and planning at the local level. Data collected should include:</p> <ul style="list-style-type: none"> ▪ Was an alcohol and drug use screen administered ▪ Results of screen ▪ Observational notations 	<p>6. Collect data on clients with children and child welfare status and use for program planning at the local level. Data should include:</p> <ul style="list-style-type: none"> ▪ Number of children ▪ Number with past and present child welfare system involvement ▪ Pertinent characteristics including past and present history of child welfare system involvement. 	<p>6. Ensure that data regarding children of substance abuse treatment clients and results of substance use screens are consistently recorded and monitored and are used for program planning (including workloads) and resource allocation at the local and statewide level.</p>
<p>7. Actively develop and participate in a cross-system multi-disciplinary team that ensures that a comprehensive family assessment is conducted and includes assessment of other co-occurring issues.</p>	<p>7. Actively develop and participate in a cross-system multi-disciplinary team that ensures that a comprehensive family assessment is conducted and includes assessment of other co-occurring issues.</p>	<p>7. Actively develop and participate in a cross-system multi-disciplinary team that ensures that a comprehensive family assessment is conducted and includes assessment of other co-occurring issues.</p>

IV. Assessment: Nature and Extent

Screening (discussed in the previous section) is never diagnostic in and of itself, but indicates whether a comprehensive assessment or evaluation is needed. Assessment involves the collection of detailed information to determine whether or not an individual has a given condition or meets diagnostic criteria for a given disorder and can also determine the level of care and treatment plan to appropriately treat an individual.

Assessment is used in conjunction with the investigation of abuse or neglect in the child welfare system and is used in conjunction with diagnosis in the alcohol and drug services system. Assessment in both systems helps to answer the questions “What is the nature of the substance use or child abuse or neglect issue?” and “What is the extent of the substance abuse or child abuse or neglect issue?”

Assessment in both systems is a cumulative process of information gathering. Workers must weigh information from numerous sources including interactions with family members and other service providers in addition to the assessment tools used. The more child welfare system and alcohol and drug services workers communicate and exchange information in a comprehensive and systematic way, the more complete and beneficial the assessment process will be. This shared information is important in developing the case plan (treatment plan to alcohol and drug services providers) and in working with the parents and children. The dependency court can aid in obtaining needed information by the court ordering that an assessment be conducted and that the results become part of the court ordered case plan.

Child abuse and neglect occurs on a continuum. Two areas that the child welfare worker must continue to assess while the case is open are child safety and risk of future harm. Safety is immediate and examines whether or not a child is safe from harm in his or her home now. Risk of future harm assesses risk factors in the home in relation to potential abuse or neglect of the child at a future point in time.

Alcohol and drug use also occurs on a continuum, generally classified as “use”, “abuse”, and “dependence.” Dependence is also known as “addiction.” It is important to realize that a parent does not need to be addicted to alcohol or drugs to place the child at risk of abuse or neglect. The table^{iv} below defines the continuum and highlights implications for risk to children based on parental substance use, abuse, or dependence.

ALCOHOL AND DRUG USE CONTINUUM	Implications for Child Welfare/ Examples of Risk to Children
<p>Use of alcohol or drugs to socialize and feel effects. Use may not appear abusive and may not lead to dependence; however circumstances under which a parent uses can put children at risk of harm.</p>	<ul style="list-style-type: none"> ▪ Driving with children in the car while under the influence ▪ Use during pregnancy can harm the fetus
<p>Abuse of alcohol or drugs includes at least one of these factors in the last 12 months:</p> <ul style="list-style-type: none"> ▪ Effects have seriously interfered with health, work, or social functioning ▪ Person has engaged in hazardous activity on a recurring basis, such as driving or operating machinery under the influence ▪ Person has experienced use-related legal problems ▪ Person has continued use despite ongoing or recurring problems caused or exacerbated by use—this includes a 	<ul style="list-style-type: none"> ▪ Children may be left in unsafe care—with an inappropriate caretaker or unattended—while parent is partying ▪ Parent may take children to location where parent or others party or get high ▪ 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,

maladaptive pattern of use, such as binge drinking	such as a pattern of screaming insults then expressing remorse
<p>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:</p> <ul style="list-style-type: none"> ▪ Tolerance—needing more of the drug or alcohol to get “high” ▪ Withdrawal—physical symptoms when alcohol or drugs are not used, such as tremors, nausea, sweating, and shakiness ▪ Unable to control use—a strong craving or compulsion to use and an inability to limit use. ▪ The alcohol or drug increasingly becomes the focus of the person’s life at the expense of all other areas, including family, work, social, and recreational ▪ Continued use despite ongoing or recurring physical or psychological problems caused or exacerbated by the alcohol and drug use^{v, vi} 	<ul style="list-style-type: none"> ▪ 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 drugs, while 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 <p><i>From: Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers</i></p>

Practice Elements

Practice elements for assessment to determine nature and extent include:

Child Welfare System (CWS) should:	Alcohol and Drug Services (ADS) System should:	Dependency Court (DC) System should:
<p>1. Share nature of the case with alcohol and drug services agency upon referral using standardized forms.</p> <ul style="list-style-type: none"> ▪ Signed consents for disclosure comply with 42 CFR Part II ▪ Precipitating events in the child welfare case are shared ▪ Results of child welfare observations and assessments are communicated 	<p>1. Share diagnostic information with the child welfare system within 7 days of assessment using a standardized form to make information sharing uniform.</p> <ul style="list-style-type: none"> ▪ Ensure that the child welfare system has provided consent forms signed by the parent that meet 42 CFR Part II requirements so that “no shows” can be communicated ▪ Include information on level of care needed and diagnostic impression. 	<p>1. Ensure that substance use diagnosis and results of multi-dimensional assessment are submitted in all cases where a substance use screen was confirmed. Ensure that the child welfare system and alcohol and drug services have shared information about this family and are working collaboratively.</p>

<p>2. In determining extent of the issue, family information obtained through the Family Assessment of Needs and Strengths, is shared with alcohol and drug services agency within 45 days using standardized forms that include:</p> <ul style="list-style-type: none"> ▪ Criminal and civil court history ▪ Prior child abuse/neglect reports and substantiations ▪ Use by significant other or other adults in the home ▪ Information about home environment, including past or present family violence and domestic violence ▪ Was parent a CWS dependent ▪ Does parent have history of mental illness (results of psychological evaluation) ▪ Does the Indian Child Welfare Act (ICWA) or Interstate Compact on Placement of Children (ICPC) apply? ▪ CWS drug testing requirements and results ▪ Parents' perception of issue ▪ Extended family, family strengths, connections to community, culture, and available resources ▪ Children's assessments ▪ Other case issues that impact parents, family, or child. 	<p>2. Conduct a bio-psycho-social assessment to determine extent substance use disorder within 30 days and share results with the child welfare system within 7 days. Written report is delivered to the child welfare system and information is shared using standardized forms that include:</p> <ul style="list-style-type: none"> ▪ Frequency of use ▪ Impact of drug toxicity ▪ Parent functioning resulting from use (e.g., blackouts) ▪ Level of impairment (Is parent's ability to meet child's basic needs impaired?) ▪ Family connections, strengths, extended family ▪ Employment/education status ▪ Parent's trauma history ▪ Assessment of motivation and engagement level ▪ Who cares for child during parental alcohol/drug use or substance seeking behavior ▪ Parent's perception of relationship between substance use and her/his parenting ▪ Treatment recommendations – level of care, length of time in treatment, can children remain with parent, parent-child visitation in treatment ▪ Other family changes (e.g., marriages, deaths, moves) ▪ Additional services needed. 	<p>2. Ensure reports include:</p> <ul style="list-style-type: none"> ▪ Information on treatment recommendations ▪ Level of care determination ▪ Culturally relevant assessments and recommendations ▪ If child is placed with a relative, ensure that alcohol or other drug use has been screened out as a possible concern in the placement.
<p>3. Conduct on-going assessment at each decision point in case and share with alcohol and drug services and the dependency court.</p>	<p>3. Reassessment information is shared with child welfare system.</p>	<p>3. Ensure that case plan is amended to reflect current re-assessment information and services needed.</p>
<p>4. Child welfare system, alcohol and drug services, dependency court staff, attorneys and family meet to discuss assessment results and jointly plan services/case plans. Inter-actions comfortable for families in regards to language, culture, etc.</p>	<p>4. Alcohol and drug services, child welfare system, dependency court staff, attorneys and family meet to discuss assessment results and to develop case plans. Meetings are conducted in a manner that is comfortable for families in regards to language, culture, etc.</p>	<p>4. Child welfare system, alcohol and drug services, dependency court staff, attorneys and family meet to discuss assessment results and to develop case plans. Meetings are conducted in a manner that is comfortable for families in regards to language, culture, etc.</p>

V. Engagement and Retention

Once the allegation of child abuse or neglect has been substantiated and the substance use disorder has been assessed, there are still many issues to be addressed. Some of the questions and decisions include:

- What is the response by the child welfare system, alcohol and drug services, or the dependency court system?
- What strengths were identified in the family?
- What other issues of concern were identified in the family?
- What services are needed for the parents and the children?

- Are there barriers to overcome for the parent to access needed services? Is there a plan to overcome these barriers?
- What are the goals of the treatment plan/case plan?
- Are there demonstrable changes?

The Role of Motivation

Motivation for change is an important component of engagement and retention in both the child welfare and alcohol and drug services systems. The Prochaska and DiClemente^{vii} model of change may provide a useful framework for the child welfare, alcohol and drug services, and dependency court systems for understanding the process of change. Six stages describe the progression of change that individuals experience in changing behaviors or working to resolve problems. The six stages of change are:

1. Pre-contemplation,
2. Contemplation,
3. Determination,
4. Action,
5. Maintenance, and
6. Relapse.

In both the child welfare and alcohol and drug service systems it is important to identify where the parent is in terms of recognizing problematic behaviors and the parent's readiness and willingness to change. Some parents may feel ambivalent about changing. Among the reasons for ambivalence to change are: current behaviors seem to work, parents view their behavior(s) as normal, they are comfortable with a passive role (e.g., "someone else must fix it for me"), or it seems too hard or overwhelming to change. Ambivalence is viewed as positive because it opens the door to examination of other options. Ambivalence should not be confused with rationalizations intended to justify and maintain the status quo.

The Michigan Child Protective Services Manual (CFP 713-7) recognizes that laboratory screens for alcohol or drug use can serve several useful functions. For example,

- testing may be appropriate to help a parent or other child caretaker overcome denial and agree to seek treatment;
- if substance abuse is known to be a contributing factor of abuse or neglect, testing can assist with monitoring compliance with the services plan;
- testing may also identify or eliminate contributing factors in the assessment of risk of future harm to the child.

Either the child welfare or alcohol and drug service system can conduct drug screens. Once again, we must highlight that the information is to be shared across systems.

Motivation to change and motivational interventions go hand in hand with readiness to change and the change process. The child welfare worker, substance abuse counselor, the judge, and significant persons in the life of a substance-abusing parent can promote and support motivation to change. The table below describes the stages of change and identifies motivational tasks to address with the substance-abusing parent.

Parent's Stages of Change		Motivational Tasks for Child Welfare Worker and Substance Abuse Counselor
Pre-contemplation	No perception of having a problem or need to change.	Increase parent's perception of the risks and problems with their current behavior. Raise parent's doubts about behavior A worker may say: "When you get high, who takes care of your children? What would happen if one of your children was hurt and needed her mother? How does your alcohol/drug use affect your ability to be a good parent? How does your use affect your judgment?"
Contemplation	Initial recognition that behavior may be a problem and ambivalence about change.	Foster and evoke reasons to change and the risks of not changing. Tip the balance toward change. A worker may say: "Child protective services must assess how safe your child is in your home and if there is a future risk of harm to your children. Treatment will help you maintain sobriety and reduce the risk that your children will be removed."
Decision to change	Makes a conscious decision to change. Some motivation for change identified.	Help parent identify best actions to take for change. Support motivations for change. A worker may say: "Your decision to enter intensive outpatient treatment and attend 4 Narcotics Anonymous and Alcoholics Anonymous meetings a week is a strong indicator to the judge of your commitment to regain custody of your children."
Action	Takes steps to change.	Help parent address barriers, implement strategies and take steps. A worker may say: "You have a treatment program lined up, our agency has arranged transportation to and from treatment, and you will be able to visit your children once a week. What else do you need to consider in order to meet your goals?"
Maintenance	Actively works on sustaining change strategies and maintaining long-term change.	Help parent to identify triggers and use strategies to prevent relapse. A worker may say: "Spending the holidays with your family sounds very stressful. What are some things you could do to reduce this level of stress and reduce the possibility of relapse?"
Lapse or Relapse	Lapses from a change strategy or returns to previous problem behavior patterns (relapse).	Help parent re-engage in the contemplation, decision, and action stages. A worker may say: "Let's re-examine the reasons why you think treatment is a good decision for you. What are some of the benefits of sobriety? What are some of the benefits of continuing to use? What actions will help you to become reunited with your children?"

Table Adapted from: *Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers*

With the family's involvement, both alcohol and drug services and the child welfare system develop intervention plans that address the desired changes or services needed. Services are provided and

monitored through individual treatment plans (alcohol and drug services) and case plans (child welfare services) and through the development and monitoring of outcome measures. In the dependency court the case is guided through the issuance of a court order and the monitoring of compliance with that order.

Relapse

During the phases of engagement and retention, the child welfare system and alcohol and drug services system must work closely together and maintain regular communication. It is essential to reengage the parent in treatment as soon as possible if a relapse occurs. Reports to the dependency court need to reflect the parent's participation and compliance, so that the power of the bench can be used to support continued sobriety or encourage the parent to re-engage in treatment.

It is important to remember that relapse is not the same as treatment failure. Recurrence of substance use can happen at any point in the recovery process. When a parent has a relapse, it is important to work with the parent to re-engage her or him in treatment as soon as possible. Child welfare workers in concert with the alcohol and drug services counselor can assist parents to view a relapse episode as a means for learning to identify what triggers desire or cravings to use.

Family and Domestic Violence

Domestic violence in a home presents considerable threat to the children. More than half of men who assault their partners are also physically abusive to their children^{viii} and as many as 90% of children of abusers witness the abuse.^{ix} Children can experience serious detrimental effects, including somatic, behavioral, and emotional problems in response to being battered or witnessing the battering of a parent.^x When domestic violence is present, "substance abuse treatment alone is unlikely to stop the violence."^{xi} In fact, as the woman progresses in treatment and asserts more independence in behaviors regarding visitation or reunification with her children, she may be at increased risk of being battered. Many victims' use of alcohol or drugs is coerced by their partners as a mechanism of control, and recovery efforts are often actively sabotaged by their partners.^{xii} Interventions for the abusive partner and for the battered parent must be individualized. Case plans and treatment plans must address both ongoing safety needs and the assaultive behavior of the abusing partner. Family therapy, couples or marriage counseling, or other programs in which the victim and abuser must cooperatively participate should not be required of families in which there is domestic violence.^{xiii} Local programs, including domestic violence prevention and shelter agencies and batterers intervention programs should be involved in assessing needs and developing case plans for the battered parent and the batterer. Specific steps should be taken to assess the impact of the domestic violence on the children. Two screening instruments for domestic violence are included in Appendix IV.

Addressing Other Needs and Barriers

In almost all cases, parents and other caregivers have other issues which must be addressed for treatment to be effective. For example, if a parent is to focus on treatment, he or she needs housing and basic living needs met. Engagement and retention in treatment require stable, reliable transportation. In addition, when child welfare workers seek treatment for a substance-abusing mother, gender specific components are important considerations. If barriers and other service needs are not identified and addressed, our systems fail vulnerable children and their parents. In addition to alcohol and drug abuse counseling, education, and treatment services, a number of common barriers and co-occurring needs are reflected in the lists below (adapted from a comprehensive treatment model with three levels of services for women with substance abuse issues):^{xiv}

Clinical Treatment Services: Detoxification, crisis intervention, case management, trauma specific services, medical care, mental health services, drug monitoring, and continuing care.

Clinical Support Services: Primary health care services, life skills, parenting and child development education, family programs, educational remediation and support, employment readiness services, linkages with legal system, housing support advocacy, and recovery community support services.

Community Support Services: Recovery management, recovery community support services, housing services, family strengthening, child care, transportation, Temporary Assistance for Needy Families (TANF) linkages, employer support services, vocational and academic education services, faith-based organization support.

Practice Elements

Practice elements for engagement and retention include:

Child Welfare System (CWS) should:	Alcohol and Drug Services (ADS) System should:	Dependency Court (DC) System should:
<p>1. Best Practice: Partners (including family) develop family driven case plans with shared objectives. Fundamental Practice: Alcohol and drug services and the child welfare system have input into development of each other's case plan with shared ownership of objectives.</p>	<p>1. Best Practice: Partners (including family) develop family driven case plans with shared objectives. Fundamental Practice: Alcohol and drug services and the child welfare system have input into development of each other's case plan with shared ownership of objectives.</p>	<p>1. Best Practice: Partners (including family) develop family driven case plans with shared objectives. Fundamental Practice: Communication and shared knowledge between alcohol and drug services, the child welfare system and dependency court drive court orders</p>
<p>2. Plans include the following:</p> <ul style="list-style-type: none"> ▪ Joint child welfare system-alcohol drug services ownership of goals ▪ Ensure that child welfare system activities, objectives and service strategies do not conflict with alcohol and drug treatment services. ▪ Court interventions are used therapeutically 	<p>2. Plans include the following:</p> <ul style="list-style-type: none"> ▪ Joint child welfare system-alcohol drug services ownership of goals ▪ Ensure that alcohol and drug treatment services incorporate child welfare system activities, services, and timetables. ▪ Court interventions are used therapeutically with families. 	<p>2. Court Orders reflect the following:</p> <ul style="list-style-type: none"> ▪ Dependency court supports child welfare system-alcohol drug services goals. ▪ Treatment is court ordered. ▪ Dependency court oversees integration of timelines within the Adoption and Safe Families Act (ASFA) framework. ▪ Court interventions are used therapeutically with families.
<p>3. Share qualitative and quantitative information about compliance with court orders and meeting treatment objectives with alcohol and drug services and dependency court at standardized intervals and critical incidents.</p> <ul style="list-style-type: none"> ▪ Discuss best use of drug screens (when and how to handle results) with alcohol and drug services partner. ▪ Determine who will conduct drug and alcohol screens (if any) and how results will be communicated ▪ Plan for joint response to relapse on an individualized case basis ▪ Request additional dependency court hearings if needed to reinforce the parent's commitment to treatment 	<p>3. Share qualitative and quantitative information about compliance with court orders and meeting treatment objectives with child welfare system and dependency court at standardized intervals and critical incidents.</p> <ul style="list-style-type: none"> ▪ Discuss best use of drug screens (when and how to handle results) with child welfare system partner. ▪ Determine who will conduct drug and alcohol screens (if any) and how results will be communicated ▪ Plan for joint response to relapse on an individualized case basis ▪ Review with child welfare partners whether or not additional dependency court hearings can facilitate the parent's recovery and retention in treatment 	<p>3. Review progress of the parent and results of screens during review hearings.</p> <ul style="list-style-type: none"> ▪ Reinforce positive strides made by the parent. ▪ Support joint child welfare system and alcohol and drug services plan for effective use of drug screens. ▪ Encourage commitment or a recommitment to sobriety and treatment if slips or relapse has occurred. ▪ Support the bond developed between parent and treatment provider and between parent and child welfare worker. ▪ Reinforce parent's motivation to change through immediate and timely consequences (e.g., spending a day in jail).
<p>4. Monitor treatment compliance and frequently share with alcohol and drug services and dependency court information about:</p> <ul style="list-style-type: none"> ▪ Number of drug tests required and results of tests ▪ Progress in obtaining and maintaining abstinence ▪ Number of group and individual sessions required and attended 	<p>4. Monitor treatment compliance and frequently share with child welfare system and dependency court information about:</p> <ul style="list-style-type: none"> ▪ Number of drug tests required and results of tests ▪ Progress in obtaining and maintaining abstinence ▪ Number of group and individual sessions required and attended 	<p>4. Review treatment compliance and use the power of the bench for therapeutic intervention or support of recovery.</p>

<ul style="list-style-type: none"> ▪ Treatment goals and progress toward treatment goals. 	<ul style="list-style-type: none"> ▪ Treatment goals and progress toward treatment goals. 	
<p>5. Continually assess movement through stages of change</p> <ul style="list-style-type: none"> ▪ Use positive urine test and motivation for return of child as therapeutic tools to reengage parent. ▪ Always share drug screen results with alcohol and drug services. 	<p>5. Continually assess movement through stages of change</p> <ul style="list-style-type: none"> ▪ Use positive urine test as a therapeutic tool with child welfare system and the courts. ▪ Always share drug screen results with child welfare system. 	<p>5. Support parent's motivation for return of child as a therapeutic tool for re-engaging the parent in treatment.</p>
<p>6. Incorporate children into parent's treatment and increase parenting time through more frequent and longer visits with child as parent progresses in treatment.</p>	<p>6. Incorporate children into parent's treatment and increase parenting time through more frequent and longer visits with child as parent progresses in treatment.</p>	<p>6. Reinforce a parent's progress and continued commitment to treatment by supporting increased visitation with children.</p>
<p>7. Assess for domestic violence and other mental health, behavioral and environmental issues that present barriers to compliance with the case plan. Address linkages to services jointly with the alcohol and drug services system.</p>	<p>7. Assess for domestic violence and other mental health, behavioral and environmental issues that present barriers to compliance with the treatment plan. Address linkages to services jointly with the child welfare system.</p>	<p>7. Ensure that the families other needs and issues are explored and addressed, including domestic violence, and other issues such as mental health, behavioral and environmental needs that must be addressed for reunification to occur.</p>

VI. Transition Planning, Aftercare, and Recovery Services

After a parent has demonstrated progress in meeting her or his treatment objectives, the child welfare system, alcohol and drug services provider, and dependency court must examine whether or not the family is ready for transition. Transition planning involves an assessment of the individual's ongoing recovery plan. It involves an assessment of when and under what circumstances the children will be reunited with the parent. Important questions include:

- Is the family ready for transition?
- Did the interventions work?
- What are the results of a risk, safety and/or reunification assessment at this time?
- How soon can we reunify the child with the parent?
- What additional interventions are needed to support the parent's recovery?
- What additional interventions or supports are needed to reinforce the reunification stability and well-being of the child?

The child welfare system's transition plan for the return of the child parallels the alcohol and drug services plan for aftercare. Continuing care, or "aftercare," or recovery services are essential to sustaining treatment success, child safety and family well-being. They give the family an opportunity to anchor new behaviors and practice drug-free living and relapse prevention techniques. Without aftercare services and community supports, relapse rates can be high, even after periods of long sobriety during treatment. Continuing care includes clinical treatment and community support, addresses individual needs identified in the parent's relapse prevention plan, and builds a supportive net around the individual and his or her family to encourage recovery.

Practice Elements

Practice elements for transition planning and aftercare include:

Child Welfare System (CWS) should:	Alcohol and Drug Services (ADS) System should:	Dependency Court (DC) System should:
1. Develop and use indicators of capacity of families with substance use disorders to meet the needs of their children regarding safety, permanency, and well-being in outcome measures.	1. Develop and use indicators of capacity of families with substance use disorders to meet the needs of their children regarding safety, permanency, and well-being in outcome measures.	1. Participate in development of indicators of families with substance use disorders to meet the needs of their children regarding safety, permanency, and well-being outcome measures.
2. Changes in family functioning, parent's recovery, and child welfare goals are the key indicators in determining transition plans.	2. Changes in family functioning, parent's recovery, and child welfare goals are the key indicators in determining treatment completion and aftercare plans.	2. Dependency court reviews changes in family functioning, parent's recovery, and child welfare goals in developing court orders for reunification and determining when the case should be closed.
3. Communication and shared knowledge drives scheduling of court hearings and return of child, versus the timelines of the court driving the communication. Collaboratively developed plans and timelines for reunification of child and family are shared with partners.	3. Communication and shared knowledge about parent's treatment and recovery assists in development of plans for reunification of child with the parents.	3. Dependency court ensures that plans for reunification are developed from shared information between alcohol and drug services, the child welfare system, and other community providers of services to the parents and children.
4. Child welfare system recommendations for case closure incorporate alcohol and drug treatment aftercare service recommendations and acknowledge their importance for optimal long-term family functioning.	4. Alcohol and drug services aftercare incorporates child welfare goals and supports optimal long-term family connections.	4. The court acknowledges the importance of alcohol and drug aftercare services, their contribution to child welfare goals, and supports these continuing services.
5. Post-reunification services are developed with awareness of the potential impact of the child's reunification on the parent's recovery. <ul style="list-style-type: none"> ▪ Additional services are provided as appropriate to support the parent's continuing sobriety. ▪ Information continues to be shared across systems with the alcohol and drug services partner. 	5. Aftercare services incorporate changes in the child's status (e.g., returned home) and the impact on the parent's recovery. <ul style="list-style-type: none"> ▪ Additional services are provided as appropriate to support the parent's continuing sobriety. ▪ Information continues to be shared across systems with the alcohol and drug services partner. 	5. The dependency court encourages and monitors continued collaboration between the child welfare system and alcohol and drug treatment services to maximize support of the parent's continued sobriety and stability for the child.
6. Cross agency and community-wide funding strategies are employed to sustain programs.	6. Cross agency and community-wide funding strategies are employed to sustain programs.	6. Cross agency and community-wide funding strategies are employed to sustain programs.
7. Outcome results are used for program planning and resource allocations	7. Outcome results are used for program planning and resource allocations	7. Outcome results are used for program planning and resource allocations

APPENDICES

Appendix I: Collaborative Values Inventory

Appendix II: Michigan Pathways of Communication Template

Appendix III: Memoranda of Understanding

Eaton County Substance Abuse Protocol

Saginaw County Protocol

Baraga County Substance Abuse/Child Welfare Protocol

Baraga County Workgroup Basic Tenets

Appendix IV: Screening Instruments

Appendix V: Collaborative Capacity Inventory

Appendix I: Collaborative Values Inventory goes here – 7 pp

Download from: http://www.ncsacw.samhsa.gov/files/CVI_5_17_03.pdf

Appendix II Michigan Pathways of Communication Template goes here.

Appendix III:
Memoranda of Understanding

Eaton County Substance Abuse Protocol

Saginaw County Protocol

Baraga County Substance Abuse/Child Welfare Protocol

Baraga County Workgroup Basic Tenets

Eaton County Substance Abuse Protocol

COLLABORATIVE AGREEMENT BETWEEN THE EATON SUBSTANCE ABUSE PROGRAM *and the Eaton County Family Independence Agency*

Purpose:

The purpose of the Eaton County Substance Abuse Protocol is to ensure effective substance abuse treatment for mutual clients of the Eaton Substance Abuse Program (ESAP) and the Eaton County Family Independence Agency. Effective treatment and enhanced customer service will be sustained through a streamlined referral process, coordinated service delivery, and effective, timely communication. The Eaton County Substance Abuse Protocol (protocol) will assure the two agencies work together for the benefit of our mutual clients. A coordinated multi-agency response will afford families the most successful intervention with an outcome of family stability. Substance abuse is a major factor in child welfare cases whether Protective Services, Foster Care or Juvenile Justice.

Goals:

With the development of a community protocol, the protocol goals are to:

- Improve communication
- Enhance the service delivery system for individuals and families
- Provide training and continuing education for staff
- Allow for regularly scheduled meetings to address issues/concerns to best meet the needs of the family, referring agency and service provider
- Identify and address gaps in service delivery

Referral Process:

A referral will be made by the Family Independence Agency worker utilizing the Eaton County Service Referral Form. This form identifies the service authorization period, number of units, payment source and identified service. The services that are available through ESAP include: a comprehensive assessment, substance abuse assessment, substance abuse intake (to be utilized when the client has previously had an intensive assessment) and ongoing substance abuse treatment.

If possible, the FIA worker will attach a signed release of information to the referral. If obtaining a release prior to the sending the referral to ESAP is not possible, the Eaton Substance Abuse Program service provider will request the release of information from the client.

It is the responsibility of the FIA referring worker to inform the client that a referral for substance abuse service has been made. The referring worker will inform the client to contact ESAP to schedule an appointment. If the referring worker has provided a release of information to ESAP, FIA will be notified if the client does not attend their appointments. If ESAP has not received a signed release of information, the referring worker will not be contacted when a no show occurs.

Reporting Requirements:

Client Evaluation Report (CER):

Within 5 working days of the assessment or intake, a Client Evaluation Report will be completed by the substance abuse provider and sent to the referring worker.

Client Progress Report (CPR):

A Client Progress Report will be completed by the case manager each month. The CPR will be submitted to the referring worker by the 15th day of the month following treatment.

Termination Summary Report:

A discharge summary will be submitted within 5 working days of the date of case closure to the referring worker.

Client Contacts:

Initially, the number of client contacts will be identified on the FIA Services Referral Form. Through mutual agreement between FIA, ESAP and the family, the number of client sessions can be modified, after the assessment period. Client contact must be established at a minimum of one time each month.

Court Appearances:

The Eaton Substance Abuse Program provider will appear at court hearings only when subpoenaed for an appearance.

Client Transportation:

If the client is unable to find transportation to the scheduled appointment, it is the client's responsibility to contact either their Eaton Substance Abuse Program provider or the Family Independence Agency worker to arrange transportation. Available options include bus tokens, taxicabs and volunteer transportation.

Continuing Education:

Within the first 3 months of the protocol being signed, a joint orientation will be held for Family Independence Agency staff and the Eaton Substance Abuse providers. The joint orientation will include details of the protocol, discussion of the referring forms, reports, scheduled training and other pertinent information. Open dialog will occur on prior successes, current issues and potential resolutions.

Thereafter, FIA and ESAP managers will meet at a minimum of 2 times a year to review and discuss the protocol, services, treatment options and all topics relevant to effective services. Annually, joint training will be provided to ESAP and FIA staff. Training will be pertinent to current service topics or identified needs of either staff.

Conflict Resolution:

If a client referred from the Family Independence Agency has a complaint about substance abuse services, they will contact their caseworker for assistance in resolving the issue.

It is the intent of this partnership to resolve disputes at the level closest to the onset on the concern. If concerns arise that cannot be resolved at the worker or middle management level, the directors of the respective agencies will meet to review and resolve any issues.

If there is a complaint or grievance from a customer regarding access, level of care decisions or provision of services, the customer will follow the existing grievance appeal and recipients rights procedure as applicable to the service system (in addition to contacting their FIA worker).

Customers of Eaton Substance Abuse Program will follow the Patient's Rights Procedure for assistance in resolving alleged violations of their legal rights.

Identifying and Addressing Gaps in Customer Services:

The bi-annual meeting between FIA and ESAP shall be used to discuss enhancing service and to explore funding opportunities through grant writing or other creative approaches.

Don Rewa, Director, Barry-Eaton Family Independence Agency

Thomas Spencer, Executive Director, Barry-Eaton District Health Department

COORDINATION OF SERVICES AGREEMENT
BETWEEN
SAGINAW COUNTY FAMILY INDEPENDENCE AGENCY (FIA)
SAGINAW COUNTY DEPARTMENT OF PUBLIC HEALTH (SCDPH)
BAY AREA SUBSTANCE ABUSE COORDINATING AGENCY (BASACA)

INTRODUCTION

The purpose of this agreement is to support state and local policy of coordination and collaboration between the Saginaw County Family Independence Agency, the Saginaw County Department of Public Health and the Bay Area Substance Abuse Coordinating Agency. In Saginaw County the Bay Area Substance Abuse Coordinating Agency is a division of the Saginaw County Department of Public Health.

This agreement recognizes the mutuality of many of the individuals and families served by each agency. This agreement is seen as a means to enhance the services and programs now offered by each of the agencies in ways that will increase the effectiveness of said programs for the families served. This agreement promotes and facilitates compliance with the Federal and State confidentiality laws of Bay Area Substance Abuse Coordinating Agency, the Saginaw County Department of Public Health and of the Saginaw County Family Independence Agency, while permitting the communication and collaboration necessary for both the treatment of the parents and the well being of the children.

Specifically, the goals of the agreement are:

1. To enhance customer service for the individuals and families served by our agencies.
2. To facilitate eligibility determination and ensure access to services for customers.
3. To coordinate the delivery of services.
4. To facilitate communication and problem-solving.
5. To ensure continuing information exchange.
6. To identify and address unmet needs.

GENERAL PRINCIPLES

A. INFORMATION EXCHANGE AND CONFIDENTIALITY

1. Service agreements will be developed between the participating agencies to allow the transfer of initial referral information, particularly to facilitate access to the appropriate service or respond to customer emergencies. See Appendix 1 for the "Substance Abuse services Addendum between FIA, SCDPH and BASACA.
2. FIA, SCDPH and BASACA will develop and use a mutually agreed upon Release of Information form that will comply with the Federal and State Confidentiality laws. See Appendix 1 for a copy of the Release of Information Form.
3. FIA, SCDPH and BASACA programs will obtain releases of information in accordance with Federal and State regulations to allow exchange of information beyond accessing services or customer emergencies. The requirements regarding confidentiality of customer records in FIA and BASACA will be summarized and communicated to providers in each agency. See Appendices 2 and 3 for detailed statements regarding confidentiality requirements that can be distributed to staff members within the participating agencies.

B. COLLABORATION AND INFORMATION SHARING

1. FIA, SCDPH and BASACA will develop a service agreement to facilitate the exchange of information between agencies on an ongoing basis. This will include availability and access to the ADIA program. See Appendix 1 for the "Substance Abuse Services Addendum between FIA, SCDPH and BASACA.
2. The directors of FIA, BASACA and SCDPH will meet regularly at the Multi Purpose Collaborative Body (MPCB) meetings for overview, information sharing and the possible need for meetings with administrations and/or staff.
3. Representatives from the participating agencies and subprograms will meet at least annually to share information, update procedures and enhance working relationships between programs.
4. Additional collaborative initiatives will be developed as needs are identified.

C. TRAINING AND STAFF DEVELOPMENT

1. During the first six months of this agreement, there will be two training sessions between the staffs of the participating agencies to share information regarding programs, procedures and staffing.
2. A minimum of one conjoint/collaborative in-service workshop will be scheduled each year to address the coordination of programs, update policies and procedures, introduce new staff, and enhance the working relationships.
3. Information regarding conjoint/collaborative training activities sponsored by or known to participating agencies will be shared on an ongoing basis.
4. Conjoint/collaborative training activities, including local new employee orientations, sponsored by participating agencies will be open to participation by providers in the other agencies as appropriate.
5. Self-training materials developed by the participating agencies will be shared with other agencies as appropriate and available.
6. Conjoint training will be arranged as needed based on the mutual agreement of need by the FIA and BASACA.

D. PROBLEM RESOLUTION PROCESSES

1. Whenever possible, disputes should be resolved at the level closest to the onset of the concern.
2. Disagreements between staff members:
 - a. Disputes regarding coordination of care are initially handled by the providers serving a customer with the various systems of care.
 - b. Service differences that cannot be resolved at the line worker level are first directed to the line worker's supervisor, who will then contact the corresponding supervisor to discuss the problem.
 - c. Disagreements that cannot be resolved at the supervisory level are referred to the section or program manager, who will then contact the corresponding section or program manager to discuss the problem.

d. Final resolution of unresolved issues will be managed between the directors of the respective agencies.

3. Concerns of customers:

- a. Unresolved complaints and grievances from customers or providers regarding access, level of care decisions or provision of services will follow existing grievance, appeal and recipient rights procedures as applicable to each service system.
- b. Customers of FIA services may contact their worker for assistance in resolving the issues and/or to request an administrative hearing.
- c. Customers of Substance Abuse Services will follow the Patient's Rights procedures for assistance in resolving alleged violation of legal rights.

SPECIFIC PARAMATERS OF THIS AGREEMENT

This agreement is in effect until September 30, 2002. If any party desires a modification or change in procedure and/or basic programming structure, a written statement to this effect is to be sent to the directors of the other agencies. Any amendment, modification or revision must be approved by all three parties: FIA, SCDPH and BASACA.

Longino C. Gonzales, Director, Saginaw FIA	Date
John Niederhauser, Health Officer, Saginaw DPH	Date
Dr. Cheryl Pletenberg, Director, BASACA	Date

BARAGA COUNTY SUBSTANCE ABUSE/CHILD WELFARE PROTOCOL

Collaborative Agreement between Court Systems, Tribal Entities, Coordinating Agency and Substance Abuse Providers, Community Mental Health Systems, Baraga County Shelter Home, Child and Family Services, WUP-District Health Department, CC-HSCB and the Baraga County FIA

PURPOSE:

To ensure Child Safety and Well-being through effective substance abuse treatment for mutual customers of Baraga County Court Systems, Tribal Entities, Community Mental Health Systems, Coordinating Agency and Local Substance Abuse, Baraga County Shelter Home, Child and Family Services and the Family Independence Agency.

GOALS:

- To maintain effective communication¹, while meeting all federal 42 CFR Part 2 regulations and HIPAA requirements.
- To enhance service delivery for individuals and families
- To provide training and continuing education opportunities for staff
- To allow for regularly scheduled meetings to address issues/concerns of all parties
- To identify and address gaps in service delivery

REFERRAL PROCESS:

A referral process will be developed in conjunction with all parties to ensure the availability of services and to determine a realistic expectation of service delivery response and to determine reporting elements.

REPORTING/CONFIDENTIALITY:

Specific guidelines for sharing information will be developed, in accordance with State and Federal requirements for confidentiality/HIPAA compliance (to include, but limited to, MH Code, Child Welfare policy, Tribal Codes, and 42 CFR Part 2 regulations) to assure the safety and well-being of children through effective service delivery.

CONTINUING EDUCATION:

Within the first six months of this protocol being signed, a joint orientation will be organized and provided for individual agency staff and substance abuse providers to discuss the referral process, reporting process and confidentiality/HIPAA guidelines, as well as, the continuing education planning process. Thereafter, protocol members will meet a minimum of two times per year to review and discuss relative issues or areas of concern, and to address any gaps in services. Annual training will be organized and offered to protocol members to address needs, changes in laws or procedures, and pertinent current practices.

CONFLICT RESOLUTION:

This group will act in concert with agencies or providers in addressing complaints regarding substance abuse/child welfare issues that cannot be resolved at the agency or provider level. It is the intent of this partnership to resolve disputes at the level closest to the onset of the concern, following federal 42 CFR Part 2 regulations and HIPAA requirements. If concerns arise that cannot be resolved at the worker or middle management level, the directors of the respective agencies will meet to review and resolve any issues.

¹ Reference: Interagency Communication Protocol Document

Page 2
Baraga County Substance Abuse/Child Welfare Protocol Signature Page

BARAGA COUNTY FAMILY COURT _____ Date

BARAGA COUNTY SHELTER HOME _____ Date

CHILD AND FAMILY SERVICES _____ Date

COPPER COUNTY MENTAL HEALTH _____ Date

FAMILY INDEPENDENCE AGENCY _____ Date

KBIC-DSS _____ Date

KBIC-SAP _____ Date

KBIC-TRIBAL COURT _____ Date

WUPSAS-CA.INC. _____ Date

WUP-DHD _____ Date

COPPER COUNTRY-HSCB _____ Date

May 2004

***SUBSTANCE ABUSE/CHILD WELFARE/COURTS
BARAGA COUNTY WORKGROUP
BASIC TENETS***

Neglect and abuse of children is frequently associated with substance abuse and addiction. Loss of custody and possible termination of rights often is critical to bringing the parent into treatment.

Safety of children must always be assured.

The first focus of services to the parent must be assessment and treatment of the addiction, as we know that other behaviors and needs are rooted in it.

A drug/substance free, supportive living environment is critical to successful recovery.

Addiction is a disease. We acknowledge that relapse may occur and that this will require modified and/or intensified services.

No single agency contains all the resources and expertise to fully respond to the needs of the parent who is addicted and who has abused and/or neglected his/her children.

We will consult on decisions with each other and with the parents to develop and implement plans that meet family member needs to the best of our agencies' resource capabilities.

We will modify policies and procedures that impede the family's cooperation with all service providers.

We will adopt creative approaches to building family support systems, improving parenting skills, meeting child-care needs and filling gaps in service.

Our objective is reunification of the family as quickly as the children's protection can be assured. A child deserves a safe and permanent home. If the parent does not achieve recovery, consideration will be given to filing for permanent custody.

December 2003

Screening instruments for alcohol or other drug involvement (For child welfare workers):

1. CAGE (amended for drug use):

- C** Have you ever felt the need to **cut** down on your drinking or drug use?
- A** Have you ever felt **annoyed** by people criticizing your drinking or drug use?
- G** Have you ever felt bad or **guilty** about your drinking or drug use?
- E** Have you ever had a drink or used a drug first thing in the morning to steady your nerves or get rid of a hangover? (**Eye-opener.**)

Scoring: if the answer is “yes” to one or more questions, the parent should receive a formal alcohol and drug assessment. “Yes” to one or two questions may indicate alcohol and drug related problems. “Yes” to three or four questions may indicate alcohol or drug dependence (addiction).

2. TWEAK (designed for detecting drinking in pregnant women):

<i>TWEAK QUESTIONS</i>		<i>score</i>
T	Tolerance: How many drinks can you hold without falling asleep or passing out?	2 points -- if can hold 5 drinks
W	Have close friends or relatives Worried or complained about your drinking in the past year?	2 points – if yes
E	Eye-Opener: Do you sometimes take a drink in the morning when you first wake?	1 point – if yes
A	Amnesia: Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?	1 point – if yes
K (C)	Do you sometimes feel the need to Cut down on your drinking?	1 point – if yes
Scoring: Alcohol is likely to be a problem with a score of 2 or more.		

Source: Russell, 1994. ^{xv}

Screening instrument for risk of abuse or neglect of children (for use with substance using parent). Designed for Substance Abuse providers:

<i>Screening Questions</i>	<i>Indicators for Concern and Referral</i>
1. Number of children _____	1. Parent may appear overwhelmed or unable to provide for basic needs or demonstrate consistent parenting
2. Ages of children _____	2. Red flag: Any children under the age of six.
3. Where are children living?	3. Red flag: Children living part-time or full time with substance abusing parent.
4. Who cares for your children when you are using or looking for drugs?	4. Red flags: Children younger than 12 years old left alone. Children present when parent uses. Children left with partner when parent seeks drugs. Children taken with parent who is seeking drugs or partying.
5. Have you had child protective services (CPS) involved in your life? In the past? Currently?	5. Red flag: If CPS was ever involved. Note: If CPS is currently involved and the children may be at risk as a result of behaviors connected with alcohol or drug use by the parent (or parent’s partner) a report should be made.

SCREENING TOOL FOR DOMESTIC VIOLENCE

Sample questions include:

- Has anyone else in the family been hurt or assaulted?
- Has anyone made threats to hurt or kill another family member or himself?
- Have weapons been used to threaten or harm anyone?
- Have the police ever been called to the house? Have arrests been made?
- Has the batterer threatened to leave with the children?
- Has any family member stalked another family member?
- Has anyone taken a family member hostage?

DANGER ASSESSMENT

Jacquelyn C. Campbell, Ph.D., R.N.

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Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We cannot predict what will happen in our case, but we would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the last year when you were abused by your partner or ex-partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones
4. Threat to use weapon; head injury, internal injury, permanent injury
5. Use of weapon; wounds from weapon

(If any of the descriptions for the higher number apply, use the higher number.)

Mark Yes or No for each of the following. ("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

- ___ 1. Has the physical violence increased in severity or frequency over the past year?
- ___ 2. Does he own a gun?
- ___ 3. Have you left him after living together during the last year?
3a. If you have *never* lived with him, check here: ___
- ___ 4. Is he unemployed?
- ___ 5. Has he ever used a weapon against you or threatened you with a lethal weapon?
If yes, was the weapon a gun? ___
- ___ 6. Does he threaten to kill you?
- ___ 7. Has he avoided being arrested for domestic violence?
- ___ 8. Do you have a child that is not his?
- ___ 9. Has he ever forced you to have sex when you did not wish to do so?
- ___ 10. Does he ever try to choke you?
- ___ 11. Does he use illegal drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, crack, street drugs or mixtures?
- ___ 12. Is he an alcoholic or problem drinker?
- ___ 13. Does he control most or all of your daily activities? For instance: does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car? (If he tries, but you do not let him, check here: ___)
- ___ 14. Is he violently and constantly jealous of you? (For instance, does he say, "If I can't have you, no one can.")
- ___ 15. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: ___)
- ___ 16. Have you ever threatened or tried to commit suicide?
- ___ 17. Has he ever threatened to tried to commit suicide?
- ___ 18. Does he threaten to harm your children?
- ___ 19. Do you believe he is capable of killing you?
- ___ 20. Does he follow or spy on you, leave threatening notes or messages on answering machines, destroy you property, or call you when you don't want him to?

___ Total "Yes" answers

Thank you. Please talk to your nurse, advocate, or counselor about what the Danger Assessment means in terms of your situation.

APPENDIX V: Collaborative Capacity Inventory goes here – 13 pp

Download from:

http://www.cffutures.com/Children_Family_Policy/CW/EPSCG/Collaborative_Capacity_Instrument.pdf

Endnotes:

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